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A 2024 Healthcare Reform Agenda for Achieving Affordable, Accessible, High Quality Care

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The following is text of a speech given by PRI President, CEO, and Thomas W. Smith Fellow in Health Care Policy Sally C. Pipes to the BYU chapter of the Adam Smith Society.

My charge today is to outline a policy reform agenda that will make affordable, accessible, and high-quality health care available to all Americans.

It's an important and difficult task. And it's one to which I've devoted my professional career. Since moving to the United States from Canada in 1991, I've advocated for market-oriented solutions to the thorniest health policy challenges. I've also cautioned Americans against embracing the government-dominated, single-payer healthcare model of my native land.

Free markets are the most efficient, most effective way to distribute and allocate goods and services. In the healthcare context, market-oriented policies provide for robust competition among providers, minimize regulations that distort the decisions of actors in the healthcare market, and most important, empower patients.

Not that I need to explain this to any of you! As business students, you understand the laws of supply and demand that govern every sector of the economy—the very laws that proponents of government-run health care ignore at their peril.

It's been a decade since the Affordable Care Act began injecting the federal government into the healthcare marketplace on a scale not seen since President Lyndon Johnson's Great Society. For many progressives, it was only a first step toward putting the government in charge of our nation's health care.

Some, like Vermont's socialist Senator Bernie Sanders, have their eye on banning private health coverage and forcing everyone into one publicly run health plan—a scheme they've dubbed "Medicare for All."

Nevermind that countries with such healthcare systems, including Canada and the United Kingdom, are turning the other way, by increasing the private-sector's role in the delivery of and payment for health care—either legally as in the United Kingdom or illegally as in Canada.

Earlier this year, the Biden administration launched a program of price controls on prescription drugs dispensed through Medicare, the health plan for seniors, as authorized by the Inflation Reduction Act of August 2022. The first ten drugs subject to such controls were named earlier this fall; those prices take effect in 2026. Next fall, 15 more will be selected for price controls that take effect in 2027. Price controls on 15 more will take effect in 2028, and in 2029 and thereafter, 20 drugs a year will be ensnared by price controls.

For years, Democrats have been the party responsible for pushing these disastrous policies. But in recent years, something troubling has developed: the GOP, once the party of free enterprise, has become more comfortable with government meddling in the healthcare market.

In September, Republicans in North Carolina green-lit an expansion of Medicaid, one of the main policy priorities of the Affordable Care Act, after years of resisting.

Senator Josh Hawley (R-MO) has even called for the federal government to regulate the price of prescription drugs.

Still, there are glimmers of hope. At the second Republican presidential debate, between highly charged tussles over Ukraine and the southern border, candidates had a brief opportunity to discuss their visions for healthcare reform. What they said should put a smile on any free-marketer's face.

Former Vice President—and now former GOP candidate—Mike Pence called for reallocating federal healthcare dollars to the states. Nikki Haley criticized pharmaceutical industry middlemen and outdated healthcare regulations.

That's a promising start. But a few quips on the debate stage do not make an agenda.

Which brings us back to the topic at hand. Over the next few minutes, I'll outline an agenda that any presidential candidate sympathetic to free markets should be happy to endorse. I'll walk through policies that will promote innovation, competition, and transparency—and suggest some outdated and ineffective rules and regulations that lawmakers should eliminate.

To underscore the importance of a free-market healthcare agenda, I'll relate what happens when health care is left to the government, whether in countries with single-payer systems or government benefit programs here at home. I'll even propose some policies that a Democrat could like.

ELIMINATING HARMFUL REGULATIONS TO CLEAR THE PATH FOR A BRIGHTER HEALTHCARE FUTURE

As fans of free markets, we understand that most regulation is bad regulation. Anything that puts bureaucrats over businessmen or encumbers willing buyers and sellers is by definition worse than the absence of such regulation.

But of course, we must accept some regulations. The question is which ones. Which are necessary evils—or at least unavoidable nuisances? And which are actively detrimental to patients and the healthcare system?

Certificate-of-need laws are decidedly in the latter camp. These laws prohibit hospitals and other healthcare providers from modifying or expanding facilities without first obtaining permission from state government.

Certificates of need were intended to keep health costs down by preventing inflation that could be caused by the construction of excess medical capacity. If a hospital pays for a new MRI machine, the thinking goes, providers will feel compelled to use it—potentially by ordering unnecessary procedures for patients.

