# Health Freedom

A 50-State Freedom Index of Health and Healthcare

# Advanced Release

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## ABSTRACT

The Health Freedom Index is a comparative assessment of the legal, regulatory, and policy environments governing healthcare across the United States. The index compiles state-level data on the degree of choice and freedom available to patients, healthcare professionals, insurers, and entrepreneurs. Individual measures are organized into five policy domains, which are combined to produce category scores for each state, as well as an overall Health Freedom score for each state. This allows readers to compare states across a wide range of healthcare issues, identify areas of relative openness or restriction, and generate ideas for legislative opportunities. In addition to providing state rankings, the project aims to promote transparency and informed discussion about the role of freedom, voluntary exchange, and institutional design in American healthcare.



JEL codes: I100, I110, I180, H7

Keywords: health, healthcare, state policy, regulation, health professional, hospital, physician, medicine, nurse practitioner, midwifery, telemedicine, licensing, insurance, certificate-of-need

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The Center for Modem Health and the Knee Regulatory Research Center also gratefully acknowledge the Mercatus Center at George Mason University and the authors of the previous Healthcare Openness and Accessibility Project (HOAP) reports. In many ways, HOAP served as the inspiration and model for this index, and this publication is a continuation of that work.





Release: August 2026
Please note that the scores in this index reflect state law as of June 2026, or, where June 2026 was unavailable, the most recent available data.






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# EXECUTIVE SUMMARY

The Health Freedom Index is a 50-state assessment of the legal and regulatory environment governing health and healthcare in the United States. Building on the earlier Healthcare Openness and Access Project published by the Mercatus Center, this report expands the scope of analysis to 54 policy variables across five broad domains: Professional Freedom, Institutional Freedom, Patient Freedom, Payment Freedom, and Delivery Freedom. Together, these categories provide a comparative picture of how much freedom patients, healthcare professionals, insurers, entrepreneurs, and institutions have to make voluntary healthcare decisions within each state.

The premise of the index is simple: many of the most important barriers to healthcare choice are created at the state level. State laws shape who may provide care, what services they may offer, how care may be organized, what payment arrangements are allowed, and which treatment options patients may access. These rules affect not only traditional healthcare institutions, but also emerging models such as direct primary care, telehealth, telepharmacy, mutual aid arrangements, right-to-try treatments, and other alternatives to the status quo.

Each variable in the index is scored on a freedom-oriented scale from 1 to 5, with higher scores indicating a less restrictive policy environment. The variables are then grouped into five category scores and combined into an overall Health Freedom score for each state and the District of Columbia. The index is unweighted, meaning each variable receives equal treatment. This choice avoids imposing assumptions about which policies matter most and allows readers to use the underlying data to conduct their own analyses with their own weighting choices.

In the 2026 Health Freedom Index, Arizona ranks first overall, followed by Colorado, Idaho, North Dakota, and Utah. These states generally perform well across multiple categories, reflecting comparatively open environments for healthcare professionals, institutions, patients, payment arrangements, and delivery models. At the other end of the rankings are California, Rhode Island, New York, Massachusetts, and New Jersey, which tend to impose more extensive restrictions across the policy areas measured.

Several states show large changes compared with the most recent predecessor index from six years ago. New Hampshire and Florida each rose 26 places, while Arkansas and North Carolina rise 14 places. and Oklahoma rises 13 places. Other states move substantially downward: Michigan, Hawaii, Nebraska, Mississippi, Louisiana, and Pennsylvania. Because the Health Freedom Index significantly expands and updates the earlier HOAP framework, these changes should be interpreted as only approximate indicators rather than exact comparisons. Still, they highlight how state policy environments can shift meaningfully over time.

The Health Freedom Index is not a measure of healthcare quality, population health, affordability, or any other health outcome or economic goal. Nor should small differences in ranking be overinterpreted. States dose together in the rankings may not differ meaningfully. The greatest value of the index lies not merely in the overall ranking, but in the category and variable-level data that reveal each state's particular strengths and weaknesses.

Ultimately, this report is designed to be a conversation starter. I.e., a tool for those seeking to expand choice, competition, innovation, and voluntary exchange in American healthcare. By making state policy environments more transparent and comparable, we aim to support a more informed discussion about how states can remove unnecessary barriers and create more open healthcare systems.

This report and the associated data are available for download on both organization's websites.

Center for Modern Health: https://centerformodemhealth.org

Knee Regulatory Research Center: https://knee.wvu.edu

# INTRODUCTION & METHODOLOGY

The push for national healthcare reform has stalled in America, and most piecemeal policy reforms that have managed to get passed tend toward greater regulation and less choice for Americans. One reason for this is that reform efforts often fixate on grand federal programs to assure comprehensive coverage to various populations. This emphasis on insurance causes people to forget that health insurance is not the same as healthcare. It also causes some people to forget that much of healthcare is regulated at the state-level.

Market-oriented reformers can remind people that their insurance card can't heal them and that healthcare exists outside of the DC beltway. But an even better message is to show them a viable alternative to the ideal of comprehensive health insurance.

Indeed, even when alternative payment models are proposed, such as catastrophic insurance paired with Health Savings Accounts (HSAs) or direct primary care memberships, they face an uphill battle because they are all judged from the ideal of comprehensive health insurance. The way to introduce more choice is not by showing how new payment models can live up to the comprehensive ideal. It is to show how that very ideal is in fact not an ideal worth having, and to promote a new ideal to strive for.

Faith in the insurance-driven mindset, however, has started to crack. More and more both those who pay for healthcare and those who provide it are recognizing the value of shopping for healthcare. Liberating Americans from over-insurance frees them from medical bureaucracy, allowing them to pursue their health in ways that meet their individual needs at a price that they can afford. Whether out of desperation or opportunity, Americans are more open to rethinking healthcare. They are looking for alternatives.

We already see this with the growth of direct primary care, with PBM disruptors such as Mark Cuban's Cost Plus Drugs and other direct-to-consumer models, and with more employers self-funding their health benefits. Yet at the same time, and often in the name of liberating the healthcare market, we see calls for breaking up vertically integrated healthcare corporations, adding even more regulations to prescription drug pricing, and tightening corporate practice of medicine laws.

Where there is opportunity, there is also risk. The risk with the nascent disruptions in healthcare is that it is still too reactive and therefore unprincipled. What is needed is a positive and principled alternative to show that more regulations, even in the name of moving away from comprehensive health insurance, would just move us from one regulated and top-down model to another. At the very least, people should be clear on what freedom is and is not, and adding more regulations in the name of freedom is a clear contradiction in terms.

But just having some new ideas about health reform is not enough. We need people—patients, employers, healthcare professionals, businessmen, legislators, and those who have made it their business to advance state policy to expand individual rights and freedom— to communicate and defend these ideas with clear principles in order to bring about change.

This effort requires data and a sense of what our starting points are with each state. This report is a tool to help people from all states understand how free their state is in healthcare right now. It enables them to compare their state to other states, and to gauge whether their state is becoming more or less free in healthcare over time. Armed with the information in this report, reformers can see where the opportunities for reform lie, make their case for change to legislators, and motivate themselves and their allies to move their state towards more health freedom.

**How the Index is Structured**

HFI indexes the health freedom for every State and the District of Columbia. It gives a rough measure of how free a particular state is in healthcare based on five categories of health freedom: (1) Professional Freedom, (2) Institutional Freedom, (3) Payment Freedom, (4) Delivery Freedom, and (5) Patient Freedom.

Each category is made up of many specific policy variables. There are 13 policy variables in the Professional Freedom category, 11 policy variables in the Payment Freedom category, and 10 policy variables in each of the other three categories. On each of these policy variables, each state is rated on a scale of 1 to 5, with 1 being the least free and 5 being the most free. Some variables have possible scores of 1, 2,3, 4, or 5. Other variables have fewer distinct possible scores, and so states are given possible scores of 1, 3, or 5. A few variables have just a simple 1 or 5 scoring mechanism.

Some variables reasonably could have been organized into categories differently. For example, we put the freedom for Medicaid providers to receive cash payment from Medicaid patients outside of the program under Payment Freedom, but it also could have been categorized under Professional Freedom or Patient Freedom. Because health freedoms themselves overlap, it is expected that the categories used to measure health freedom will overlap too. Such categories are supposed to capture the fact that there are important differences in areas of freedom, such as for professionals versus patients, even when those differences don't always separate cleanly.

**Using the Index**

The primary function of the Health Freedom Index is to identify opportunities to remove barriers to health freedom. Legislators can't work to remove barriers to health freedom if they don't know what the issues are. Leaming that a barrier to health freedom exists is valuable and the first step to removing it. Relatedly, the health freedom categories can also reveal structural barriers to reform. For example, lower Institutional and Payment Freedoms relative to Professional and Patient freedom might help explain why healthcare professionals and patients can't make more of the freedom they do have.

When interpreting the rankings, an important thing to keep in mind is that two states that might be close in their overall health freedom ranking might have different health freedom profiles in the sense that they might have very different scores from category to category. Likewise, two states might have a similar overall ranking even though one state is a story of wildly fluctuating extremes (e.g., many individual policy variable scores of 1 and many scores of 5) while another state is very middle-of-the-road with many scores of 3. These types of differences would not be visible in the overall ranking, but readers can look for them by exploring the category-level and variable-level scores.

Another function of the Health Freedom Index is to enable cross-state comparisons on new and often under-studied areas of healthcare. For some of the topics that we cover in this index, such as Certificate-of-Need and Telehealth, other think tanks and organizations have published specialized reports with state comparisons on these topics. But most of the topics we examine in this index do not have dedicated reports circulating out there. Bringing as many variables as possible together in one place helps to make broad state-wide comparisons possible.

A final function of this report is to assist in the tracking of health freedom efforts over time. Just as it is helpful to compare states on health freedom in the present, it is also valuable to compare a state with itself over time, so as to see improvements, declines, or the lack thereof. We can witness some states move “up" in the rankings while other states move “down." Tracking can provide motivation for organization and action. A decreasing ranking in health freedom can be used as a “wake-up call" for a state to rethink its approach to health policy, especially when related to other poor outcomes. An unchanged lower rank can be used to point out the need to shake up stagnation in policy efforts. An increasing ranking can in tum be used to galvanize continued support to push for policies that expand health freedom. Simply knowing whether your state's ranking in health freedom overall, a specific health freedom category, or policy variable, is decreasing, staying more or less the same, or increasing, is valuable. It is the first step to understanding such trends and directing it towards freedom.

Such data, and the awareness it provides, is the purpose of this report. Moreover, it is our intention that this report will serve as a foundation and a tool for those who advance health freedom in their state to build on and use to further their own ends. It is therefore our hope that the wider community of people who advance health freedom in their states will help us grow and improve this report.

## Limitations

There are, of course, some limitations to any state ranking exercise such as this. One limitation to note is that fine differences between states that are very close in rank are likely not statistically meaningful. In other words, the differences, say, between 3rd and 4th, or 29th and 30th, or 49th and 50th are not actually significant. What is significant, however, is the difference between states in the top, the middle, and the bottom of the rankings. In other words, two states that are separated by one or two places in rank probably do not have a meaningful difference in health freedom, but two states separated by many places in our index probably do have a meaningful difference in health freedom.

Finally, the policy variables in this index are unweighted. This is important. since a reasonable argument could be made that they should be weighted to get closer to the "true" overall health freedom of a given state. Undoubtedly there are differences between policy variables in their overall impact on health freedom, with some variables impacting it more (or less) than others. For simplicity, we avoided making these judgements for the reader. Rather, we invite readers and members of our wider community to use our data and index to run their own experiments and simulations with different weightings as they see fit and to report the results.

## STATE SCORES BY INDIVIDUAL POLICY VARIABLE

Due to space limitations, this printed report does not reproduce every state's score on each individual policy variable. Instead, the full dataset is available as a downloadable spreadsheet. That spreadsheet includes each state's score for every variable, along with category scores and overall scores, allowing readers to examine the data in greater detail, compare states across specific policy areas, and conduct their own analyses. Readers are encouraged to consult the spreadsheet when interpreting the rankings, since states with similar overall scores may differ substantially in their underlying policy profiles.

## STATE SCORES BY CATEGORY

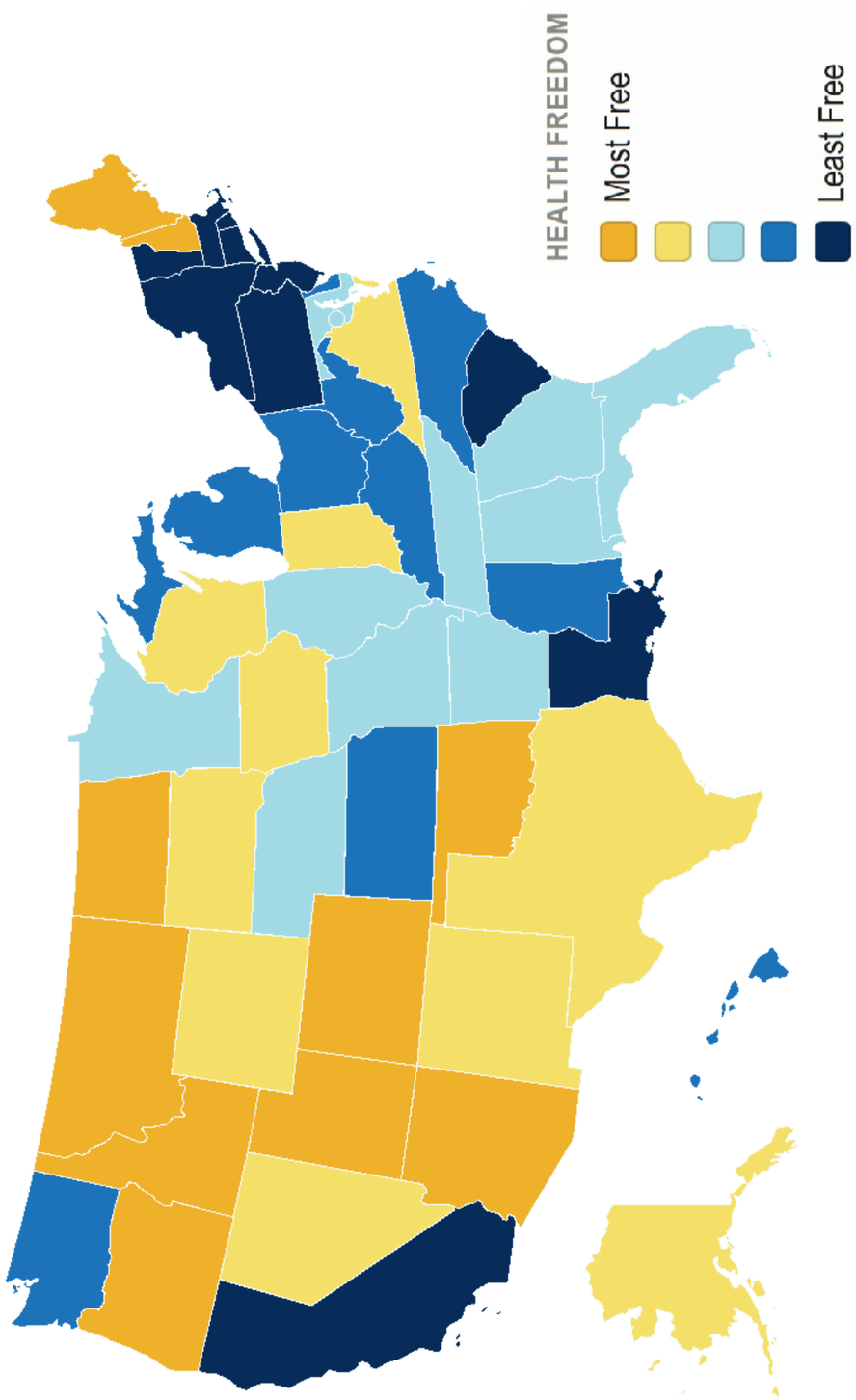
Below are the mean 2026 Health Freedom Index (HFI) state scores for each category.

| State | Professional Freedom | Institutional Freedom | Patient Freedom | Payment Freedom | Delivery Freedom | Total |
|---|---|---|---|---|---|---|
| Alabama | 2.9 | 3.3 | 2.6 | 3.5 | 4.1 | 16.4 |
| Alaska | 3.0 | 3.4 | 3.6 | 3.4 | 3.8 | 17.2 |
| Arizona | 3.5 | 4.4 | 3.7 | 3.4 | 4.1 | 19.0 |
| Arkansas | 2.9 | 3.4 | 3.2 | 2.8 | 4.1 | 16.4 |
| California | 2.5 | 2.6 | 3.7 | 1.8 | 3.5 | 14.1 |
| Colorado | 4.1 | 3.3 | 4.4 | 3.2 | 4.0 | 19.0 |
| Connecticut | 2.5 | 2.0 | 2.9 | 3.4 | 3.3 | 14.0 |
| Delaware | 3.5 | 3.2 | 3.1 | 2.9 | 2.9 | 15.6 |
| Florida | 3.1 | 3.8 | 2.7 | 3.2 | 3.7 | 16.5 |
| Georgia | 2.2 | 3.2 | 2.9 | 3.9 | 4.1 | 16.3 |
| Hawaii | 3.0 | 3.0 | 2.9 | 3.4 | 3.4 | 15.7 |
| Idaho | 3.9 | 3.9 | 2.8 | 3.5 | 4.7 | 18.8 |
| Illinois | 3.5 | 2.7 | 3.5 | 2.7 | 4.0 | 16.5 |
| Indiana | 3.5 | 2.6 | 3.3 | 3.5 | 3.6 | 16.5 |
| Iowa | 4.2 | 2.5 | 3.1 | 3.5 | 4.0 | 17.4 |
| Kansas | 3.3 | 3.3 | 2.4 | 3.2 | 3.6 | 15.8 |
| Kentucky | 3.0 | 3.2 | 2.3 | 3.5 | 3.8 | 15.8 |
| Louisiana | 3.4 | 3.1 | 2.3 | 2.8 | 3.4 | 15.0 |
| Maine | 3.2 | 3.3 | 3.5 | 3.3 | 4.4 | 17.6 |
| Maryland | 3.3 | 2.6 | 3.6 | 2.7 | 3.8 | 16.0 |
| Massachusetts | 2.5 | 1.8 | 3.1 | 2.6 | 3.4 | 13.4 |
| Michigan | 2.9 | 3.3 | 3.2 | 2.6 | 3.6 | 15.6 |
| Minnesota | 3.7 | 2.5 | 3.2 | 2.8 | 4.0 | 16.2 |
| Mississippi | 2.4 | 3.2 | 2.9 | 3.6 | 3.4 | 15.5 |
| Missouri | 3.2 | 2.6 | 2.6 | 3.5 | 4.3 | 16.3 |
| Montana | 3.7 | 3.3 | 3.5 | 3.3 | 3.9 | 17.7 |
| Nebraska | 3.1 | 3.6 | 2.6 | 3.0 | 3.8 | 16.1 |
| Nevada | 3.0 | 3.7 | 3.5 | 3.4 | 3.6 | 17.2 |
| New Hampshire | 3.3 | 4.1 | 3.2 | 3.2 | 3.9 | 17.7 |
| New Jersey | 2.3 | 2.7 | 3.5 | 2.4 | 2.3 | 13.2 |
| New Mexico | 3.7 | 2.9 | 3.8 | 2.7 | 3.5 | 16.6 |
| New York | 2.2 | 2.4 | 3.5 | 2.5 | 3.1 | 13.8 |
| North Carolina | 2.5 | 3.1 | 3.3 | 3.2 | 3.9 | 15.9 |
| North Dakota | 3.2 | 4.1 | 2.3 | 3.3 | 5.0 | 17.9 |
| Ohio | 2.5 | 3.5 | 2.2 | 3.5 | 3.9 | 15.6 |
| Oklahoma | 3.2 | 3.7 | 2.8 | 3.9 | 3.9 | 17.5 |
| Oregon | 3.5 | 2.3 | 4.0 | 3.1 | 4.5 | 17.4 |
| Pennsylvania | 2.5 | 3.0 | 2.5 | 3.3 | 3.4 | 14.6 |
| Rhode Island | 2.9 | 2.1 | 2.7 | 2.8 | 3.3 | 13.8 |
| South Carolina | 2.0 | 3.1 | 3.5 | 3.3 | 2.7 | 14.6 |
| South Dakota | 3.5 | 3.9 | 2.5 | 3.3 | 4.1 | 17.3 |
| Tennessee | 3.2 | 2.9 | 3.0 | 3.3 | 3.8 | 16.1 |
| Texas | 3.1 | 3.9 | 2.4 | 3.3 | 4.1 | 16.7 |
| Utah | 3.9 | 3.6 | 2.8 | 3.3 | 4.2 | 17.8 |
| Vermont | 3.0 | 2.1 | 3.6 | 1.8 | 4.0 | 14.5 |
| Virginia | 2.8 | 4.1 | 3.5 | 2.9 | 3.9 | 17.2 |
| Washington | 3.2 | 2.3 | 3.3 | 2.9 | 4.0 | 15.7 |
| West Virginia | 3.0 | 2.8 | 3.0 | 2.5 | 3.7 | 15.0 |
| Wisconsin | 3.7 | 3.3 | 2.6 | 3.3 | 3.8 | 16.7 |
| Wyoming | 3.4 | 3.7 | 2.5 | 3.6 | 3.4 | 16.6 |
| District of Columbia | 3.4 | 2.6 | 3.4 | 3.0 | 4.0 | 16.4 |

# OVERALL STATE RANKINGS

Below are the 2026 Health Freedom Index (HFI) rankings, along with the rankings from the most recent predecessor index (the Healthcare Openness and Access Project from 2020), and the delta between the old and the new rankings.

| State | HFI 2026 | HOAP 2020 | Change |
|---|---|---|---|
| Arizona | 1 | 2 | 1 |
| Colorado | 2 | 1 | -1 |
| Idaho | 3 | 5 | 2 |
| North Dakota | 4 | 8 | 4 |
| Utah | 5 | 3 | -2 |
| New Hampshire | 6 | 32 | 26 |
| Montana | 7 | 7 | 0 |
| Maine | 8 | 18 | 10 |
| Oklahoma | 9 | 22 | 13 |
| Oregon | 10 | 6 | -4 |
| Iowa | 11 | 16 | 5 |
| South Dakota | 12 | 4 | -8 |
| Alaska | 13 | 14 | 1 |
| Nevada | 13 | 15 | 2 |
| Virginia | 15 | 18 | 3 |
| Texas | 16 | 27 | 11 |
| Wisconsin | 17 | 10 | -7 |
| Wyoming | 18 | 13 | -5 |
| New Mexico | 19 | 21 | 2 |
| Indiana | 20 | 16 | -4 |
| Florida | 21 | 47 | 26 |
| Illinois | 22 | 29 | 7 |
| Georgia | 23 | 25 | 2 |
| Alabama | 24 | 35 | 11 |
| District of Columbia | 25 | 23 | -2 |
| Arkansas | 26 | 40 | 14 |
| Missouri | 27 | 20 | -7 |
| Minnesota | 28 | 34 | 6 |
| Tennessee | 29 | 33 | 4 |
| Nebraska | 30 | 9 | -21 |
| Maryland | 31 | 26 | -5 |
| North Carolina | 32 | 46 | 14 |
| Kentucky | 33 | 44 | 11 |
| Kansas | 34 | 37 | 3 |
| Hawaii | 35 | 11 | -24 |
| Washington | 36 | 28 | -8 |
| Delaware | 37 | 41 | 4 |
| Ohio | 37 | 36 | -1 |
| Mississippi | 39 | 24 | -15 |
| Michigan | 40 | 12 | -28 |
| West Virginia | 41 | 38 | -3 |
| Louisiana | 42 | 30 | -12 |
| Pennsylvania | 43 | 31 | -12 |
| South Carolina | 44 | 39 | -5 |
| Vermont | 45 | 43 | -2 |
| Connecticut | 46 | 45 | -1 |
| California | 47 | 42 | -5 |
| Rhode Island | 48 | 48 | 0 |
| New York | 49 | 49 | 0 |
| Massachusetts | 50 | 50 | 0 |
| New Jersey | 51 | 51 | 0 |




# EXPLANATION OF CATEGORIES & VARIABLES

## PROFESSIONAL FREEDOM

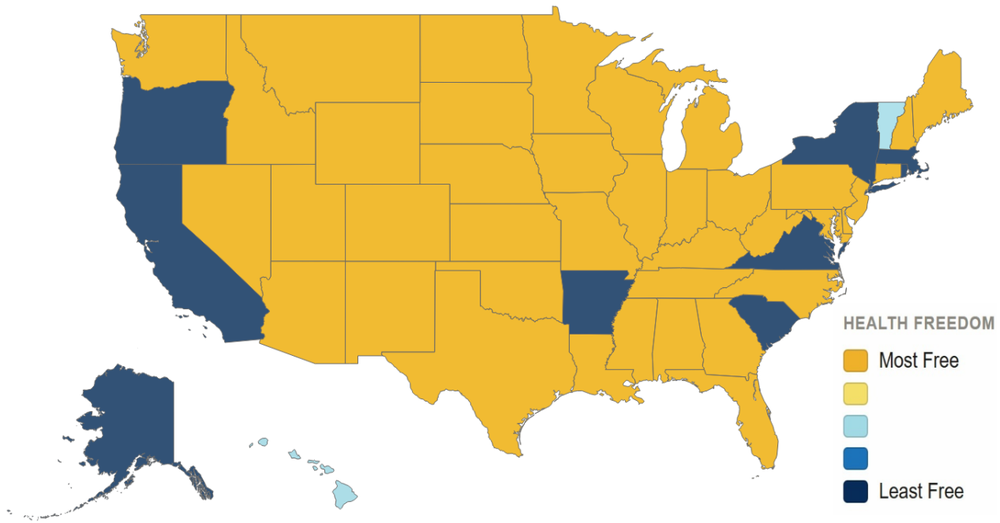
The Professional Freedom category examines the extent to which governments restrict the activities of healthcare professionals through licensing requirements, scope-of-practice rules, credentialing standards, and other forms of occupational regulation. These policies are often adopted with the stated goal of protecting patients or ensuring quality, but they also limit who may provide services, under what conditions, and by what methods.

From a freedom-oriented perspective, such restrictions deserve careful scrutiny because they constrain the ability of individuals to enter professions, develop innovative business models, and voluntarily contract with willing patients. While some regulations are intended to reduce risk or establish minimum standards, they can also create barriers to competition, reduce access to care, and inhibit experimentation with new approaches. Moreover, regulatory systems frequently produce unintended effects that prompt calls for additional rules, creating a cycle of intervention that can further limit professional autonomy and patient choice. States that impose fewer unnecessary restrictions on healthcare professionals received higher scores in this section.

## 1. State allows medical license portability

Medical license portability refers to the extent to which physicians who are licensed in one state can practice in another state without obtaining a completely separate license or navigating burdensome regulatory barriers. States that recognize out-of-state licenses, participate in interstate licensure compacts, or otherwise streamline cross-state practice allow physicians greater freedom to offer their services and patients greater freedom to access care from providers of their choice. License portability can increase competition, expand access to medical expertise, and facilitate new modalities such as telemedicine. Conversely, states that require physicians to obtain separate licenses through lengthy, costly, or duplicative processes restrict the voluntary exchange of medical services and limit both provider and patient choice.

This variable is scored on a scale of 1/3/5. States that have no medical license portability received a score of 1. States that have limited license portability received a score of 3. States that have full medical license portability received a score of 5.

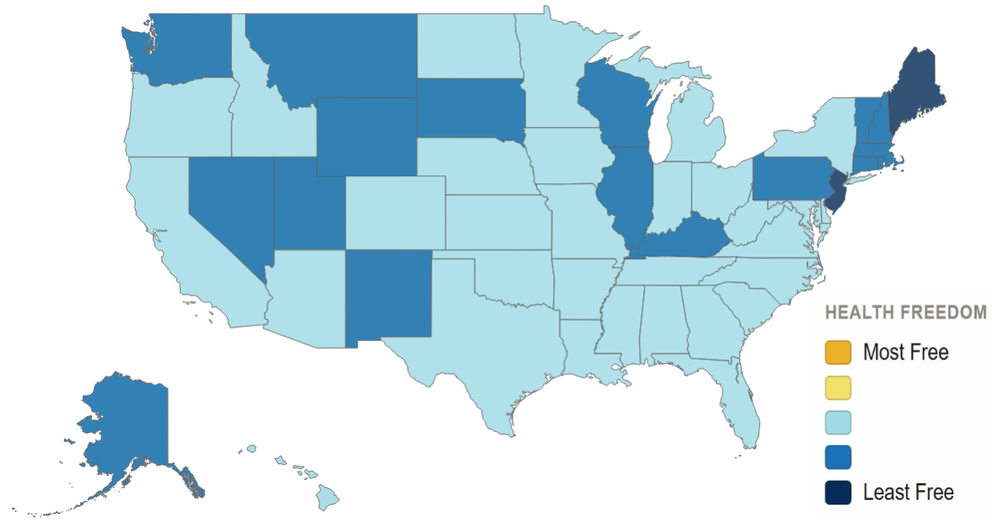





## 2. State requires less postgraduate training for U.S. medical graduates

States vary in the amount of postgraduate medical training, commonly referred to as residency training, that physicians must complete before they are eligible for an unrestricted medical license. States that require fewer years of postgraduate training allow qualified medical graduates to enter independent practice sooner, increasing professional autonomy and reducing barriers to workforce participation. Lower training requirements may also expand the supply of physicians and improve access to care, particularly in underserved areas. By contrast. states that require additional years of training impose a higher regulatory threshold before physicians may fully exercise their profession, limiting entry into practice and reducing the freedom of both providers and patients to engage in voluntary healthcare arrangements.

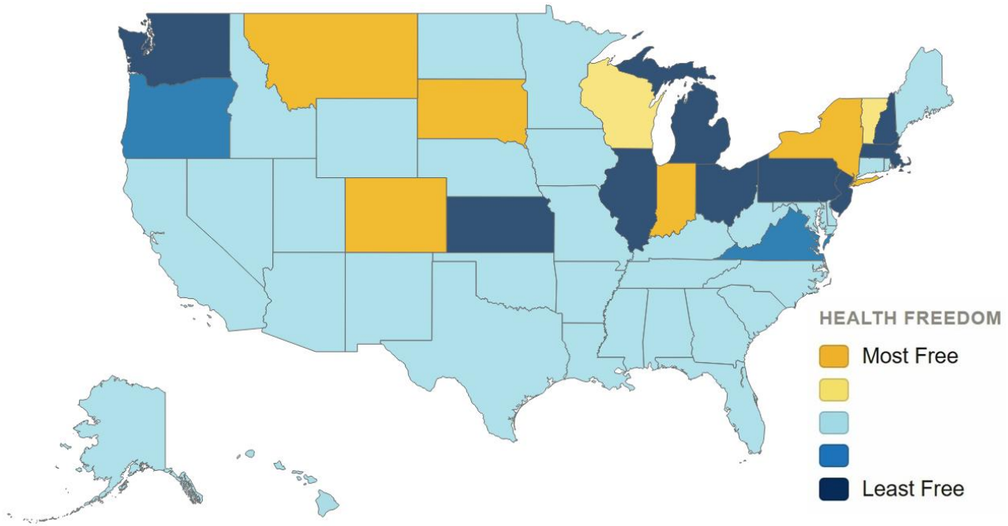
This variable is scored on a scale of 1-5. States that require at least 3 years of postgraduate training for U.S. medical graduates received a score of 1. A requirement of at least 2 years of training yielded a score of 2. A requirement of at least 1 year of training yielded a score of 3. A requirement of at least 6 months of training yielded a score of 4. No requirement for postgraduate training (i.e., U.S. medical graduates could apply for a general practitioner's license right away) yielded a score of 5.



## 3. State has fewer continuing medical education requirements

Continuing medical education (CME) requirements mandate that licensed physicians complete a specified number of educational hours or activities in order to maintain their medical licenses. States with fewer CME requirements impose a lower ongoing regulatory burden on practicing physicians, allowing them greater discretion in determining how best to maintain and update their professional knowledge and skills. Conversely, states with more extensive CME requirements require physicians to devote additional time and resources to state-prescribed educational activities, thereby increasing regulatory oversight of the profession and reducing professional autonomy.

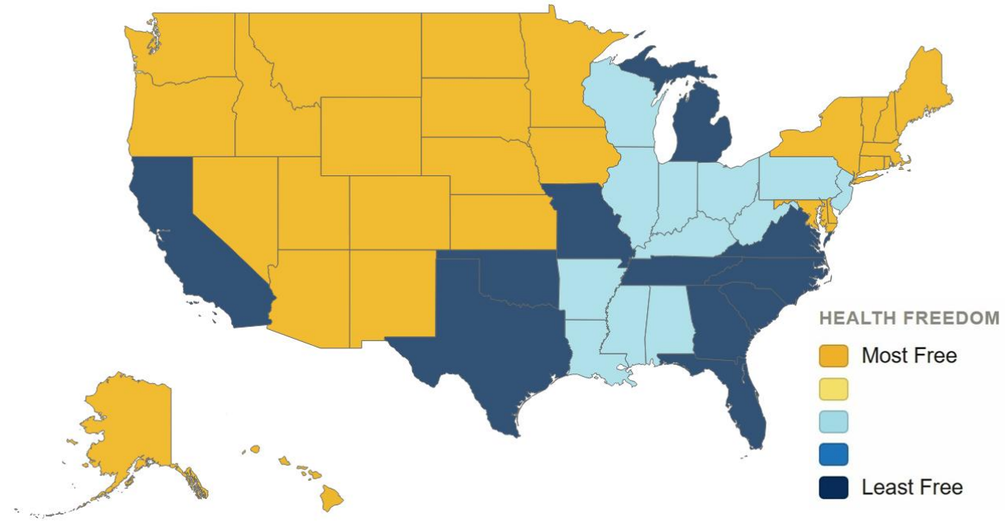
This variable is scored on a scale of 1-5. States that require at least 40 or more hours of CME per year received a score of 1. A requirement of 30-39 hours yielded a score of 2. A requirement of 20-29 hours yielded a score of 3. A requirement of 1-19 hours yielded a score of 4. No CME requirement yielded a score of 5.




## 4. State grants nurse practitioners broad scope of practice

Scope-of-practice laws determine the range of healthcare services that nurse practitioners (NPs) may provide and the degree to which they must be supervised by or collaborate with physicians. States that grant nurse practitioners broad scope of practice permit them to diagnose patients, prescribe medications, and provide care independently or with minimal regulatory restrictions. Greater practice authority expands professional freedom, increases the supply of healthcare services, and gives patients more options for obtaining care. Conversely, states that impose extensive supervision, collaboration, or practice restrictions limit the ability of nurse practitioners to fully utilize their training and expertise, reducing provider autonomy and restricting patient choice in the healthcare marketplace.

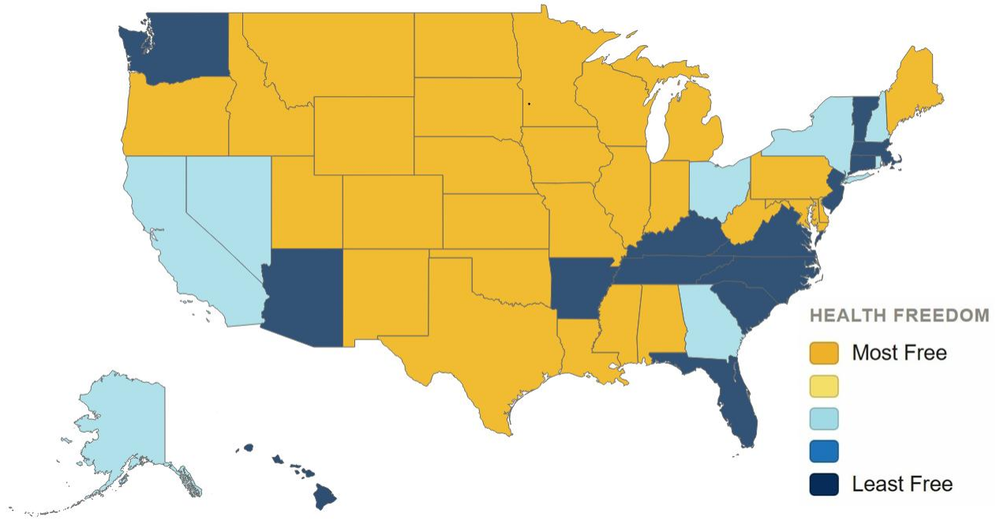
This variable is scored on a scale of 1/3/5. States that have what is generally regarded as a “restricted” scope of practice for NPs received a score of 1. States that have what is generally regarded as a “reduced” scope of practice received a score of 3. States that have “full” scope of practice received a score of 5.



## 5. State has fewer optician licensing requirements

Optician licensing requirements govern the qualifications individuals must obtain before they are permitted to fit, dispense, or adjust eyeglasses and contact lenses. States that impose lower barriers to entry into the profession make it easier for qualified individuals to offer optical services, increasing consumer access to vision care, promoting competition, and expanding employment opportunities. Conversely, states with more extensive licensing requirements limit entry into the profession through additional mandates on experience, thereby restricting occupational freedom and reducing the range of choices available to consumers.

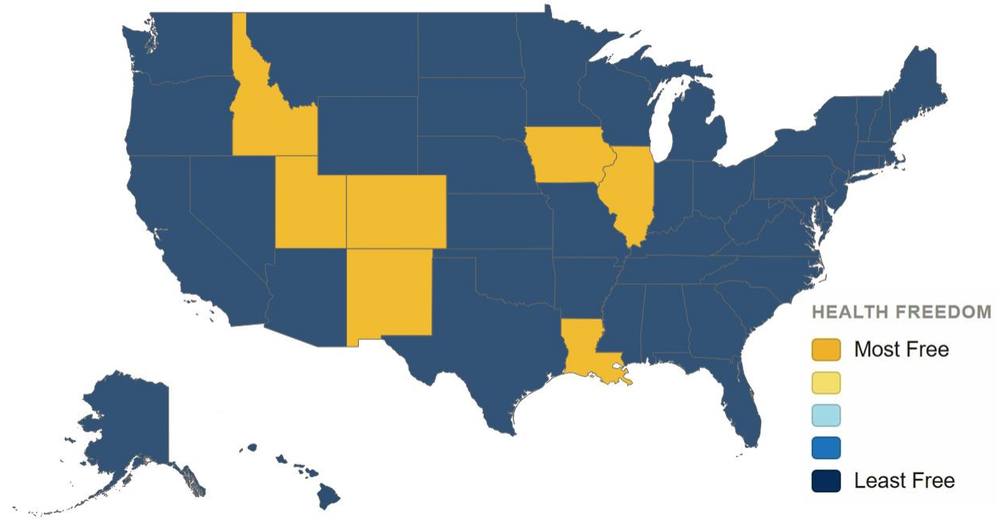
This variable is scored on a scale of 1/3/5. States that require more than 4,000 hours of experience between training and apprenticeship received a score of 1. States that require up to 4,000 hours of experience received a score of 3. States that do not mandate a minimum number of hours of experience for opticians received a score of 5.




## 6. State grants psychologists prescriptive authority

States differ in whether they allow trained psychologists to prescribe psychotropic medications, such as antidepressants, anxiolytics, and mood stabilizers. In most states, prescribing authority is limited to physicians and certain other healthcare professionals, while a small number of states permit psychologists who have completed additional education and training to prescribe medications, which helps to address needs related to mental health. Such flexibility may be particularly valuable in underserved areas where access to psychiatrists is limited.

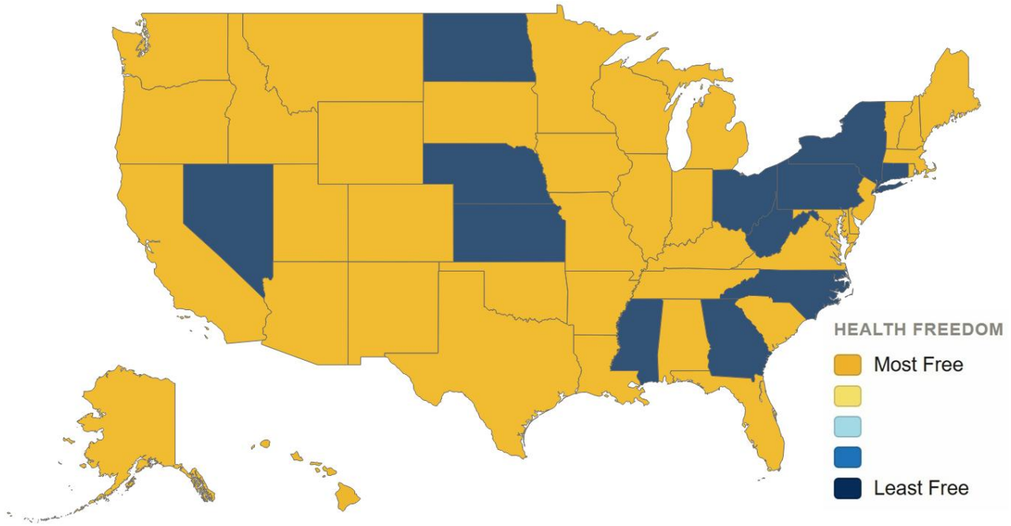
This variable is scored on a scale of 1/5. States that do not grant prescriptive authority to psychologists received a score of 1. States that do grant prescriptive authority to psychologists received a score of 5.