These laws are on the books in 35 states and the District of Columbia. And they've utterly failed in their intended pursuit.

Certificate-of-need laws stifle competition by giving incumbent healthcare providers the opportunity to lobby against the entry of competitors into the markets where they operate.

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Restraining competition is a recipe for higher costs. Indeed, as research from the Mercatus Center has concluded, "The balance of evidence suggests that certificate-of-need laws are associated with higher per unit costs and higher total healthcare spending."

The federal government can't order states to repeal their certificate-of-need laws. But it can make it worth their while to do so.

Bob Moffit at the Heritage Foundation has suggested that lawmakers slash federal Obamacare and Medicaid subsidies to states that still have certificate-of-need laws. After all, the amount that the feds spend subsidizing Obamacare plans or state Medicaid programs depends in large part on how high a state's healthcare costs are.

If certificate-of-need laws drive up a state's health costs, then they also drive up the federal government's health bill, too.

Why should taxpayers subsidize states' misguided policies? Pursuing the kind of policy Bob suggests would save the country money and nudge states like Vermont and New York to scrap these outdated policies.

As an aside, Utah is one of the 15 states that has completely scrapped certificate-of-need laws. That's one reason Utah has the lowest per-person healthcare costs in the country. Average annual health spending in the Beehive State is just over $7,200 per person, according to research compiled by Forbes. Average annual health spending in New York is nearly $6,000 higher.

Here's another reason health costs are so low in Utah—the state has loose scope-of-practice laws, which prevent nurse practitioners and physician assistants from diagnosing, treating, and prescribing drugs to patients without a doctor's supervision.

Like certificate-of-need laws, scope-of-practice regulations are well-intentioned. The idea behind them is that only doctors have the requisite training and knowledge to fully treat patients.

But research has repeatedly and conclusively shown that nurse practitioners perform as well as physicians in both primary and specialty care settings.

There are over 350,000 nurse practitioners in the United States. They all have graduate degrees, advanced training, and prescribing privileges.

And in half the country, they can't diagnose or treat patients without a doctor's approval. Physician assistants face similar restrictions in many states.

In other words, America's healthcare system has hundreds of thousands of qualified practitioners who could see and treat more patients but for government regulation.

When supply goes up, prices tend to go down. Indeed, repealing scope-of-practice laws for nurse practitioners alone could save the healthcare system $810 million, according to one estimate.

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In addition to cutting costs, repealing scope-of-practice rules will help address the physician shortage that's hitting low-income and rural areas particularly hard.

Another way to increase the effective supply of health care is by ensuring that telehealth remains a viable option for patients across the country. During the coronavirus pandemic, virtual doctor visits went from novelty to necessity.

Democrats and Republicans alike have expressed support for making COVID-era expansions of telehealth permanent by making it easier for private and public insurance to cover virtual visits like they do in-person visits.

A permanent extension of telehealth flexibility could be the silk purse made out of the sow's ear of a pandemic.

REFORMING THE HEALTH CARE INSURANCE MARKET

It also brings us to the next part of the healthcare sector where reform is desperately needed: the insurance market.

Roughly 8% of Americans were uninsured in 2022. The remainder got their health insurance from one of three sources: the government, their employer, or the individual market. Each payer has its problems.

Consider employer-sponsored insurance, which covers a little over half of Americans—170 million. For decades, it's been the gold standard for health coverage.

Employer-sponsored insurance really took off during World War II, when wage controls limited employers' options for recruiting and retaining workers. They began using health benefits, which were exempt from income tax and not subject to the wage controls, to attract and keep employees.

But employer-sponsored insurance is expensive. What should have been raises and cost-of-living adjustments for employees are instead going to health insurers in the form of ever-increasing premiums. As the Hamilton Project at the Brookings Institution has shown, "benefits have made up an increasingly large share of compensation" in recent decades, while "wage growth has lagged."

In his book *Catastrophic Care,* Sesame Care CEO David Goldhill posits that a hypothetical employee making $40,000 a year would lose nearly $2 million in wages to insurance premiums over the course of his or her career.

Employers spend about $8,400 on average to insure a single employee, a 7% increase from last year, according to the Kaiser Family Foundation's annual Employer Health Benefits Survey.The comparable premium for a family is nearly $24,000.