## 7. State allows midwives broad scope of practice

Regulations for midwives determine the ease with which individuals may enter the profession of midwifery, which provides women with prenatal care, labor and delivery, and postpartum support. States that allow these professionals to enter midwifery directly increase provider choice and flexibility, and can improve access to services, particularly in areas with shortages of obstetric providers. By contrast, states with more restrictive rules require that midwives become licensed and/or work under close physician supervision, thereby limiting midwives' independence and reducing options available to patients.

This variable is scored on a scale of 1/5. States that require licensing for midwifery received a score of 1. States that allow direct-entry midwifery received a score of 5.

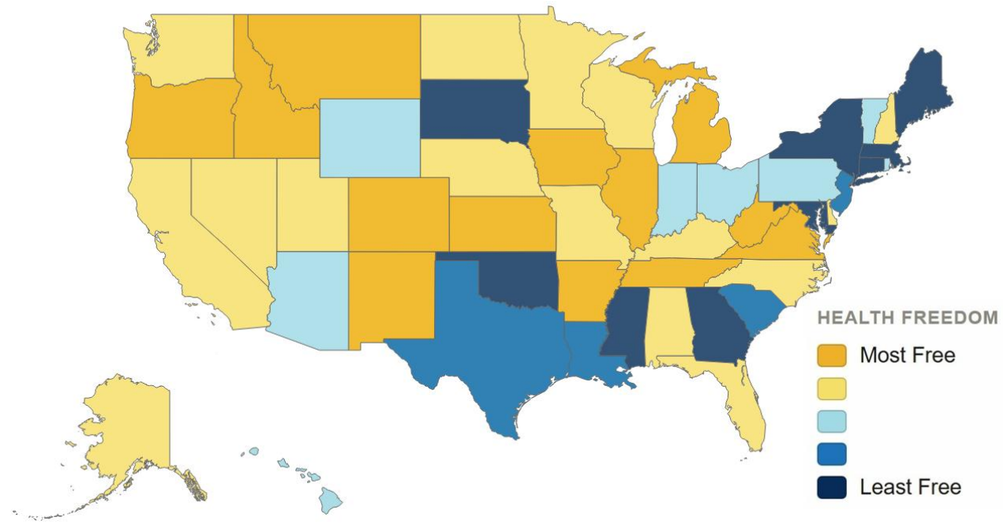





## 8. State grants pharmacists broad scope of practice

Scope-of-practice laws determine the range of healthcare services that pharmacists may provide beyond the traditional role of dispensing medications. States that grant pharmacists broad scope of practice allow them to perform services such as administering vaccines, prescribing certain medications, ordering and interpreting tests, and managing drug therapy with minimal regulatory barriers. Expanded practice authority gives pharmacists greater professional autonomy, increases the availability of healthcare services, and provides patients with additional avenues for accessing care. Conversely, states that impose more restrictive scope-of-practice rules limit the services pharmacists may offer and often require additional approvals or supervision, thereby constraining professional freedom and reducing consumer choice in the healthcare marketplace.

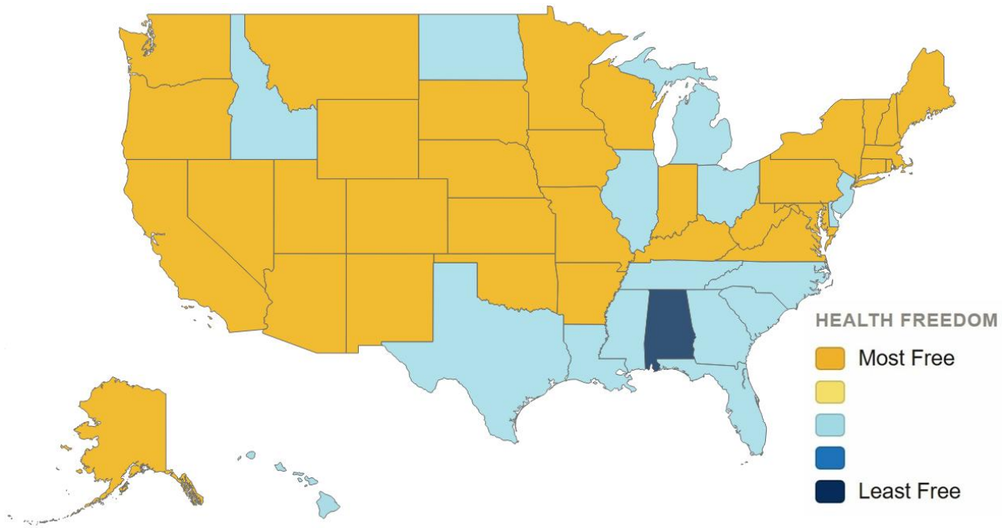
This variable is scored on a scale of 1-5. The National Association of Boards of Pharmacy Survey of Pharmacy have identified 9 indicators that are relevant for "independent pharmacy practice." States that get "Yes" on zero or one of these nine pharmacist prescribing independence indicators received a score of 1. States that get "Yes" on two or three of the indicators received a score of 2. States that get "Yes" on four or five indicators received a 3. States that get "Yes" on six or seven indicators received a 4. States that get "Yes" on eight or nine indicators received a 5.



## 9. State grants dental hygienists broad scope of practice

Scope-of-practice laws for dental hygienists determine the range of preventive and therapeutic dental services they may provide and the degree of supervision required from a dentist. States that grant dental hygienists broad scope of practice allow them to perform a wider array of services and, in some cases, practice with reduced supervision or in independent settings. Greater practice authority expands professional freedom, increases the supply of oral healthcare services, and can improve access to care, particularly in underserved communities. By contrast. states that impose stricter supervision requirements or limit the services dental hygienists may provide restrict occupational autonomy and reduce the number of options available to patients seeking routine dental care.

This variable is scored on a scale of 1/3/5. States that require supervision with a dentist needing to be present received a score of 1. States that require general supervision by a dentist to authorize procedures but the dentist does not need to be present received a score of 3. States that allow direct access to dental hygienists, independent of a dentist, received a score of 5.



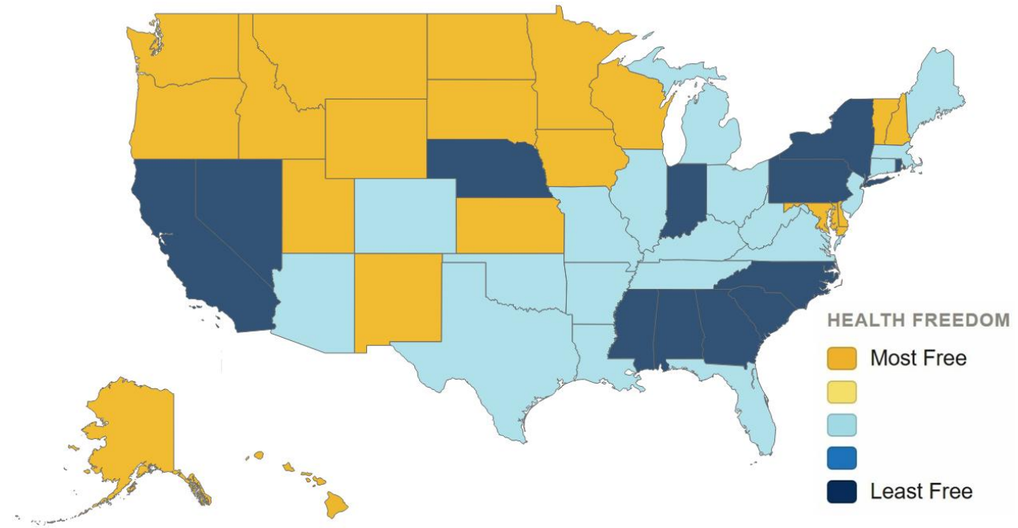





## 10. State has less restrictive prescriptive authority for certified registered nurse anesthetists

Certified Registered Nurse Anesthetists (CRNAs) are advanced practice registered nurses who provide anesthesia and related services in a variety of healthcare settings. CRNA prescriptive authority refers to their ability to prescribe medications, including controlled substances, outside of the immediate perioperative or surgical setting. (An example of a medication that a CRNA would prescribe independently is a medication to prevent or treat post-operative nausea and vomiting.) States differ in the extent to which CRNAs may do this. States with less restrictive requirements allow CRNAs greater professional autonomy and flexibility in delivering this kind of care. Conversely, states that impose more extensive supervision or practice restrictions limit the ability of CRNAs to fully utilize their training and expertise, reducing provider freedom and narrowing the range of available healthcare options for patients.

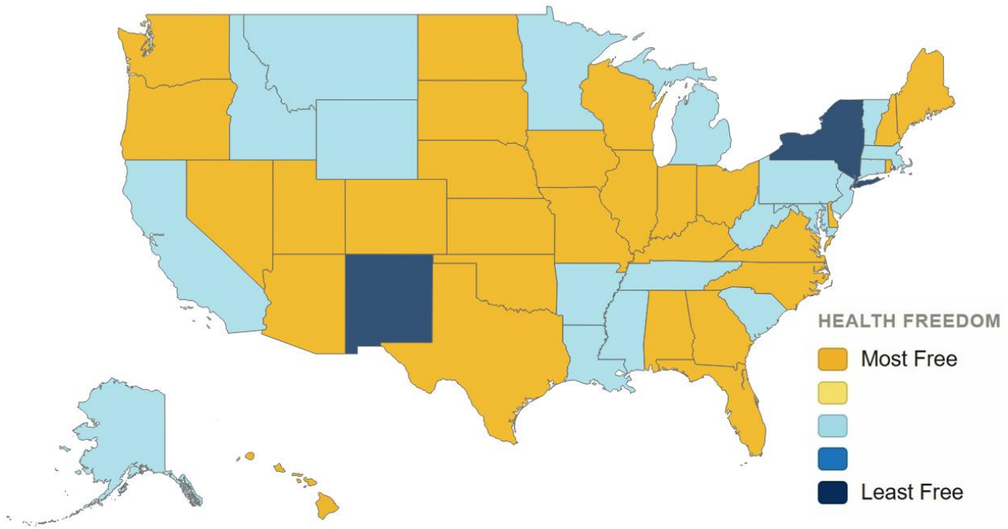
This variable is scored on a scale of 1/3/5. States that allow CRNAs no prescriptive authority received a score of 1. States that allow CRNAs limited prescriptive authority received a score of 3. States that allow CRNAs independent prescriptive authority received a score of 5.



## 11. State limits liability for charity caregivers

Liability laws are not anti-freedom, but in the context of charity care, the pro-freedom stance is not to have extensive liability protections that might discourage willing providers from offering services in the first place; the pro-freedom stance is to remove that potential barrier and let care be provided. Liability protections for charity caregivers limit the legal exposure of healthcare professionals who voluntarily provide medical services without compensation. States that offer broader protections reduce the risk that physicians, nurses, and other providers will face costly litigation for acts performed in the course of charitable care, provided they meet applicable standards of conduct

This variable is scored on a scale of 1/3/5. States that offer no legal protection for volunteer or charitable providers received a score of 1. States that offer moderate legal protection for volunteer or charitable providers received a score of 3. States that offer extensive legal protection for volunteer or charitable providers received a score of 5.

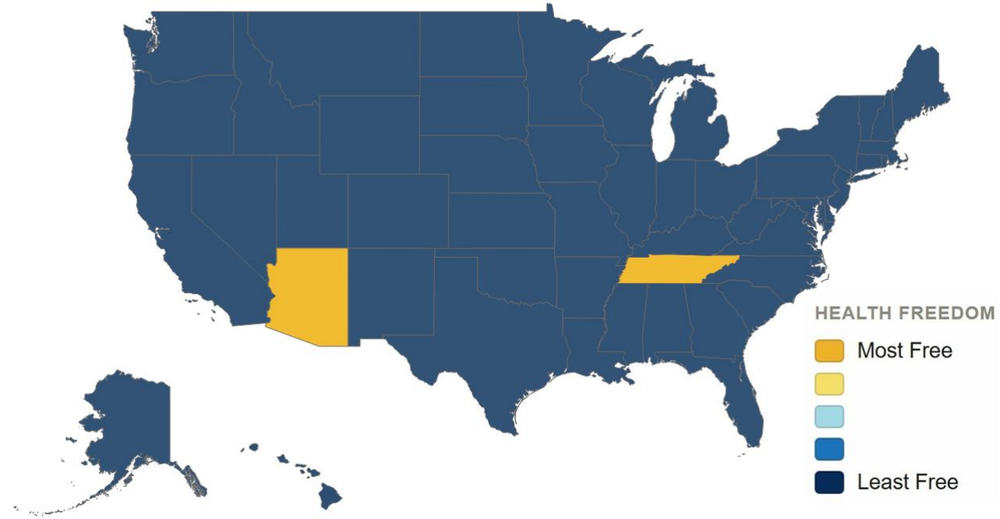





## 12. State recognizes off-label free speech in medicine

Off-label prescribing is when a physician uses an approved medication for a purpose, patient population, dosage, or treatment regimen that has not been specifically approved by the federal government While physicians generally retain broad authority to prescribe medications off-label states differ in the extent to which they protect communications about off-label uses and refrain from imposing additional restrictions on such practices. States that more fully recognize off-label free speech allow physicians, researchers, manufacturers, and other healthcare participants greater freedom to exchange truthful, non-misleading information about potential medical uses of approved products. From a healthcare freedom perspective, the open exchange of scientific and clinical information promotes professional judgment and medical innovation. States that impose greater restrictions on off-label communications limit the flow of information and reduce the scope for individualized medical decision-making.

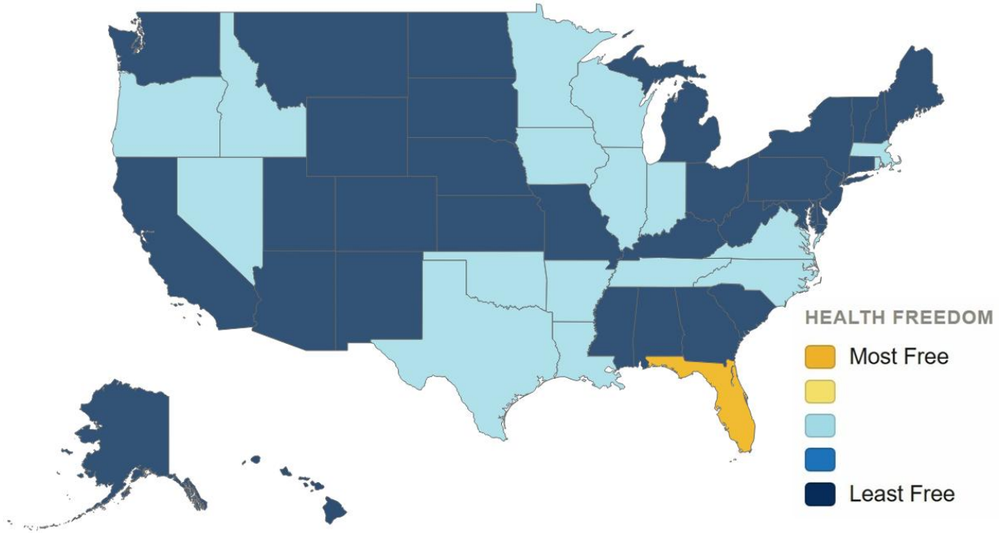
This variable is scored on a scale of 1/3/5. States that forbid truthful speech about off-label pharmaceutical use received a score of 1. States that have no law protecting truthful speech about off-label pharmaceutical use but have not taken legal action against anyone received a score of 3. States explicitly protect truthful speech about off-label pharmaceutical use received a score of 5.



## 13. State allows foreign-trained physicians to apply for a license without repeating residency training

Many states require physicians who completed their medical education and postgraduate training outside the United States to repeat some or all residency training before becoming eligible for a medical license, even when they have extensive clinical experience and qualifications from other countries. States that allow foreign-trained physicians to obtain licensure without repeating residency training recognize alternative pathways to demonstrating competence and reduce barriers to entering medical practice. In some states, this includes getting an offer of employment from an institution that is willing to supervise the foreign-trained physician for a period of time. Such policies expand professional opportunity, increase the supply of healthcare providers, and respect the rights of patients to see one of these physicians if they so choose. Conversely, states that require experienced foreign-trained physicians to repeat residency training violate the rights of those physicians to work for people who would otherwise be willing to hire them.

This variable is scored on a scale of 1/3/5. States that do not recognize residency training of foreign-trained physicians received a score of 1. States that allow licensure after a supervisory period or with other moderate limitations received a score of 3. States that allow foreign-trained physicians to apply for licensure directly received a score of 5.






# INSTITUTIONAL FREEDOM

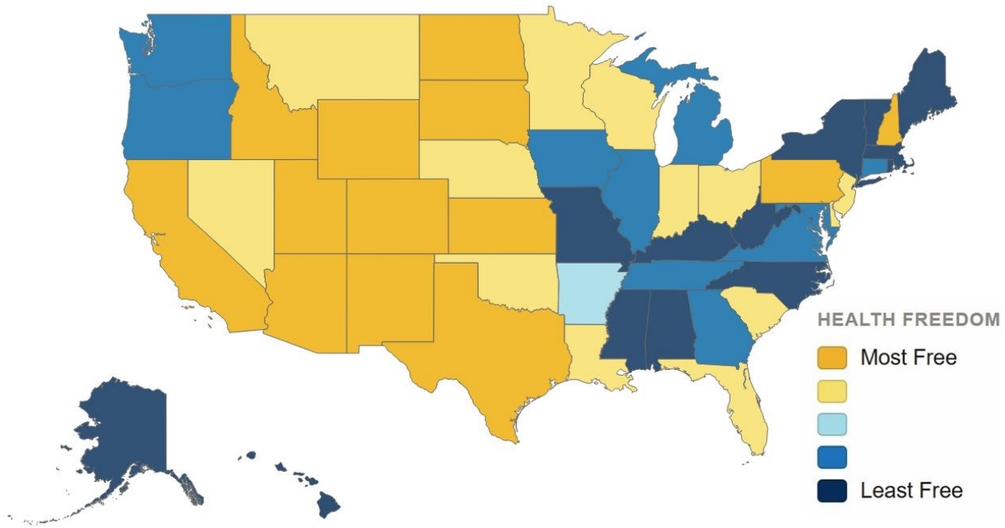
The Institutional Freedom category examines the extent to which governments restrict the organization, ownership, financing, and operation of healthcare institutions. This includes policies affecting hospitals, clinics, birth centers, pharmacies, insurers, mutual aid organizations, and other entities that deliver, finance, or support healthcare services. These regulations are often adopted to promote safety, accountability, or market stability, but they also influence which institutions may enter the market, how they may operate, and what forms of innovation are permitted.

From a freedom-oriented perspective, healthcare institutions should generally be free to organize themselves, attract investment, develop new business models, and respond to consumer demand without unnecessary regulatory interference. Restrictions on ownership structures, facility development, financing arrangements, and organizational design can limit entrepreneurship, reduce competition, and narrow the range of options available to patients and providers. While institutional regulations are often well-intentioned, they can also create barriers that protect incumbent organizations and discourage experimentation with alternative approaches to delivering care. States that place fewer unnecessary constraints on healthcare institutions received higher scores in this section.

## 14. State has fewer certificate-of-need restrictions

Certificate of need laws require major capital expenditures in healthcare to obtain approval from a state based regulatory board. They were instituted in an attempt to control healthcare costs by restricting duplicate services and to ensure that new services would meet community needs. States with stricter and more expansive CON laws have more limits on the entry of new practices as well as on expansion of new services lines. Often, CON boards include representatives from incumbent systems and practices, who have an incentive to disallow competitors. This can result in consumers having fewer choices of services and higher cost of care. Many states have begun to repeal or create exemptions for CON laws in order to improve supply of services and increase competition.