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Employer-sponsored insurance has some other weaknesses. As its name indicates, it's tied to a specific employer. Workers can't take their coverage with them if they'd like to leave a job—perhaps to take care of a family member or to start their own business. That locks people into jobs that may not be good fits—and results in a less dynamic economy.

Employer-sponsored coverage also encourages beneficiaries to use more health care than they might need because they're not paying for it directly. It's often a "use-it-or-lose it" proposition.

And in many cases, employer-sponsored coverage kicks in from the very first dollar a person spends on health care. That incentive for over-consumption raises overall health costs.

A functional individual market would address some of the weaknesses of the employer-sponsored market. But Obamacare has rendered our individual market completely dysfunctional.

Average individual market premiums more than doubled between 2013—the year before Obamacare took effect—and 2019. Those surging premiums are largely a function of Obamacare's rules and regulations.

For example, the law requires that all plans sold through Obamacare's exchanges cover 10 "essential health benefits," including addiction care and maternity coverage—regardless of whether someone wants or needs those benefits.

That means that a childless 35-year-old man can't purchase an exchange plan that only covers doctor visits and hospital coverage to save money. He has to buy an Obamacare-compliant plan, at inflated prices.

The law also mandates that insurers sell to all comers, regardless of health status or history, and bars insurers from charging the old any more than three times what they charge the young. Those rules may be popular. But they have the effect of raising the cost of coverage for everyone, especially the young.

Short-term, limited-duration insurance plans cover enrollees for up to a year and can be renewed by insurers for a maximum term of three years.

They also create a series of perverse incentives, whereby insurers attempt to avoid signing up older or sicker people by constructing narrow networks that may not include best-in-class providers.

Fortunately, some plans in the individual market are exempt from the Affordable Care Act's costly mandates.

Short-term, limited-duration insurance plans cover enrollees for up to a year and can be renewed by insurers for a maximum term of three years. They do not have to cover Obamacare's essential health benefits, and insurers can take a person's health status and history into account when setting premiums or deciding whether to offer coverage.

As a result, the average short-term insurance plan costs around 70% less than a comparable, unsubsidized Obamacare plan.

Such affordable plans can be particularly good fits for people who are between jobs and have lost their coverage or cannot afford COBRA coverage. Young adults who typically secure health coverage through a university when enrolled may find short-term plans useful, too.

A few years ago, the Manhattan Institute's Chris Pope looked at what a 30-year-old male nonsmoker in Atlanta could get on the short-term market, versus what was available in the exchange.

He found that our hypothetical young man would pay $467 a month for a mid-level silver plan on the exchange—and just $250 a month for a similar 360-day short-term plan.

Unfortunately, Democrats have waged an all-out war on these plans, which they decry as "junk insurance." They claim that short-term plans skimp on benefits and expose beneficiaries to high costs if they fall ill and require medical treatment.

But Pope's research found that short-term plans often offered access to a wider array of providers than exchange plans—and at a fraction of the cost. As he wrote, "For equivalent insurance protection, the premiums for short-term plans are lower than—in some cases, almost half the cost of—premiums on the exchange."

Or from another perspective, many people can secure more generous coverage in the short-term market than they can get for equivalent premiums on the exchanges.

Once again, Utah is on the right side of this issue. The Beehive State allows for short-term plans with up to 36 months of renewability.

It is precisely because short-term plans threaten to undermine the Affordable Care Act by providing people with an escape hatch that Democrats have fought so hard to smother them.

Blue states like New York and California have banned short-term insurance plans outright. The Biden administration is trying to set the maximum term for a short-term plan at three months, with an option to renew for one additional month.

Fortunately, there is movement afoot in Congress to expand access to association health plans.

Deregulating short-term plans would quickly and easily expand access to affordable coverage. Democrats say that's their goal—but their actions suggest otherwise.

They're deploying the same playbook against association health plans, which allow individual workers and small employers in the same sector to join together to purchase health coverage as a group. The idea is that there's strength in numbers—they can extract better terms from insurers or providers as a group than they could on their own.

For years, regulators have attached so many strings to association plans that forming them has been essentially impossible. The Trump administration tried to make it easier to form AHPs in 2018, but Blue states quickly imposed their own restrictions, and the Biden White House reversed the Trump administration's guidance earlier this year.