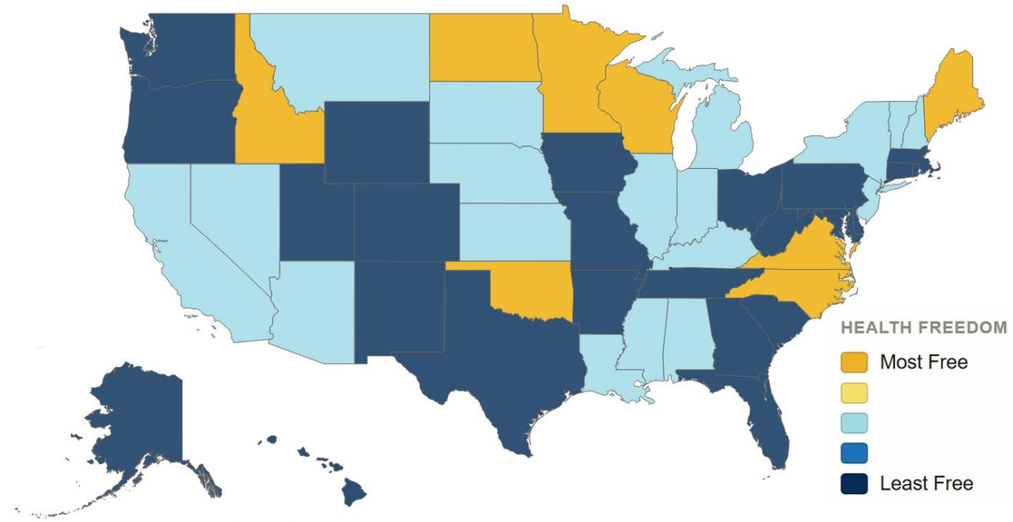
This variable is scored on a scale of 1-5. States that have 20 or more services subject to CON laws received a score of 1. Those with 10-19 services received a score of 2, 6-9 services a score of 3, 1-5 services a score of 4. Those with no CON laws received a score of 5.




## 15. State allows freestanding birth centers

Freestanding birth centers are healthcare facilities that provide prenatal labor, delivery, and postpartum services outside the traditional hospital setting. They can be a nice option for women with low-risk pregnancies who are looking for an alternative to the hospital environment. States differ in the extent to which they permit the establishment and operation of such centers. States that allow freestanding birth centers and subject them to fewer rules and restrictions expand the range of maternity care options that are available to expectant mothers. Allowing birth centers promotes patient choice, provider autonomy, and competition among healthcare delivery settings. Conversely, states that prohibit freestanding birth centers or impose burdensome requirements on them limit choice and hinder marketplace diversity.

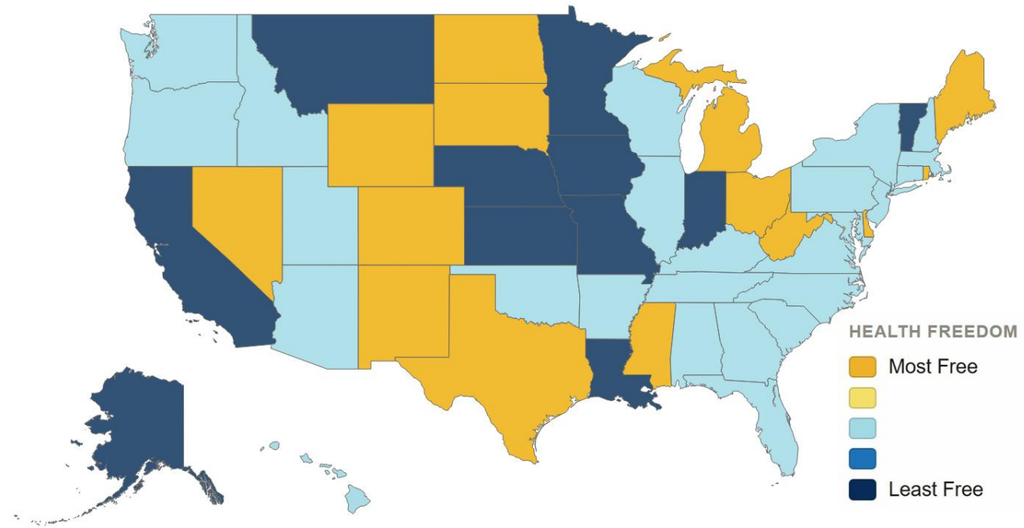
This variable is scored on a scale of 1/3/5. States where freestanding birth centers are effectively not viable because hospital integration or physician oversight are required received a score of 1. States where these facilities are viable but face substantial restrictions (e.g., state licensing, staffing, facility regulations) received a score of 3. States where a fully independent model is permitted received a score of 5.



## 16. State allows freestanding emergency departments

Freestanding emergency departments (FSEDs) are facilities that provide emergency care without being physically attached to a hospital campus. States vary in whether they permit the establishment of freestanding emergency departments and in the regulatory requirements governing their operation. States that allow FSEOs and impose fewer barriers to their development enable healthcare providers to offer emergency services through alternative organizational models that may increase convenience, responsiveness, and geographic access to care. From a healthcare freedom perspective, permitting freestanding emergency departments expands entrepreneurial opportunities, encourages competition among providers, and gives patients greater choice about where to seek emergency treatment. Conversely, states that prohibit FSEDs or subject them to restrictive licensing or operational requirements limit innovation in healthcare delivery and reduce the range of options available.

This variable is scored on a scale of 1/3/5. States where freestanding emergency departments are highly restricted received a score of 1. States where these facilities are allowed under state law but require hospital affiliation or system ownership received a score of 3. States where independent (non-hospital-owned) FSEDs are explicitly permitted received a score of 5.



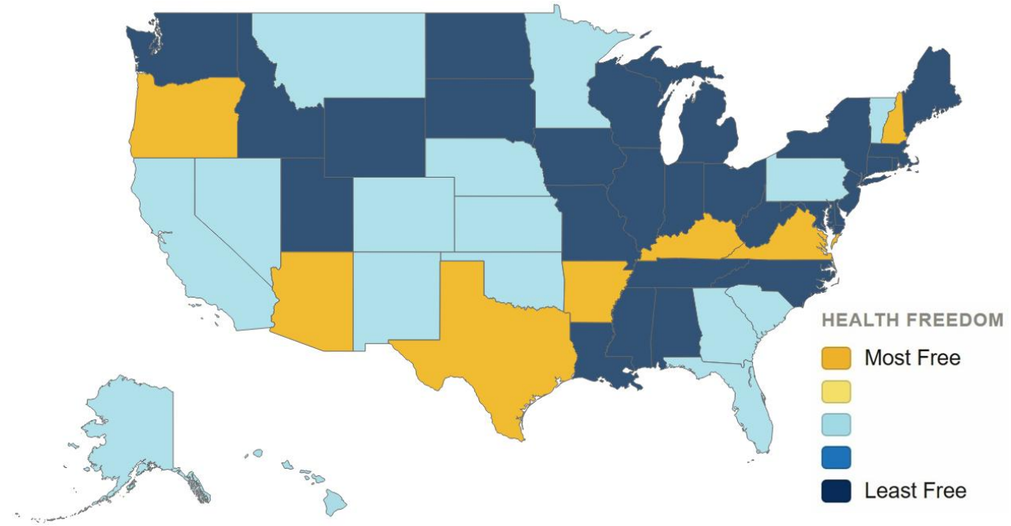





## 17. State puts fewer restrictions on compounding pharmacies

Compounding pharmacies prepare customized medications tailored to the specific needs of individual patients. This can include altering dosage forms or producing formulations that are not commercially available. States differ in the extent to which they regulate compounding activities beyond federal requirements. States that impose fewer restrictions on compounding pharmacies allow pharmacists and patients greater flexibility to develop individualized treatment options when standard manufactured products may not be suitable. From a healthcare freedom perspective, fewer regulatory barriers can encourage innovation, expand treatment choices, and support personalized approaches to care. By contrast, states that impose more extensive restrictions or more frequent inspections limit the ability of pharmacists to respond to patient needs.

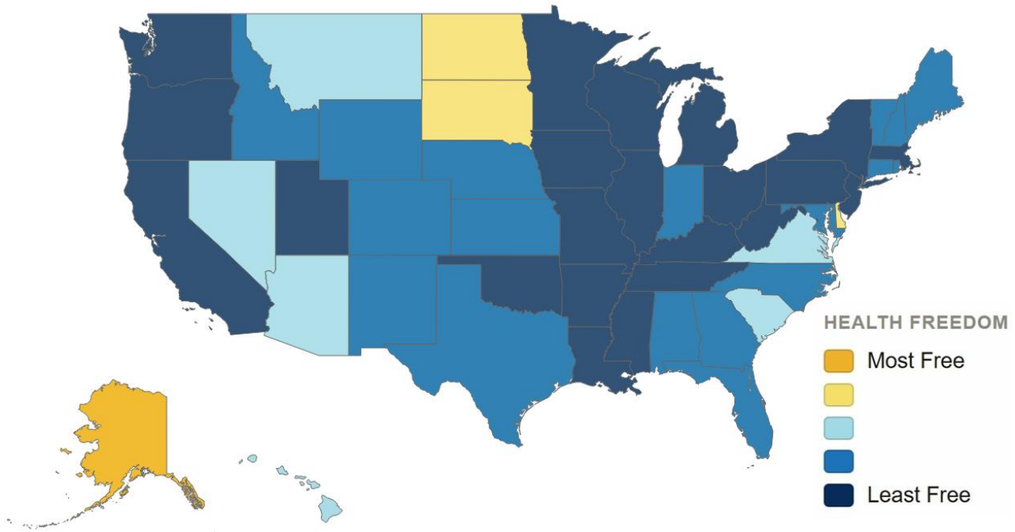
This variable is scored on a scale of 1/3/5. States with restrictions that are even tighter than the federal baseline received a score of 1. States that generally follow the federal guidelines without significant additional restrictions received a score of 3. States that follow the federal guidelines and add no additional restrictions received a score of 5.



## 18. State has fewer provider taxes

Provider taxes are levies imposed by states on healthcare entities such as hospitals, nursing facilities, managed care organizations, or other healthcare providers. These taxes are often used to help finance state healthcare programs and may be structured in conjunction with federal matching funds. States with fewer provider taxes place a lower fiscal burden on healthcare organizations, allowing providers to retain more resources for patient care, investment, and operational decision-making. Conversely, states that rely more heavily on provider taxes increase the financial obligations imposed on healthcare organizations and expand the role of government in directing the flow of healthcare funds.

This variable is scored on a scale of 1·5. States that have four or more provider taxes or fees received a score of 1. Those with three provider taxes or fees received a score of 2. Those with two provider taxes or fees received a score of 3. Those with one provider tax or fee received a score of 4. Those with no provider taxes or fees received a score of 5.



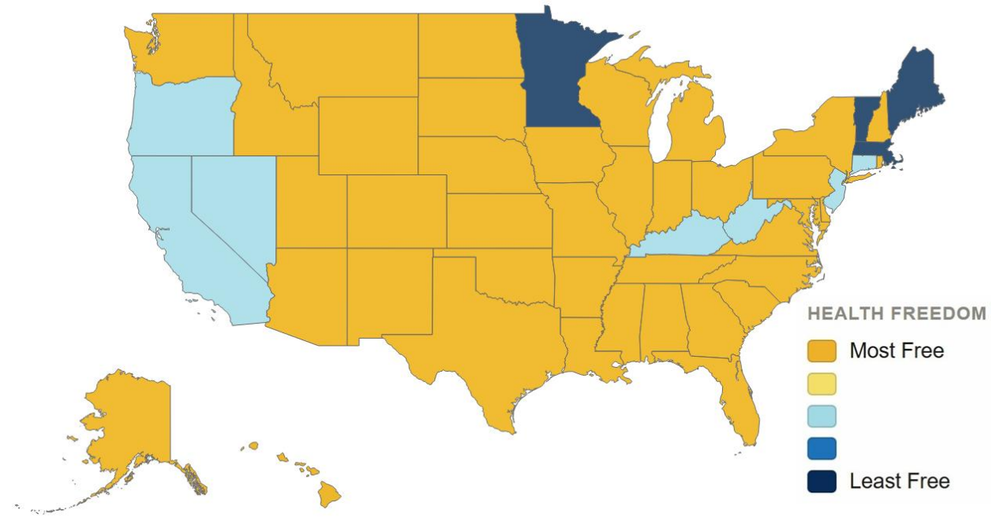





## 19. State does not restrict pharmaceutical company access to physicians

States differ in the extent to which they regulate interactions between people in the pharmaceutical industry and healthcare professionals, including restrictions on educational visits, informational materials, sponsored events, and the communication of scientific and clinical information. The impetus for these regulations is typically to reduce the opportunity for conflicts of interest to arise, however from a healthcare freedom perspective, physicians (or their hospital employers) should generally be free to decide what information they wish to receive and from whom, and pharmaceutical companies should be free to communicate truthful, non-misleading information about their products.

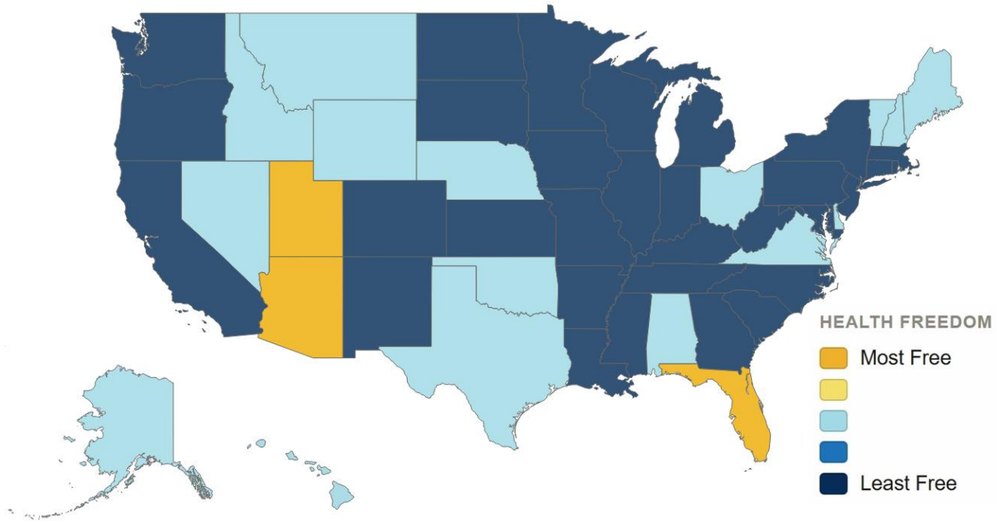
This variable is scored on a scale of 1/3/5. States that place broad bans on gifts and access received a score of 1. States that generally allow gifts or access but have some limitations or reporting requirements in place received a score of 3. States with essentially no regulations on gifts or access received a score of 5.



## 20. State allows ownership freedom for medical practices

Ownership freedom for medical practices refers to the extent to which individuals and organizations may own, invest in, or operate healthcare practices without being constrained by laws against the “corporate practice of medicine” (CPOM). While ownership regulations are often intended to preserve professional independence or protect patients, they can also limit competition and prevent people from coming up with new business models. States that permit a wider range of ownership structures allow physicians, entrepreneurs, investors, and other stakeholders greater flexibility to organize medical practices in ways that meet patient needs and business objectives.

This variable is scored on a scale of 1/3/5. States that have and enforce laws against the corporate practice of medicine received a score of 1. States that have laws in place against the corporate practice of medicine but also allow workarounds (e.g., via management services organizations) received a score of 3. States that allow a wide variety of ownership models received a score of 5.

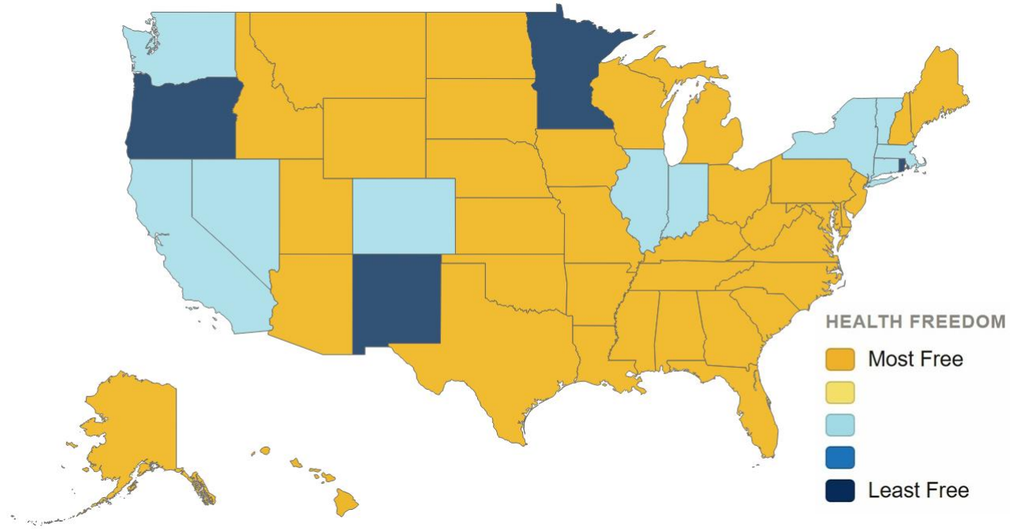





## 21. State does not require advance notice for private equity activity

Some states require private equity firms to provide advance notice to regulators before completing certain acquisitions, ownership changes, mergers, or other transactions involving healthcare entities. States that do not impose such advance-notice requirements allow private parties greater freedom to engage in voluntary business transactions without prior government review or procedural delays. Although private equity has come under fire for certain management practices that some firms engage in after these business ownership transactions take place, there is no justification from a business freedom perspective for onerous pre-transaction burdens on voluntary business decisions regarding ownership.

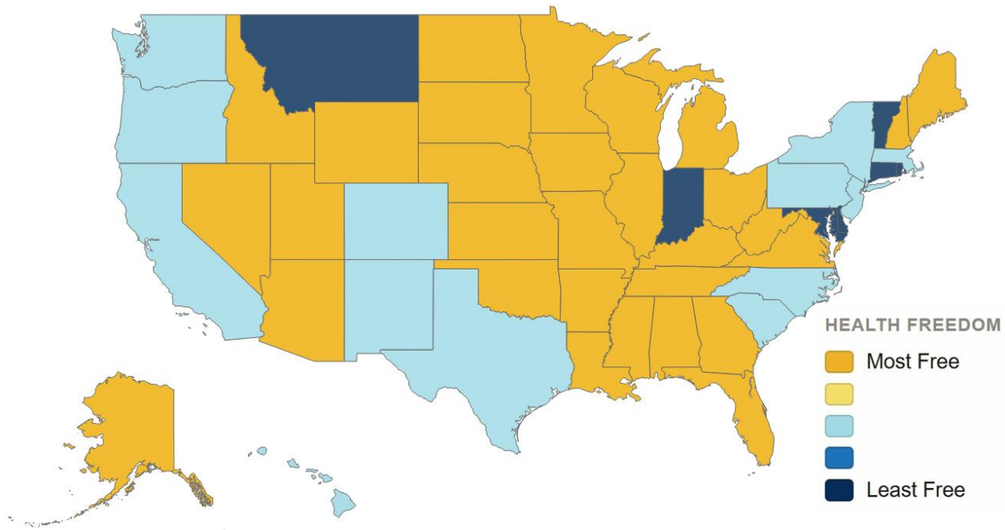
This variable is scored on a scale of 1/3/5. States that reserve the power to block private equity deals in healthcare received a score of 1. States that do not have the power to block private equity deals but that still require advance notice received a score of 3. States that allow voluntary private equity deals to happen freely received a score of 5.



## 22. State does not impose rate-setting or price controls on hospitals

Hospital rate-setting and price controls are policies through which governments directly try to regulate the prices that hospitals may charge for healthcare services. Statewide rate-setting commissions that cap specific hospital charges or reimbursement rates are an example of this kind of policy. These price controls, however, distort market signals and often cause downstream problems or the need for additional intervention. Market-based pricing allows prices to emerge through negotiations and voluntary contracts. and respects the rights of producers and service providers.

This variable is scored on a scale of 1/3/5. States that impose broad rate-setting or price controls on hospitals received a score of 1. States that some rate-setting or price controls on hospitals, but only for a relatively narrow set of services, received a score of 3. States that do not engage in rate-setting or have price controls received a score of 5.



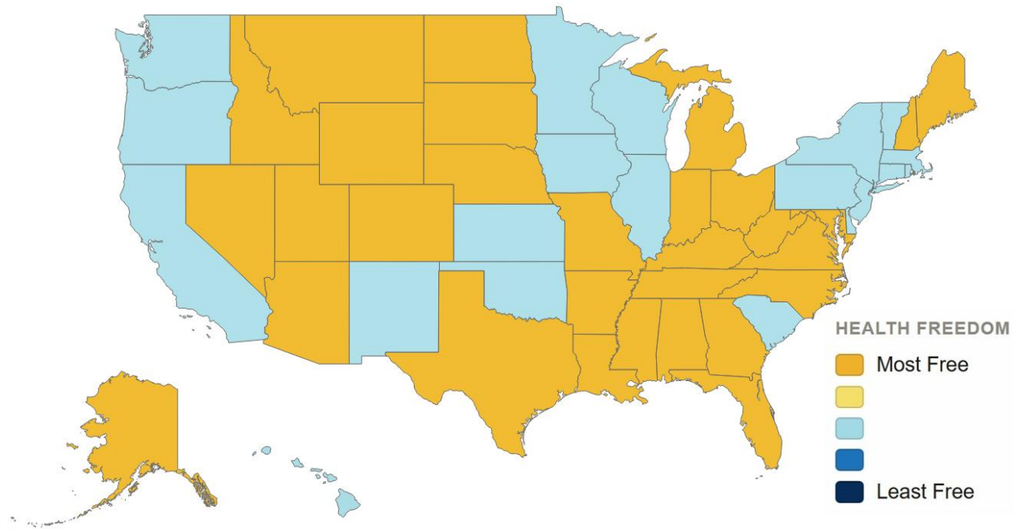





## 23. State allows mutual aid societies to operate freely

Mutual aid societies (sometimes called health sharing ministries) are voluntary organizations through which individuals pool resources to provide assistance to one another in times of need, including support for healthcare expenses. Historically, such societies played a significant role in financing medical care and other social services before the expansion of government welfare programs and modern health insurance. States that allow mutual aid societies to operate freely impose fewer regulatory barriers on their formation, governance, membership arrangements, and benefit structures, thereby enabling individuals to organize cooperative solutions outside traditional insurance and government programs. States that subject these organizations to extensive regulation or treat them as conventional insurance entities discourage their formation and limit the freedom of individuals to come together to cooperate.

This variable is scored on a scale of 1/3/5. States that do not let mutual aid societies operate received a score of 1. States that have not enacted a safe harbor law exempting such societies from insurance regulations but do not actively pursue action against mutual aid societies received a score of 3. States that have enacted safe harbor laws received a score of 5.



# PATIENT FREEDOM

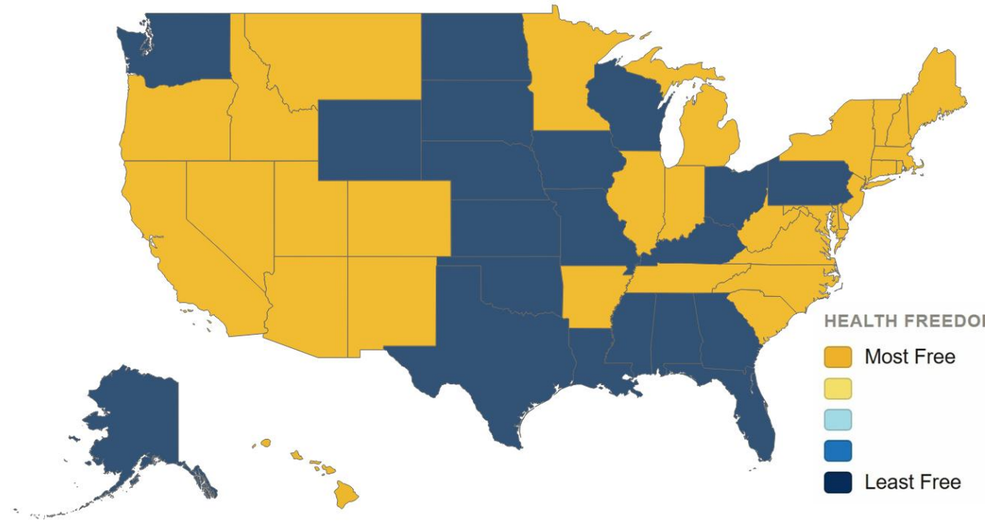
The Patient Freedom category examines the extent to which individuals are free to make decisions about their own healthcare and access the services, treatments, and care arrangements they prefer. This includes policies affecting treatment options, substances, equipment, and technologies that shape the ability of patients to exercise personal judgment in matters of personal health and medical care. These policies are often intended to protect consumers, but they can also diminish autonomy.

From a freedom-oriented perspective, patients are generally best positioned to evaluate their own needs, preferences, values, and tolerance for risk. Regulations that limit treatment options in various ways can reduce individual autonomy and narrow the set of choices available. States that provide individuals with greater freedom to choose and make their own healthcare decisions received higher scores in this section.

## 24. State allows pharmacists to dispense hormonal birth control without physician prescription

Hormonal birth control, including the morning after pill or “Plan B,” has been considered a safe and effective method of birth control for many years. Some states allow women or their partners to purchase birth control or Plan B from a pharmacist without requiring a doctor's prescription. This is particularly important in the case of Plan B, which is most effective at preventing possible pregnancy in the first 72 hours from unprotected sex.

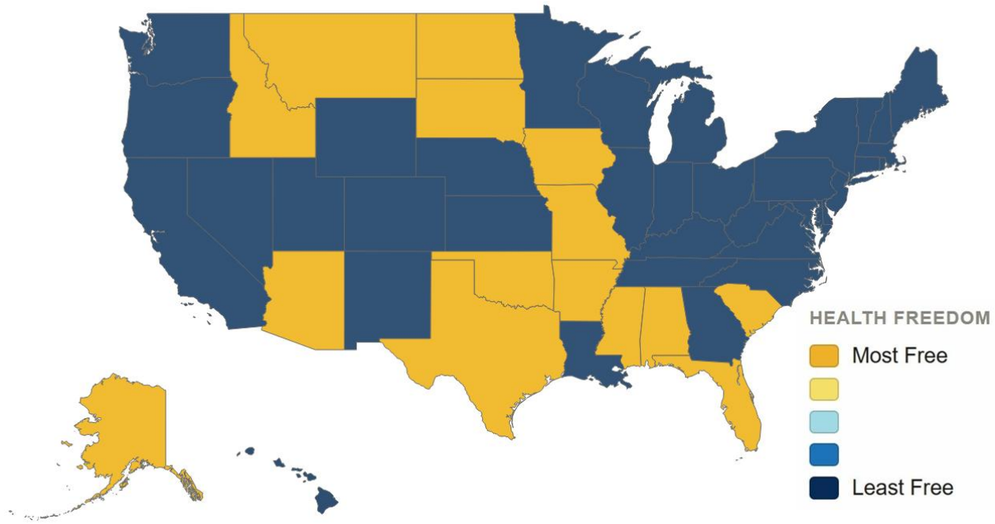
This variable is scored as either 1 indicating that pharmacists are not free to prescribe hormonal contraception or 5, indicating that pharmacists are free to prescribe contraception.



## 25. State has lower excise taxes on e-cigarettes

Excise taxes on electronic cigarettes and vaping products are special taxes imposed on the sale, manufacture, or distribution of these products. States vary widely in the rates they apply and in the methods used to calculate them. States with lower excise taxes on e-cigarettes allow consumers to retain more of their income when purchasing these products and impose fewer government-created barriers to voluntary exchange. While some consumers use e-cigarettes in an unhealthy or irrational way, it is important to recognize that for many individuals, e-cigarettes are a harm reduction product that empowers them to move away from more destructive tobacco cigarettes. Higher taxes discourage that good type of usage.

This variable is scored as either 1 or 5. States that impose an excise tax on e-cigarettes received a score of 1. States that do not impose an excise tax received a score of 5.



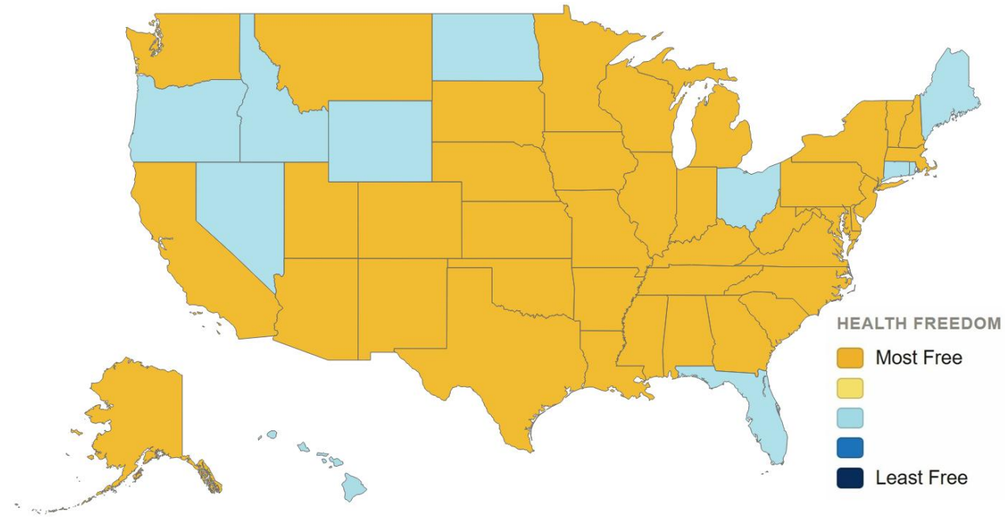





## 26. State allows lay distribution of naloxone

Naloxone is a medication that counteracts the effects of opioids such as heroin and fentanyl. In particular it can reverse respiratory depression that causes users to stop breathing. Many states have created programs to allow pharmacies to dispense naloxone with a prescription or certificate of training, and others with no prescription at all. Lay distribution of naloxone allows frequent users of opioids, their families, and members of the general public to have naloxone on hand in case of emergent need, rather than waiting for emergency personnel.

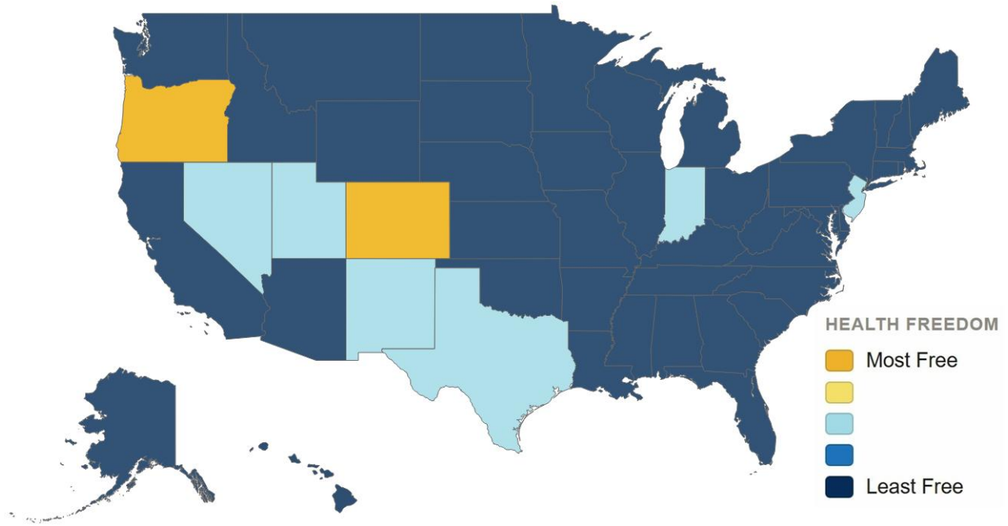
This variable is scored on a scale of 1/3/5 where 1 indicates that naloxone is highly regulated with no lay distribution allowed, 3 indicates that a prescription or training certificate is required, and 5 indicates that there is no restriction on obtaining naloxone from a pharmacy.



## 27. State allows patients to use psychedelic substances for medical use

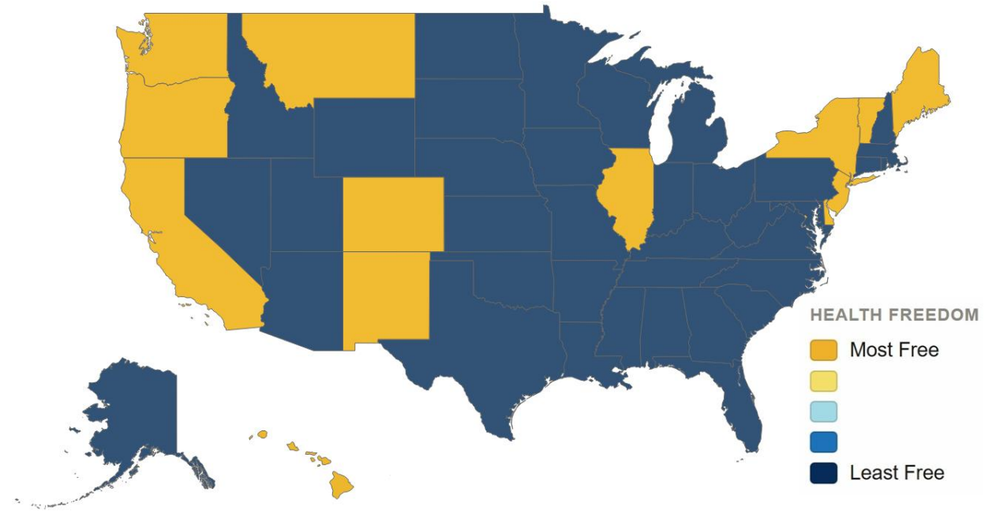
States differ in the extent to which they permit the medical use of psychedelic substances for the treatment of conditions such as depression, post-traumatic stress disorder, and substance use disorders. States that allow patients to access psychedelic therapies provide individuals and healthcare professionals with greater freedom to explore emerging treatment options. From a healthcare freedom perspective, permitting access to psychedelic therapies expands patient choice, respects the judgment of patients and practitioners, and creates opportunities for innovation in mental health treatment. States that prohibit or severely restrict access to psychedelic substances limit the range of therapeutic options that are available to patients.

This variable is scored on a scale of 1/3/5. States that prohibit the use of psychedelics received a score of 1. States that allow some medical use of psychedelics but with limitations, received a score of 3. States that grant full freedom in the medical use of psychedelics received a score of 5.




## 28. State allows patients to seek medical aid in dying

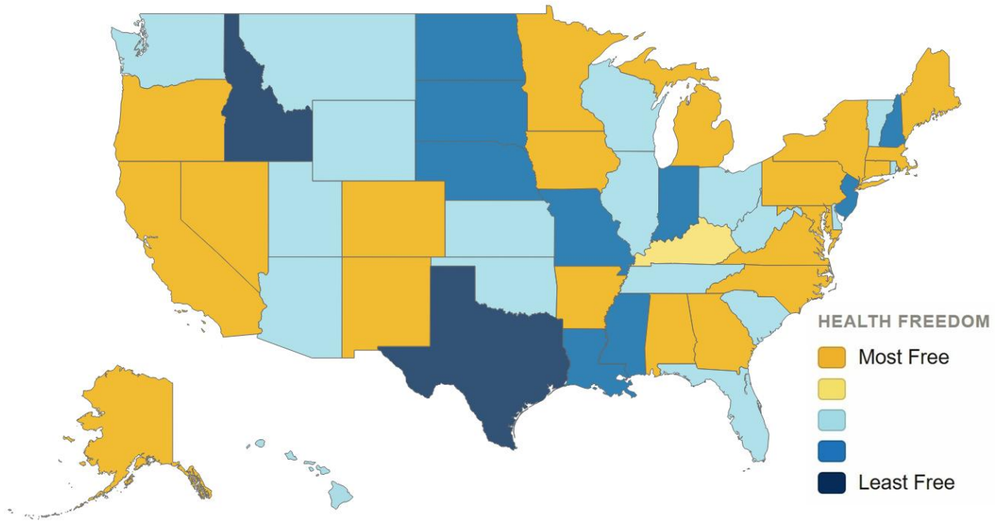
Medical aid in dying is an option for end-of-life care that allows mentally capable, terminally ill adult patients to receive a prescription that will allow them to choose the time and circumstances of their death. The medication is taken by the patient, not administered by a healthcare provider. This is an end-of-life option for terminally ill patients that gives them freedom to end their life without severe pain or suffering. At the time of writing, only a handful of states allow medical aid in dying, although others have pending legislation on this issue. This variable is scored on a yes/no scale. Either a score of 1 is assigned, indicating that medical aid in dying is not allowed, or a score of 5, indicating that medical aid in dying is allowed.



## 29. State allows minors to obtain/consent to contraception

States differ in the extent to which minors may obtain contraceptive services and consent to contraceptive care without the involvement or permission of a parent or guardian. While reasonable people may disagree about the proper balance between parental authority and adolescent autonomy, and while it might be proper for parental rights to "win out" in other areas of medical care, we believe that the behavioral component of this issue makes it appropriate for freedom to be granted to the individual who is seeking care.

This variable is scored on a 1-5 scale. A score of 1 indicates that the state requires parental consent in order for minors to obtain contraception. A score of 2 indicates that the state requires parental consent, but allows for some exceptions. A score of 3 indicates that minors may access contraception under "mature minor" doctrine or explicit statutory permission. A score of 4 indicates that minors can generally obtain contraception without parental consent or notification. A score of 5 indicates that minors can independently consent to contraception in generally all cases.

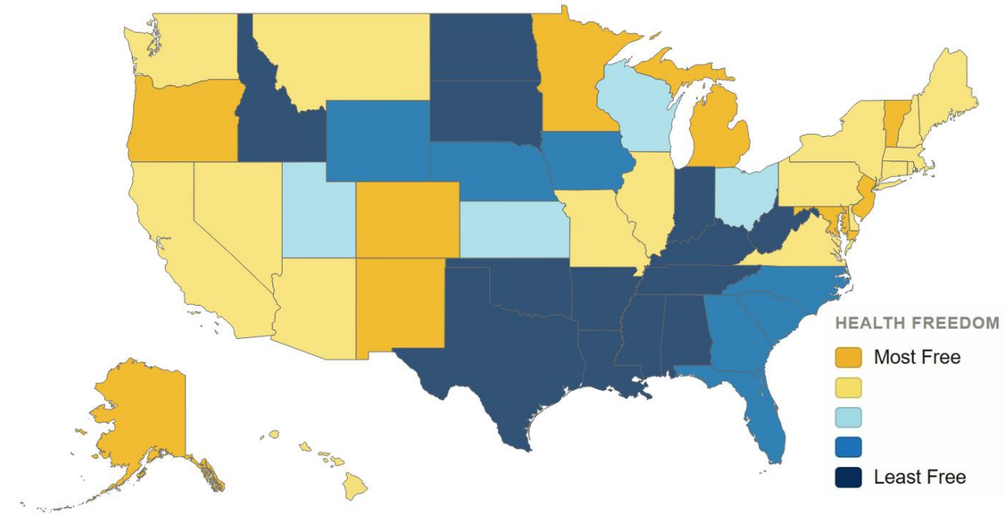





## 30. State allows abortion

Since the repeal of Roe v Wade, the question of whether and when to allow abortions has transferred to state legislatures. While some states allow broad freedom to access abortion for women, many others have instituted varying degrees of restrictions based on circumstance and gestational age of the pregnancy. These restrictions limit women's freedom to choose what happens to their own bodies.

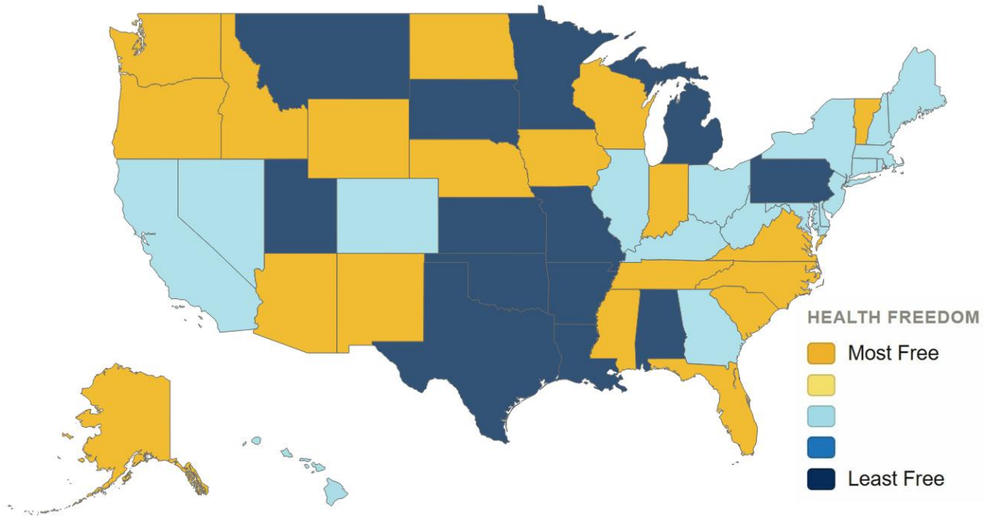
This variable is scored on a 1-5 scale. A score of 1 indicates that abortion is completely prohibited except in very narrow circumstances such as the life of the mother. A score of 2 indicates that abortion is allowed with very early gestational limits and/or multiple procedural restrictions. A score of 3 will be assigned to states with mid-generational age limits and required waiting periods and counseling. A score of 4 indicates abortion is restricted after the fetus reaches a viable gestational age and there are few procedural requirements. Finally, a score of 5 will be assigned if abortion is allowed throughout pregnancy without procedural limits.