Fortunately, there is movement afoot in Congress to expand access to association health plans. The House of Representatives recently passed the CHOICE Arrangement Act, which would increase the number of Americans who could form associations for the purposes of purchasing health insurance.

CHANGING HOW WE PAY FOR HEALTH CARE

Thus far, I've focused on reforms that can increase the supply of health care. Now I'll focus on the demand side of the equation.

And by that, I mean, we need to change how we pay for health care.

Under the healthcare status quo, third-party payment rules. Employers or individuals purchase insurance, and providers file claims with those insurers for compensation. Beneficiaries are generally unaware of the prices of the healthcare services they consume.

Providers themselves may be unaware of those prices—they simply file a claim, and then the insurer turns around what would seem to most observers an arbitrary reimbursement.

The system is opaque and rife with misaligned incentives. The insurers' customers aren't the beneficiaries—they're the employers. Providers' customers aren't the beneficiaries—they're the insurers. Patients are almost afterthoughts.

We need to make the market for health care much more like the market for other goods and services, where consumers are in charge—where they control their own dollars and can make their own decisions about how and where to seek care.

The best way to do this is by expanding different types of tax-advantaged healthcare savings accounts.

Chief among these are Health Savings Accounts, or HSAs. HSAs have not one, but three tax advantages: savers are not taxed on contributions or withdrawals, money in the accounts grows tax-free, and unused funds can be carried forward tax-free to the next year.

Currently, individuals can contribute just under $4,000 to these accounts each year, while families can contribute about double that.

Want a surefire way to expand the benefits of these accounts? Raise those limits!

Congressman Andy Biggs (R-AZ) has introduced a bill that would raise the individual and family HSA contribution limits to $9,000 and $18,000, respectively.

But we can do more. Lawmakers from both parties have thrown their support behind a bill that would let Medicare beneficiaries contribute to HSAs. We can reform the law so that people can use the proceeds from their HSAs to cover their insurance premiums. And we can permit anyone to open and contribute to an HSA—not just those with a high-deductible plan.

HSAs aren't the only tax-advantaged accounts that ought to garner bipartisan support.

About half a million Americans currently use individual coverage health reimbursement arrangements, or ICHRAs. These accounts let employers give workers tax-free dollars to spend on insurance plans of their choice.

Rather than the open-ended defined benefit of an employer-sponsored insurance plan whose cost goes up every year, employers get the financial predictability of a defined contribution toward their employees' health care.

Employees, meanwhile, get the freedom to purchase plans that best suit them, rather than their employers. ICHRAs are particularly beneficial to smaller employers, who may not have the resources to purchase comprehensive group coverage.

Democrats should like ICHRAs, too. Their proceeds can only be used to purchase Obamacare-compliant individual market plans. No "junk insurance" here!

Yet we simply accept that we can't comparison-shop for medical care—and that we can't get a good read on the relative quality of one doctor or hospital versus another.

Whether through HSAs, ICHRAs, or other vehicles, it's important to put patients in charge of purchasing and steering their own coverage and care. Doing so will unleash a much-needed wave of competition throughout the healthcare market.

Right now, most of us don't bother looking up what a particular healthcare service costs before going to the doctor or hospital. Even if we did, there's no guarantee we'd be able to find the information we want. Hospitals hide their prices between arbitrary and inscrutable codes, and as long as you're insured, you don't pay the list price, anyway.

I'd imagine you've experienced as much firsthand. You go to the doctor for an x-ray, and a month later you get an "explanation of benefits" in the mail letting you know the service cost $1,000, insurance "negotiated" that figure down to $200, and you're responsible for $50.

This arrangement is completely unnecessary. Its only purpose, if you can call it that, is to help hospitals milk millions of dollars from insurance companies. It is precisely because of this arrangement that patients spend hours on the phone contesting billing errors—or worse, end up paying out of pocket for things they thought were covered by their insurance but were not.

We shouldn't tolerate such an extreme degree of opacity in health care. We certainly wouldn't in any other facet of our lives.

You wouldn't buy a car without comparing the prices of different makes and models at different dealerships. And you probably wouldn't book a table at a new restaurant without first checking some reviews online.

Yet we simply accept that we can't comparison-shop for medical care—and that we can't get a good read on the relative quality of one doctor or hospital versus another.