## 31. State does not interfere with reproductive technology

Assisted reproductive technologies such as in vitro fertilization (IVF), embryo storage, and related fertility services are increasingly shaped by state laws governing embryo status and insurance coverage requirements. States differ in the extent to which they impose legal constraints on these activities. States that refrain from imposing laws that recognize embryos as legal persons or mandate that private insurance plans cover fertility treatments reduce freedom for individuals. Conversely, states that get involved in these treatments exert greater influence over how reproductive technologies are used and financed.

This variable is scored on a scale of 1/3/5. States that hold a strong embryo personhood doctrine or high liability risk for clinics received a score of 1. States that have a high regulatory burden or mandate insurance coverage received a score of 3. States that have no personhood doctrine and no insurance mandates affecting contracting received a score of 5.

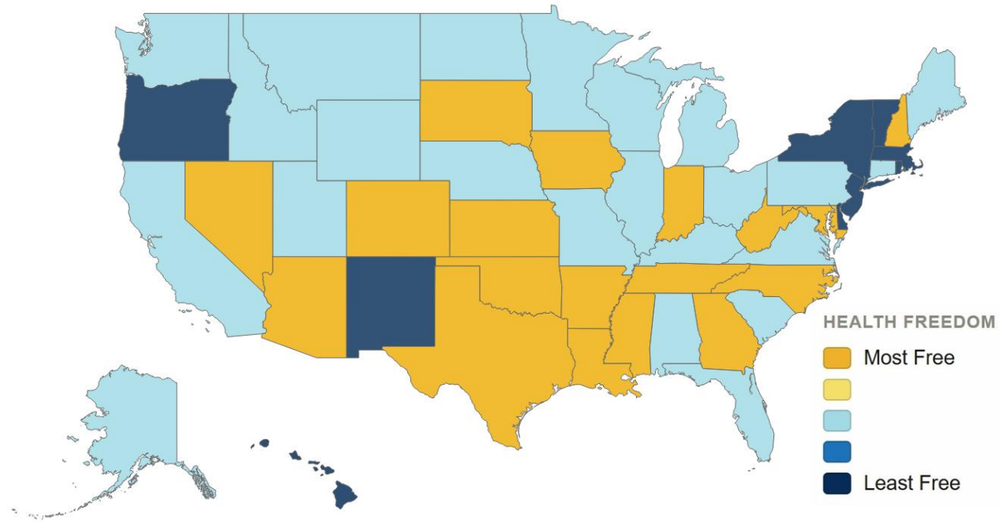





## 32. State allows patients Right-to-Try investigational treatments

Right-to-Try laws allow patients to seek access to investigational treatments that have completed at least some stage of clinical testing but have not yet received full regulatory approval. States that recognize a Right-to-Try framework provide patients and their physicians with greater freedom to pursue potentially beneficial treatment options, recognizing that competent adults should generally be free to make informed decisions about their own medical care. Right-to-Try laws emerged in the mid-2010s and were eventually signed into federal law, but still there remain some restrictions. For instance, the federal law only extends this right to patients with serious or life-threatening conditions, and some states (even ones that have passed laws supporting the Right-to-Try idea) still have enough legal ambiguity that physicians and drug companies are hesitant to use or offer this option. States can help the situation by passing laws clarifying and extending this option. Sometimes these follow-up efforts are called "Right-to-Try 2.0."

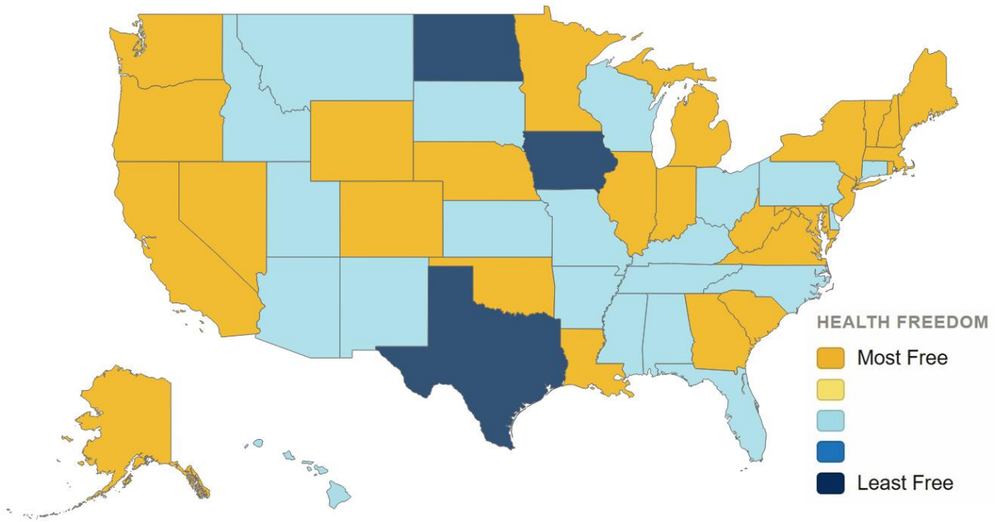
This variable is scored on a scale of 1/3/5. States that only allow what the federal law requires them to allow received a score of 1. States that have laws that provide a clear safe harbor for physicians and drug companies but do not otherwise expand on the federal law received a score of 3. States that provide clear legal safe harbor and maximal permissiveness (e.g., have expanded Right-to-Try to non-terminal conditions) received a score of 5.



## 33. State allows possession of drug checking equipment

Drug checking equipment refers to things such as fentanyl test strips and other substance-analysis tools, which allow individuals to identify the composition of drugs before consumption. Although we shouldn't want to encourage the use of illicit drugs, from a harm reduction standpoint it's helpful to people who use such substances to be able to possess these items legally. Access to information is an important component of informed decision-making, and individuals should generally be free to utilize tools that help them better understand and manage health-related risks. However, some states prohibit or restrict the possession of drug checking equipment, limiting access to potentially valuable information and unnecessarily putting people at risk of additional harm.

This variable is scored on a scale of 1/3/5. States that generally prohibit the possession of drug checking equipment received a score of 1. States that allow some possession or use of drug checking equipment received a score of 3. States that generally permit all drug checking equipment received a score of 5.




# PAYMENT FREEDOM

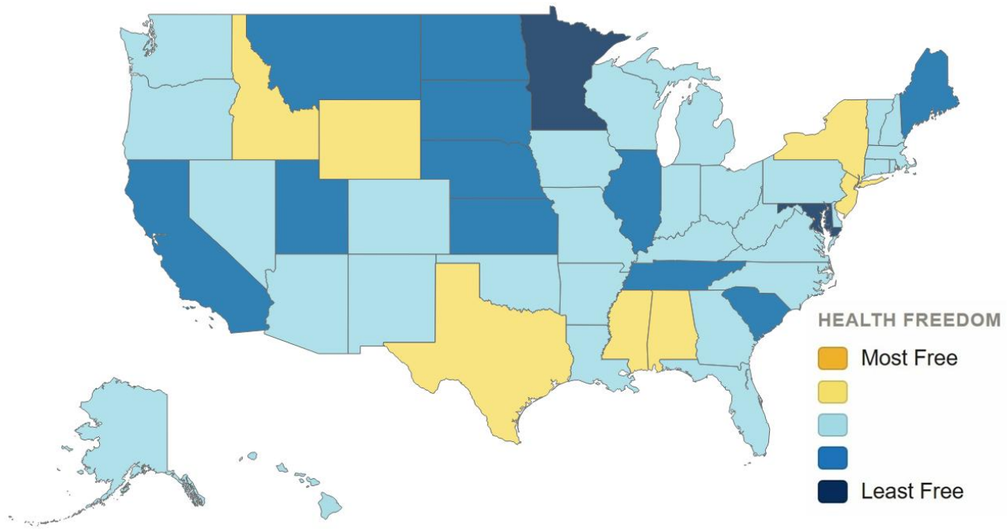
The Payment Freedom category examines the extent to which individuals and organizations are free to structure how healthcare services are paid for, including the use of insurance products, direct-pay arrangements, health savings mechanisms, pricing models, and alternative financing structures. State laws in this category are often justified as measures to improve affordability, transparency, or consumer protection, but they sometimes limit the freedom and flexibility of financial arrangements.

Flexibility in payment arrangements can support innovation, price discovery, and consumer choice. On the other hand, restrictions can limit experimentation and reinforce dependence on centralized or standardized financing structures. States that allow a wider range of voluntary and customizable payment structures received higher scores in this section.

## 34. State mandates fewer health insurance benefits

Health insurance benefit mandates require health plans to cover specific services, treatments, providers, or medical conditions regardless of whether purchasers would otherwise choose to include them in their coverage. States with fewer mandated benefits allow individuals greater flexibility to buy and sell insurance products that reflect their own preferences, budgets, and needs. Reducing benefit mandates expands consumer choice, while adding to the list of conditions and services that must be covered requires consumers to purchase benefits they may not want or need.

This variable is scored on a 1-5 scale. A score of 1 indicates that the state mandates 45 or more different services. A score of 2 indicates 30 to 44 coverage mandates. A score of 3 indicates 15 to 29 coverage mandates. A score of 4 indicates 1 to 14 coverage mandates. A score of 5 indicates no coverage mandates.



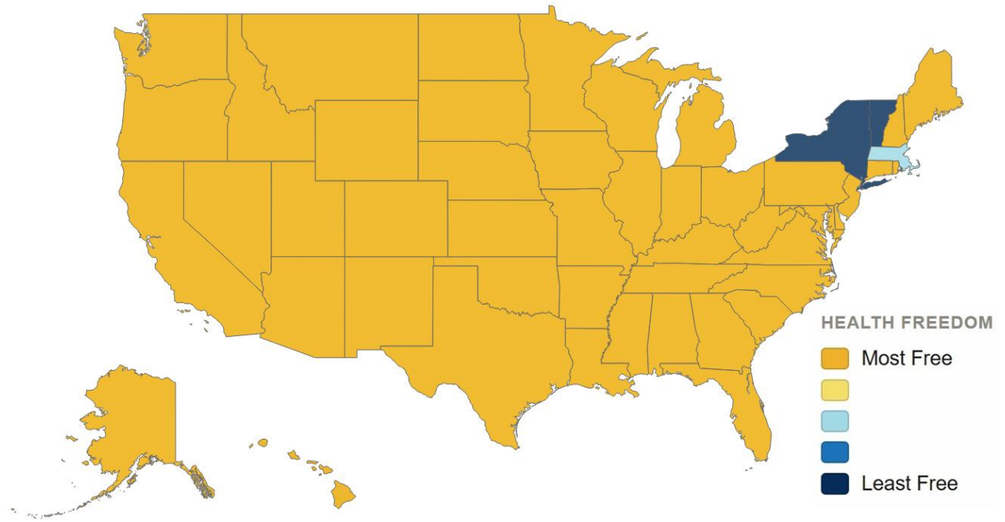





## 35. State does not constrict age rating further than federal law

Age rating refers to the extent to which health insurers may vary premiums based on an enrollee's age. Federal law permits insurers in the individual and small-group markets to adjust premiums within specified limits to reflect age-related differences in expected healthcare costs. Allowing age rating helps health insurance work like real risk-based insurance, so in that sense, more freedom to do age rating is better. Some states impose additional restrictions that further limit insurers' ability to use age-based pricing. States that do not further constrict age rating beyond federal requirements allow insurers greater flexibility to align premiums with actuarial risk and to offer a wider range of insurance products.

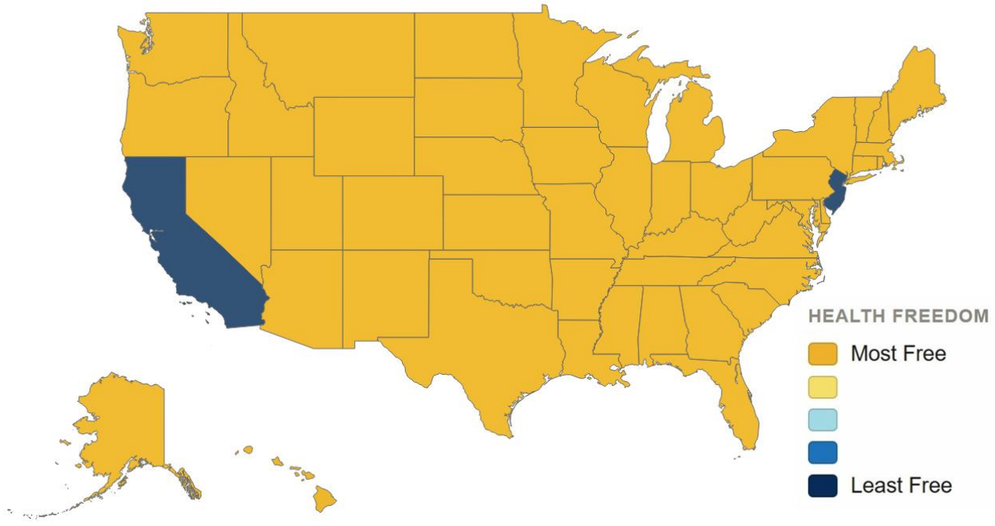
Scoring for this variable is on a 1/3/5 scale. A 1 indicates that the state goes beyond the federal government's rules on age rating and doesn't allow any age rating at all. A score of 3 is assigned if the state allows some age rating but the guidance is stricter than federal rules. A score of 5 is assigned if the state allows as much age rating as it legally can under federal rules.



## 36. State has fewer health savings account (HSA) taxes

Health Savings Accounts (HSAs) allow individuals to set aside funds on a tax-advantaged basis to pay for qualified medical expenses. While HSAs receive favorable federal tax treatment, states differ in the extent to which they conform to federal law or impose additional taxes on HSA contributions, earnings, or withdrawals. States with fewer HAS-related taxes allow individuals to retain more of their healthcare savings and provide stronger incentives for consumers to finance medical expenses directly. From a healthcare freedom perspective, favorable tax treatment of HSAs promotes personal ownership of healthcare dollars, encourages consumer engagement in healthcare purchasing decisions, and expands alternatives to third-party payment systems. Conversely, states that impose additional taxes on HSAs reduce the financial benefits of these accounts and discourage the use of consumer-directed approaches to healthcare financing.

This variable is scored on a scale of 1/5. States that tax HAS contributions or earnings (or both) received a score of 1. States that do not tax HSA contributions nor earnings received a score of 5.



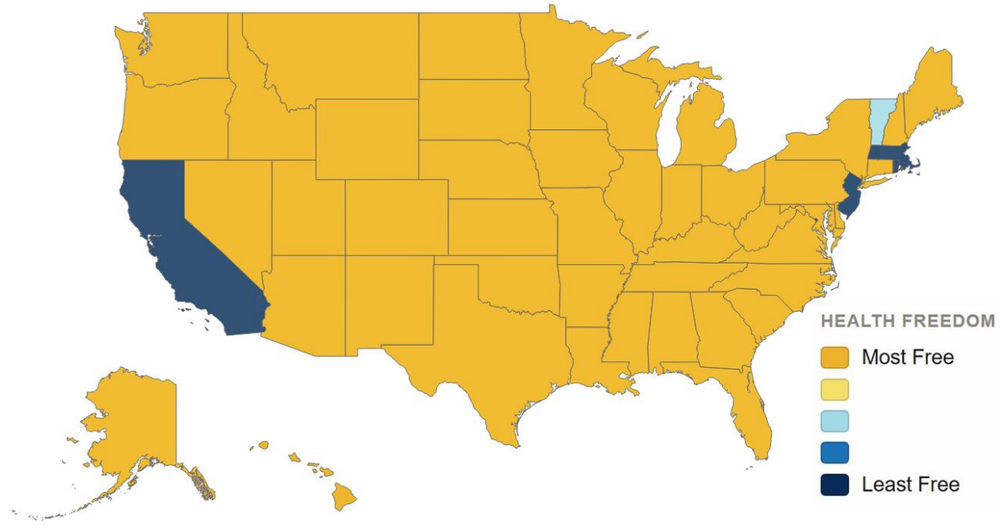





## 37. State does not mandate that individuals buy health insurance

Although the federal government has been barred from imposing an individual mandate to purchase health insurance, many states have imposed such mandates. These mandates limit individuals' freedom to determine how they interact with the healthcare system and how they pay for their care.

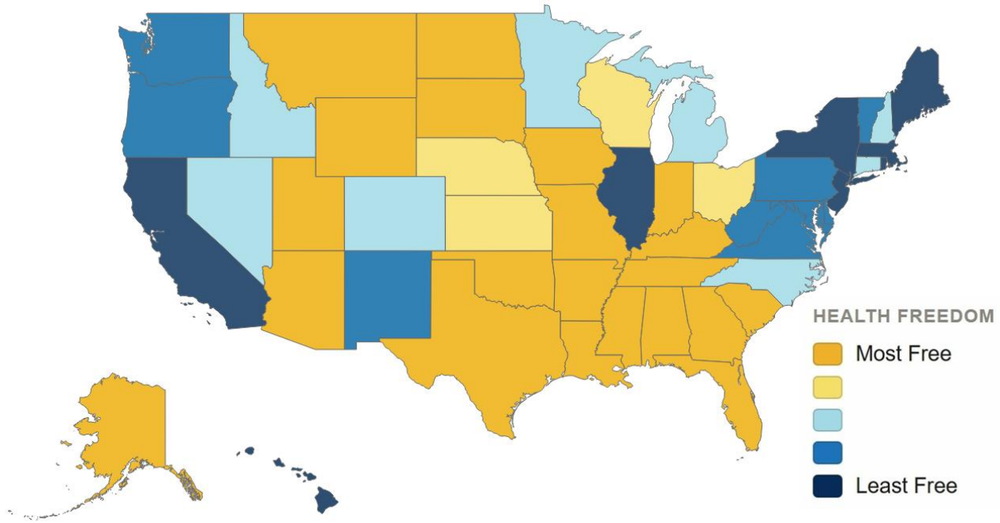
Scoring for this variable is on a 1/3/5 scale. A 1 indicates that the state has an individual mandate and imposes a penalty for noncompliance. A score of 3 is assigned if the state requires individuals to purchase and report health insurance but does not impose a penalty for noncompliance. A score of 5 indicates that there is no individual mandate.



## 38. State does not restrict short-term renewable health plans

Short-term renewable health plans are insurance products that typically offer lower-cost coverage with fewer mandated benefits and greater flexibility than plans subject to the full range of federal and state insurance regulations. States differ in whether they permit these plans and in the restrictions they impose on their duration, renewability, and availability. States that do not impose additional restrictions beyond applicable federal requirements allow consumers greater freedom to choose coverage options that align with their individual needs, preferences and financial circumstances.

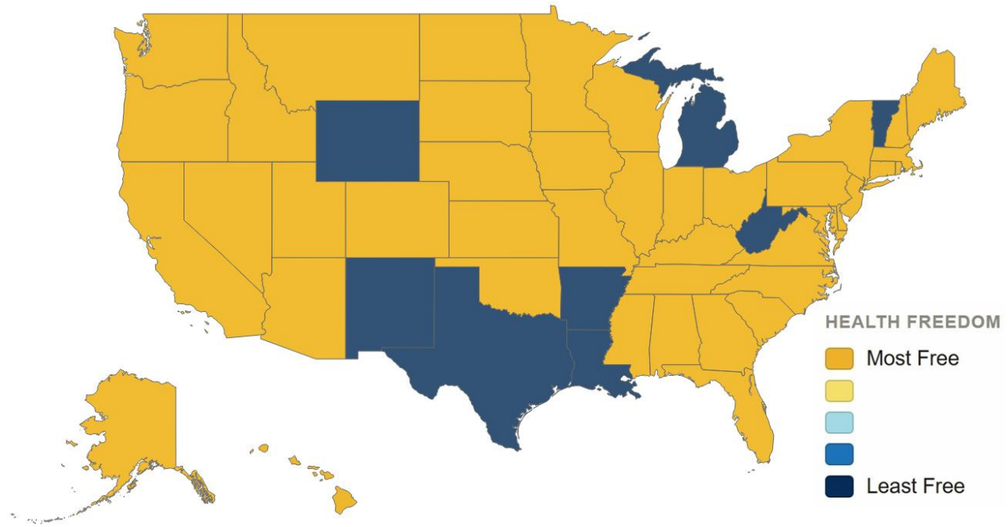
This variable is scored on a 1 -5 scale. A score of 1 indicates that the state does not allow short-term renewable plans at all. A score of 2 indicates that the state defines the allowable "'short-term duration'" to about 3 months. A score of 3 indicates a duration of about 6 months. A score of 4 indicates a duration of about 1 year. A score of 5 indicates that the state allows whatever the federally-defined maximum is (which as of this writing is 36 months, or 3 years).




## 39. State does not mandate insurers have a Gold Card program

Gold carding in health insurance is a performance-based program that exempts high-performing healthcare providers from the standard, time-consuming prior authorization process. For instance, if physicians demonstrate high approvals and low rejections for the services they order, then insurers might exempt them from prior authorization reviews. Although this may be a good idea for insurance companies to adopt voluntarily, Gold Card laws take this creative idea and make it *required.* Unfortunately, that dictates how private insurers must design and administer their utilization management programs. From a healthcare freedom perspective, it is better to let insurers adopt these programs voluntarily if they are indeed good.

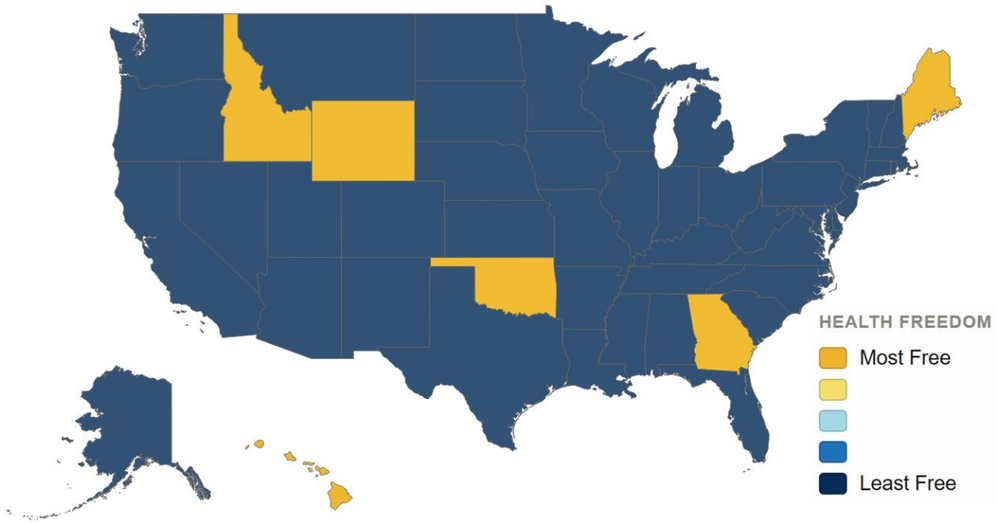
Scoring for this variable is on a 1/5 scale. A score of 1 indicates that the state requires insurers to have a Gold Card program. A score of 5 indicates that the state does not require insurers to have a Gold Card program.



## 40. State allows out-of-state insurers to issue health insurance in the state

Historically each state has regulated the sale of health insurance within its geographic borders. Some states allow out-of-state insurers to issue health insurance policies. This expands the range of coverage options available to consumers and reduces barriers to interstate competition. Conversely, states that prohibit the sale of out-of-state health insurance limit competition and reduce the ability of consumers to access insurance products that might be better for them.

This variable is scored on a scale of 1/3/5. States that prohibit out-of-state insurers from selling policies in their state received a score of 1. States that allow out-of-state insurers to sell policies but require that the company or product be approved by the state received a score of 3. States that allow out-of-state insurers to sell policies in their state received a score of 5.

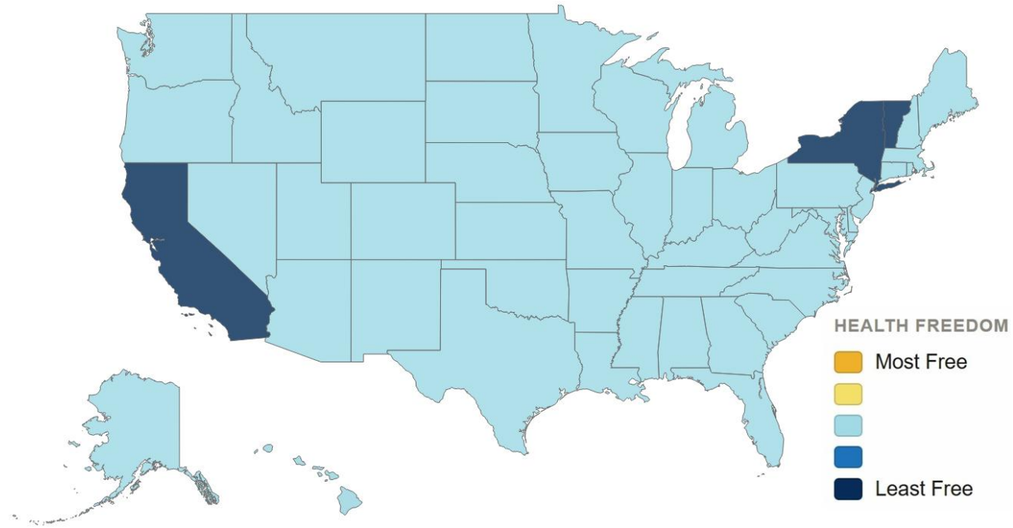





## 41. State allows underwriting (vs. guaranteed issue) starting at a lower employee threshold

Health insurance “underwriting” is the process that insurers use to evaluate an applicant's health status and medical history. In the small-group health insurance market, some states let insurers do underwriting when setting premiums or determining coverage terms, whereas other states require insurers to offer coverage regardless of health status (called “guaranteed issue”). From a healthcare freedom perspective, letting insurers do underwriting for more people is better, so the lower the threshold for the size of a small group seeking coverage, the better.

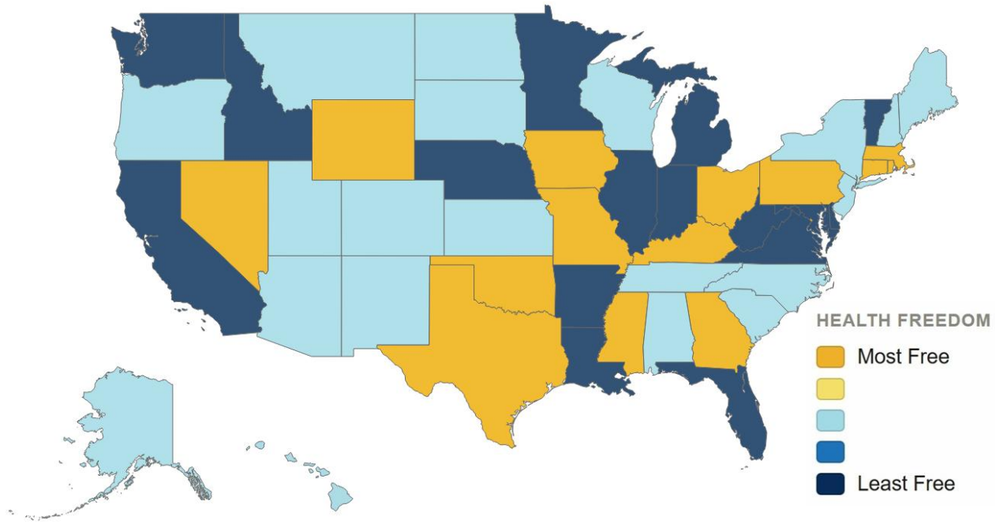
This variable is scored on a scale of 1/3/5. States that allow insurance companies to offer underwriting to businesses and organizations with 100 or more employees received a score of 1. States that allow insurance companies to offer underwriting to businesses and organizations with 50 or more employees received a score of 3. States that allow insurance companies to offer underwriting to all businesses and organizations regardless of size received a 5.



## 42. State does not regulate Pharmacy Benefit Managers (PBMs)

Pharmacy benefit managers (PBMs) are intermediaries that administer prescription drug benefits on behalf of employers, health plans, and other purchasers of healthcare. They negotiate with drug manufacturers, manage formularies, and process pharmacy claims. Although PBMs have attracted criticism for a variety of business practices, perhaps even justifiably so, a freedom-oriented perspective generally favors allowing purchasers and vendors to structure these relationships through voluntary contracts rather than trying to shape the way PBMs work through regulation. States that impose fewer PBM-specific regulations provide employers, insurers, and other healthcare purchasers greater freedom to negotiate contract terms that reflect their own priorities. By contrast, states that rely more heavily on government regulation—even if those regulations create some benefit in the short term—ultimately reduce the freedom of market participants to make contracts as they see fit.

For this variable, we looked at two types of PBM regulations: requirements that force PBMs to obtain licenses from state departments of insurance, and prohibitions on spread pricing where PBMs charge plans more than they pay pharmacies. Scoring for this variable is on a 1/3/5 scale. States that have both of the above regulations in place received a score of 1. States that have one of the above regulations in place received a score of 3. States that have neither of these PBM regulations in place received a score of 5.



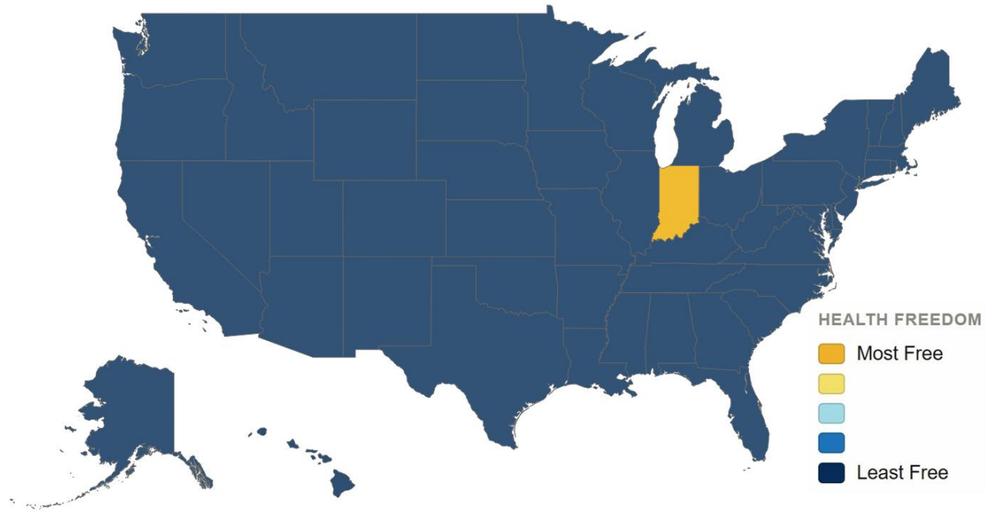





## 43. State allows health savings-like accounts within Medicaid

Some states incorporate health savings account-like features into their Medicaid programs, allowing beneficiaries to manage a portion of healthcare funds through personal accounts, contribute toward certain costs, or participate in consumer-directed arrangements that encourage greater engagement in healthcare spending decisions. States that permit such mechanisms provide beneficiaries with more opportunities to exercise choice and responsibility in the use of healthcare resources. By contrast, states that do not have this type of feature maintain a more centralized approach to healthcare resource allocation, which tends not to be good for either beneficiaries or taxpayers.

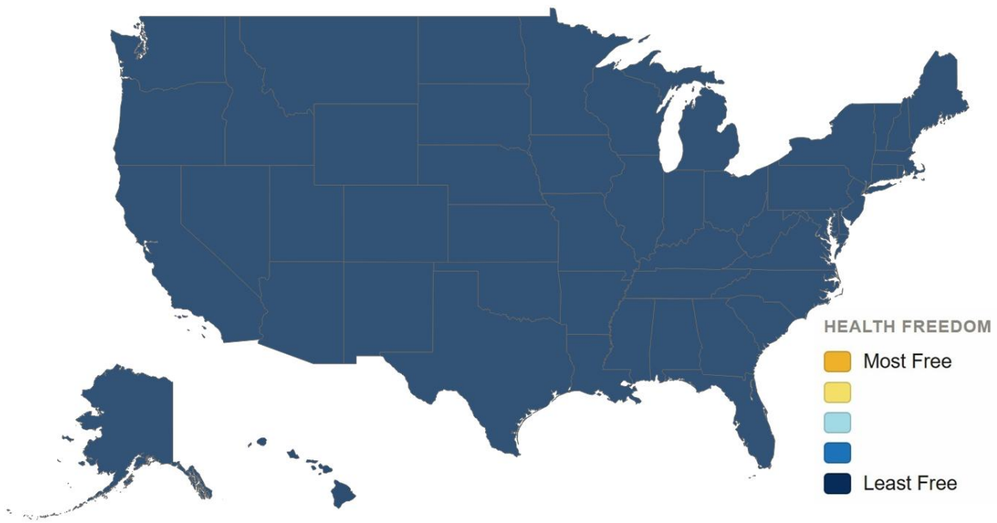
This variable is scored on a simple 1/5 scale. States that do not allow health savings-like accounts as part of their Medicaid programs received a 1. States that do allow health savings-like accounts in their Medicaid programs received a 5.



## 44. State allows Medicaid patients to engage in direct pay for covered services

States differ in the extent to which Medicaid beneficiaries may voluntarily purchase covered healthcare services directly from participating providers without submitting a claim to Medicaid. In some states, Medicaid-participating providers and patients may enter into clear, voluntary direct-pay arrangements so long as both parties understand up front that Medicaid will not be billed for the service. States that permit these arrangements give patients greater flexibility to obtain care outside the Medicaid reimbursement system and allow providers greater freedom to offer services on mutually agreed terms. From a healthcare freedom perspective, individuals should generally be free to spend their own resources on healthcare services, even when they are enrolled in a public insurance program, and providers should be free to accept such arrangements when they are transparent and voluntary. While restrictions on direct-pay arrangements are often intended to protect beneficiaries or preserve program integrity, they can also limit consumer choice and reduce opportunities for alternative payment models.

This variable is scored on a scale of 1/3/5. States that explicitly prohibit patients with Medicaid coverage from paying doctors directly for covered services received a score of 1. States that have no law on the matter and thus default to the federal language, which creates a gray area for physicians, received a score of 3. States that expressly allow patients to pay Medicaid-participating doctors directly for covered services as long as neither party also seeks reimbursement from Medicaid received a 5.






# DELIVERY FREEDOM

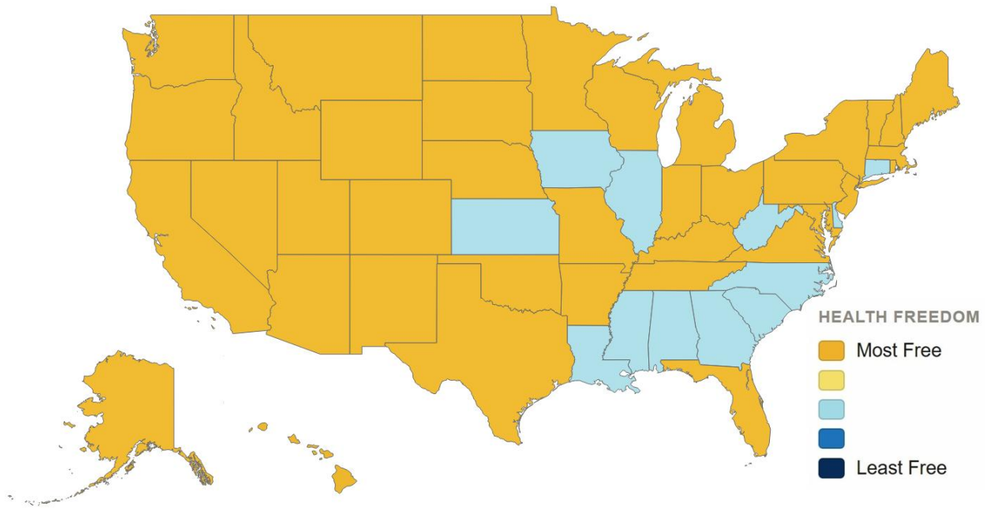
The category of Delivery Freedom examines the extent to which laws and regulations shape how, where, and by whom healthcare services may be delivered. This includes policies governing care settings, telehealth infrastructure, pharmacy operations, reimbursement eligibility across provider types, and other related healthcare delivery variables. Laws in this category are often intended to ensure safety or accountability, but they also determine the flexibility with which providers can organize and deliver care.

From a freedom-oriented perspective, healthcare delivery systems function best when providers are able to experiment with new modes of care, adopt emerging technologies, and respond directly to patient needs without unnecessary structural constraints. While there is arguably a defensible role for some regulatory oversight in some contexts, in general states that allow greater flexibility in how healthcare is delivered received higher freedom scores.

## 45. State allows broad Medicaid reimbursement by provider type

States differ in terms of which healthcare professionals are eligible to provide services for reimbursement under Medicaid. Some states limit reimbursement to services provided by physicians. Others authorize payment for a broader range of licensed professionals, including psychologists, social workers, pharmacists, and other qualified providers. In our view, allowing broader participation is good for freedom for a number of reasons, including the fact that it allows healthcare professionals to compete in the delivery of publicly financed services and potentially drive prices down (thus creating a possible taxpayer interest for flexibility in this regard). States that restrict Medicaid reimbursement to a narrower set of providers funnels all care through those provider types, which we interpret as bad for flexibility and freedom.

This variable is scored on a scale of 1/3/5. A score of 1 indicates that a state limits Medicaid reimbursement to essentially physician only. A score of 3 indicates a state allows more than just physicians to be paid by Medicaid, but not all provider types. A score of 5 indicates that essentially all qualified provider types may be paid by the state Medicaid program.

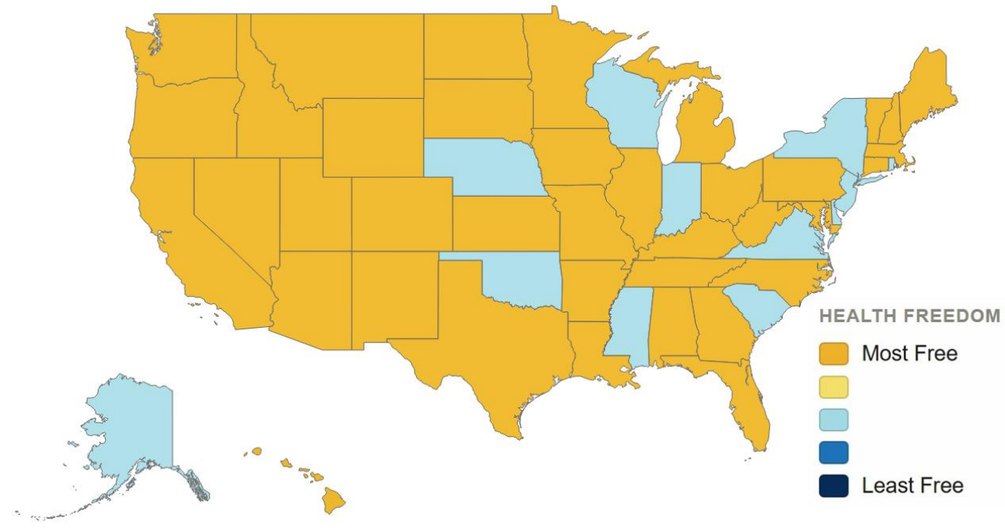





## 46. State has less restrictive telepresenter requirements

Telepresenter requirements are rules that require another healthcare professional or trained individual to be physically present with a patient during a telehealth encounter. States vary in the circumstances under which telepresenters are required and the types of professionals who may fulfill this role. While telepresenter requirements are often intended to support quality and patient safety, they can also increase costs and limit the convenience and accessibility that telehealth technologies are designed to provide. States with less restrictive telepresenter requirements allow patients and providers greater flexibility to determine when remote care can be delivered safely and effectively without an additional intermediary.

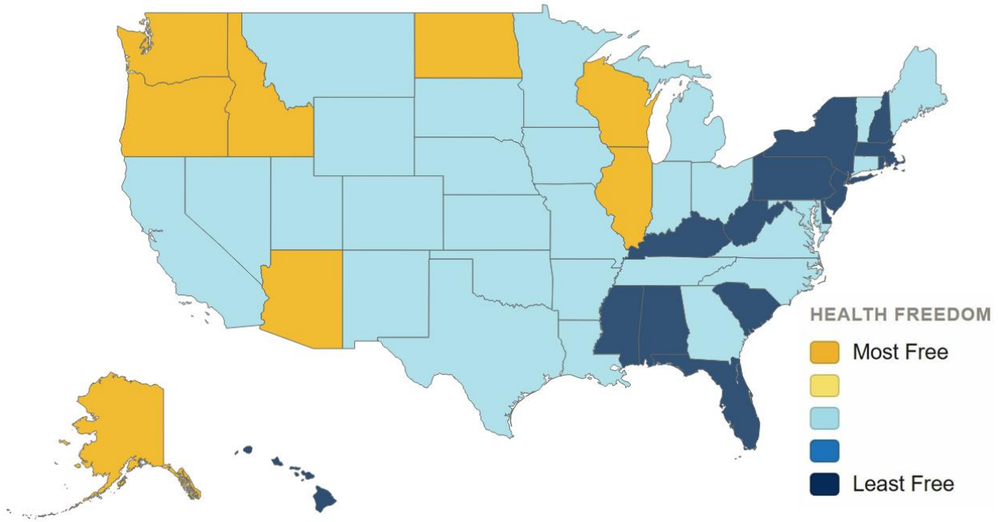
This variable is scored on a scale of 1/3/5. A score of 1 indicates that a telepresenter is required for many or all teleservices. A score of 3 indicates that a telepresenter is required for some teleservices. A score of 5 indicates that a telepresenter is not required for any teleservices.



## 47. State has less restrictive telepharmacy location laws

Telepharrnacy allows pharmacists to provide prescription verification, patient counseling, medication management, and other pharmacy services remotely via telemedicine. Some states restrict telepharmacies in various ways. For instance, some states require that a telepharmacy must be located a certain distance (e.g., 10 or 20 miles) away from any traditional, brick-and-mortar pharmacy. From a healthcare freedom perspective, fewer restrictions encourage innovation in pharmacy service delivery and expand access for patients. By contrast, geographic restrictions on telepharmacy represent a type of protectionism for traditional pharmacies.

This variable is scored on a scale of 1/3/5. A score of 1 indicates that a state does not allow telepharmacy at all. A score of 3 indicates that a state allows telepharmacy but with some restrictions. A score of 5 indicates that telepharmacy is fully allowed with essentially no restrictions.

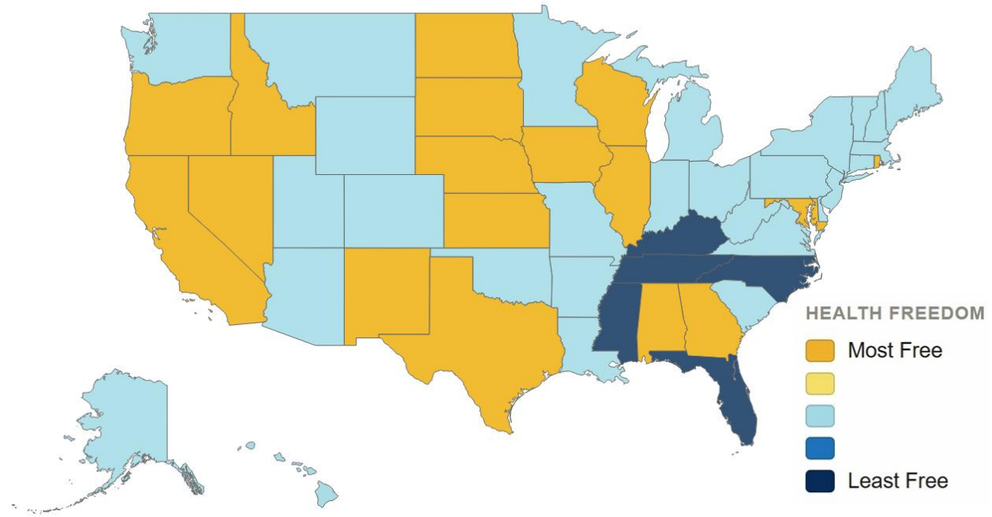





## 48. State has more flexible opioid prescription rules

In the wake of the opioid crisis, many states have enacted laws limiting doctors' ability to prescribe opioid medications for acute or chronic pain without obtaining special training and certification. This variable evaluates opioid prescribing rules for doctors in general, who have not necessarily completed this extra training.

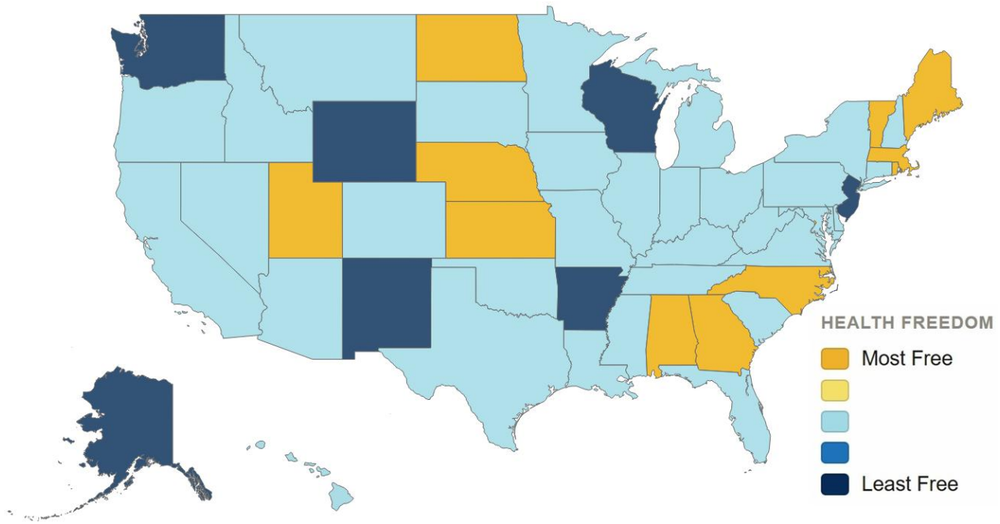
This variable is scored on a scale of 1/3/5. A score of 1 indicates that prescriptions are limited to a 3-4-day supply, 3 indicates prescriptions are limited to a 7-day supply, and a score of 5 indicates no limits on duration of opioid prescriptions for pain.



## 49. State allows online prescribing

Online prescribing refers to the ability of licensed healthcare professionals to prescribe medications through telehealth encounters without requiring an in-person visit. Some states allow healthcare professionals to prescribe online, with few or no restrictions on how it can be done. Other states allow online prescribing and require that physicians and patients establish a relationship first but allow that relationship to be established via telemedicine instead of coming into the office. Still other states do not allow online prescribing at all. From a healthcare freedom perspective, patients and providers should generally be free to determine the most appropriate means of consultation and treatment, subject to professional standards and informed consent.

This variable is scored on a scale of 1/3/5. A score of 1 indicates that online prescribing is prohibited without a physician-patient relationship, and telemedicine may not establish that relationship. A score of *3* indicates that online prescribing is allowed but only for certain substances, and/or a physician-patient relationship is required but telemedicine may be used to establish that relationship. A score of 5 indicates that the state places essentially no significant restrictions on online prescribing.



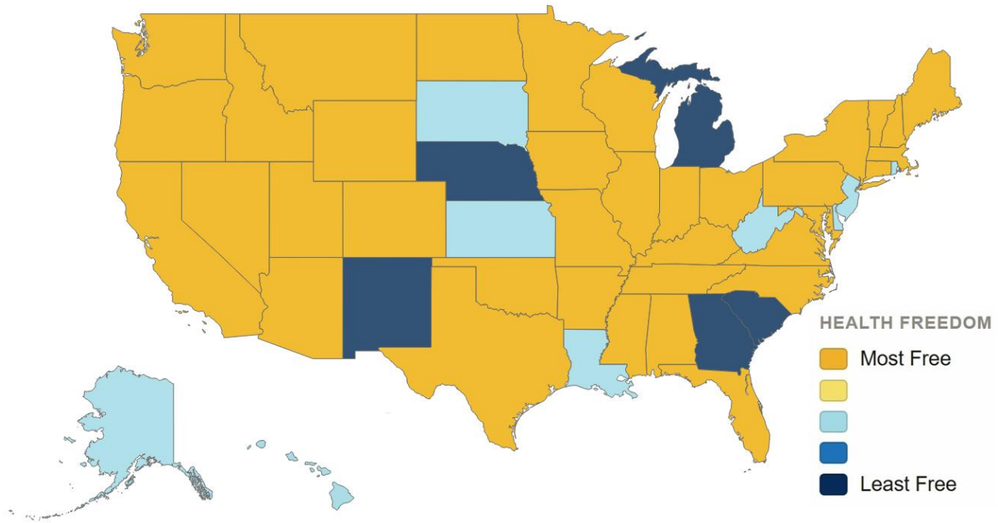





## 50. State allows online eye exams

Online eye exams use digital technologies to assess vision and, in some cases, facilitate the prescription or renewal of corrective lenses without requiring an in-person visit. States differ in the extent to which they permit these services. From a healthcare freedom perspective, permitting online eye exams expands consumer choice and encourages competition. Patients typically report satisfaction and greater convenience. However, some states prohibit or heavily restrict online eye exams, often in the name of “consumer protection.”

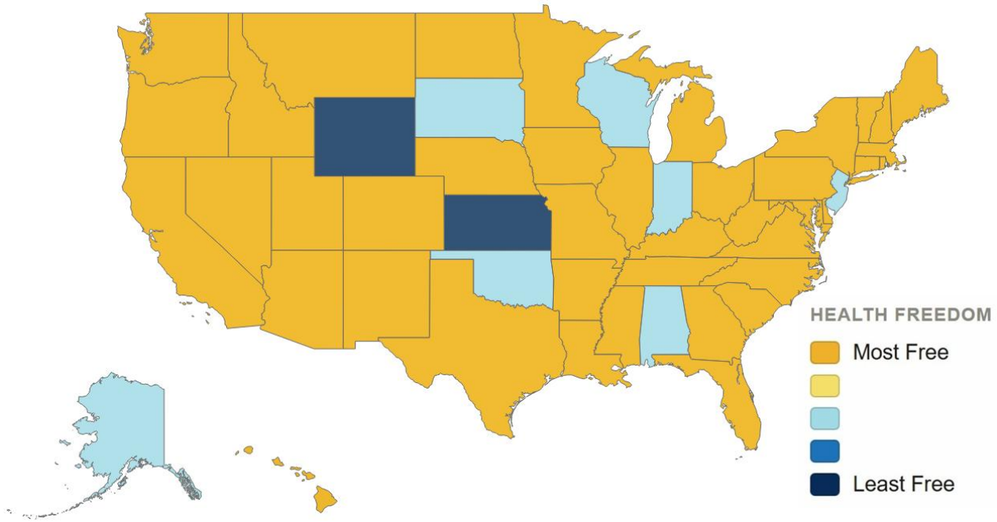
This variable is scored on a scale of 1/3/5. A score of 1 indicates that a state does not allow online eye exams, 3 indicates that a state allows online eye exams with limitations or restrictions, and a score of 5 indicates that a state allows online eye exams.



## 51. State offers protection for Good Samaritans

Good Samaritan laws afford healthcare workers who respond to emergencies outside a healthcare facility protection from being sued. Without these laws, healthcare workers are less likely to help in an emergency because they risk malpractice charges that could affect their ability to practice and their financial stability. Furthermore, malpractice insurance rarely covers healthcare workers outside of their place of employment.

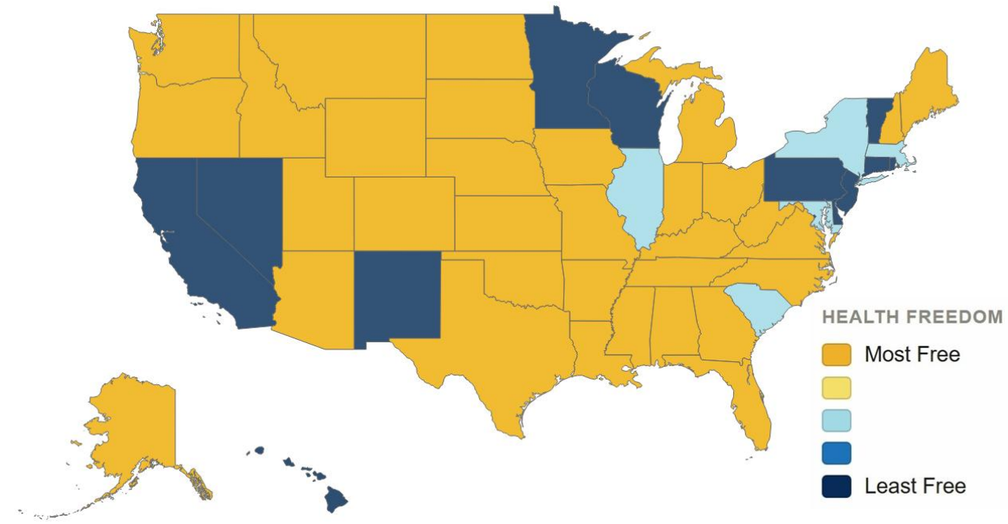
This variable is scored on a 1/3/5 scale. A score of 1 indicates that a state does not allow online eye exams. A score of 3 indicates that the state allows online eye exams but with limitations or burdens. A score of 5 indicates that the state allows online eye exams without any special limitations or burdens.




## 52. State does not treat concierge medicine / DPC practices as insurance

Direct primary care (DPC) and other concierge-style medical practices are arrangements that typically involve a recurring membership fee in exchange for access to a defined set of healthcare services (e.g., office visits, lab tests, and simple procedures). Sometimes states try to apply insurance regulations to these arrangements, which has made it necessary to pass clarifying legislation to keep these kinds of practices free from unintended restrictions.

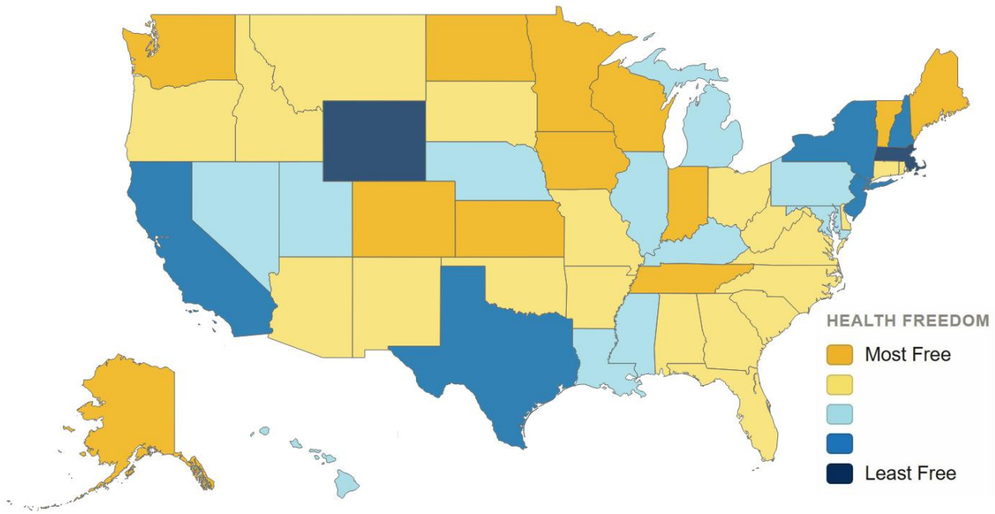
This variable is scored on a 1/3/5 scale. A score of 1 indicates that a state has (or interprets) its laws in a way that is hostile to direct primary care and other concierge-style practices. States where the insurance commission has issued a clarifying non-statutory letter that it will not treat such medical practices as insurance received a score of 3. States where a meaningful clarifying statutory law has been passed received a score of 5.



## 53. State allows drug dispensing by concierge medicine / DPC practices

Some states permit direct primary care (DPC) and other concierge-style medical practices to dispense medications directly to their patients, while others restrict this activity through pharmacy licensing requirements or other regulatory barriers. States that allow physician dispensing within DPC practices give providers greater flexibility to integrate prescription medications into their service, adding value to the membership service. Permitting this supports voluntary arrangements between patients and providers and is good for patient convenience. Conversely, prohibiting or restricting this practice reduces what these care models can offer.

This variable is scored on a 1-5 scale. States where this kind of drug dispensing is prohibited received a 1. States where drug dispensing is not prohibited but also not very viable due to other regulations in place (for example, having to do with prior authorization) received a 2. States where drug dispensing is permitted but not viable due to other regulations received a 3. States where drug dispensing is permitted but with certain requirements, such as registration, received a 4. States where drug dispensing is permitted received a 5.



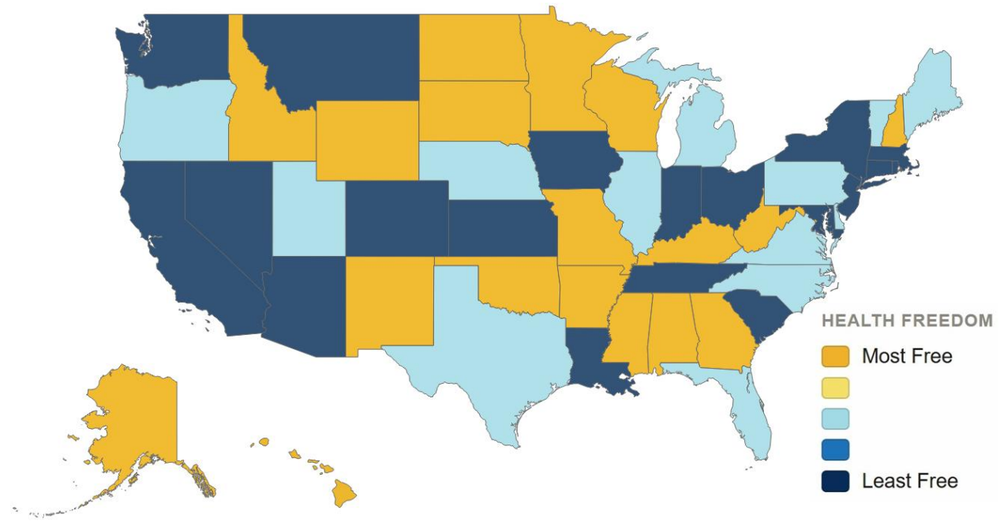





## 54. State allows wholesale lab pricing by concierge medicine / DPC practices

Some states permit direct primary care (DPC) and other concierge-style medical practices to purchase laboratory services at wholesale rates and pass those savings directly to patients without being treated as insurers. laboratories, or other regulated intermediaries. The ability to offer this service can add substantial value to the membership. States that restrict these arrangements limit the ability of innovative care models to offer bundled or discounted services and reduce opportunities for consumers to benefit from lower-cost healthcare options.

This variable is scored on a 1/3/5 scale. States where it is illegal to directly bill patients for pathology lab services received a score of 1. States where directly billing patients for pathology lab services is permitted but certain disclosures, reporting, or other requirements must be met, received a score of 3. States where directly billing patients for pathology lab services is permitted received a score of 5.



# NOTES ON DATA SOURCES

The Health Freedom Index draws on a wide range of publicly available sources, including state statutes and regulations, state agency guidance, professional board materials, Medicaid manuals, insurance department publications, policy databases, scholarly papers written on specific topics, national professional associations, prior state rankings, and issue—specific research reports.

Because the index includes 54 separate variables across all states and the District of Columbia yielding 2,754 separate scores (54 x 51), full source documentation for each variable is too extensive to reproduce in the printed report. However, a source list including citations and notes on scoring decisions for each variable will be made available online after publication of the report. Readers should interpret the scores as reflecting the best available information at the time of data collection. In cases where state law or regulatory practice was unclear, the authors used publicly available legal materials, agency guidance, and secondary sources to assign the most reasonable score. We welcome corrections, clarifications, and additional documentation from state officials, researchers, practitioners, and policy experts, and we intend to incorporate such feedback into future editions of the index.

This report and the associated data are available for download on both organization's websites.

Center for Modern Health: https://centerformodernhealth.org

Knee Regulatory Research Center: https://knee.wvu.edu



# ABOUT THE AUTHORS

Jared Rhoads, MPH, MS, is the Founder and Executive Director of the Center for Modern Health. He also teaches health policy at Geisel School of Medicine at Dartmouth. He was a Bastiat Fellow with the Mercatus Center, and one of the creators of the original *Healthcare Openness and Accessibility Project* (HOAP), which is the predecessor to this report.

Reinier Schuur, PhD, is a Policy Analyst at the Center for Modern Health. He writes on a variety of health policy issues and is the host of the podcast *The Pursuit of Health,* where he interviews people about their experiences in the American healthcare industry.

Colleen Smith, MD, is a Clinical Policy Analyst at the Center for Modern Health. She is a practicing emergency medicine physician based in New York City. She also writes about her experiences with the American healthcare system on her personal Substack, *Colleen Smith MD.*

Alicia Plemmons, PhD, is the Director of the Knee Regulatory Research Center, Director of the Center for Free Enterprise, and an Associate Professor of General Business at West Virginia University. Her research employs applied spatial and econometric methods to determine how policy changes affect health and labor markets by studying how to create environments that facilitate wellness, economic growth, and business development. Her research has been published in numerous academic journals, and she has been regularly asked to provide testimony on healthcare licensing modernization to state and federal legislatures.

Drake A Thibodaux, MBA, is the Assistant Director of the Knee Regulatory Research Center at West Virginia University's John Chambers College of Business and Economics. His research interests focus on how regulations impact occupations, healthcare, and affordability. His theoretical approach draws on ordoliberal and public choice economics.

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