If we controlled our own healthcare dollars, we wouldn't accept this status quo. When people have money on the line—real dollars they've accumulated in an HSA or ICHRA, not the abstract concept of insurance coverage—they won't settle for "well, I guess we'll see when the explanation of benefits comes!" Patients will demand that providers share the prices for their services—and then choose the option that provides the best bang for their buck.

Providers who respond to that demand will thrive. Those that choose to remain opaque will not.

Over time, providers will compete with one another for patients' business—not just by lowering prices but by offering a better value proposition. Perhaps that's more convenient hours, or a bundle of extra services, or a pitch that emphasizes more successful outcomes for the patients they treat.

Eventually, the healthcare market will begin to resemble a more conventional consumer market. Before too long, technology will catch up. We'll see apps spring up that allow patients to compare providers like they currently compare restaurants and body shops. More transparency will spur more competition—and create a virtuous cycle for patients.

Federal rules requiring hospitals to post their prices online took effect in January 2021. Similar rules went into effect for insurers in January 2023. But many of these entities are not complying with the rules, in some cases because it's easier or even less expensive to simply pay the fines than to be transparent about their prices.

HEALTH CARE IN THE PUBLIC SECTOR

Taxpayers cover roughly half of the nation's health bill. Yet we're often in the dark about how effectively and judiciously elected officials and public employees spend those dollars.

Consider Medicaid, the public health program for low-income people jointly funded and administered by the federal government and states. It's infamous for offering substandard care. One famous study of low-income people in Oregon found that those with Medicaid coverage posted health outcomes that were no better than similarly situated people without coverage of any kind but who can turn up at an ER at no cost.

People with Medicaid often struggle to find doctors who will see them because the program pays so little. Medicaid pays doctors 30% less than Medicare, which in turn pays less than private insurance. And if Medicaid beneficiaries do find a doctor who will see them, the wait for care is often much longer than what someone with private insurance would face.

Given the access issues posed by these underpayments, you might think public officials would do everything they could to cut down on unnecessary expenditures.

Unfortunately, that's not the case. Improper Medicaid payments cost taxpayers more than $80 billion in 2022, up from $36 billion in 2018.

Eliminating wasteful spending & fraud should be job one for public officials. They can do so in part by making sure that people who are enrolled in the program are actually eligible.

At the onset of the pandemic, the federal government wanted to ensure that Medicaid served its purpose as a safety-net program, as millions of people lost their jobs in the initial wave of COVID shutdowns. So it offered states a deal: the feds would pick up a greater share of state Medicaid programs' tabs as long as states did not kick anyone off their Medicaid rolls, even if they would've been ineligible under normal circumstances.

It worked. Over 23 million Americans gained coverage through Medicaid between February 2020 and March 2023.That pushed the program's total enrollment to nearly 95 million.

The feds gave states permission to begin auditing their Medicaid rolls April 1 of this year. They also began ratcheting down the extra Medicaid cash.

But the Biden administration and Democrats in Congress have also been calling on states to slow down their eligibility checks. They claim that aggressively "redetermining" whether people actually qualify for Medicaid is robbing vulnerable people of coverage.

Eliminating wasteful spending & fraud should be job one for public officials. They can do so in part by making sure that people who are enrolled in the program are actually eligible.

Yet according to research from the Paragon Institute, roughly 18 million ineligible people were enrolled in Medicaid as of April 1. Paying for their coverage runs $80 billion a year. Disenrolling them quickly would save the federal government $41 billion and states $12 billion.

It's nonsensical for the government to pay for Medicaid for people who are not eligible for the program under the law. Democrats have been arguing for just that kind of approach.

Medicare is in similar need of fiscal reform. The program's Part A Hospital Insurance Trust Fund is projected to be exhausted by 2033, as the program is paying out more per beneficiary than taxpayers are contributing.

Total Medicare spending is projected to eclipse $1 trillion this year. By the end of this decade, Medicare will account for one in four healthcare dollars spent in this country.

The share of costs for supplementary medical insurance for things like physician services and prescription drugs that's covered by Medicare beneficiaries has fallen from roughly 50% to 25%.

In other words, taxpayers have been picking up a larger and larger segment of Medicare's costs over time.

Fixing Medicare requires not just fighting fraud but changing the way benefits are administered. On this front, there are two main solutions: the easy one, and the hard one.

Let's start with the easy one.

Medicare Advantage plans are privately administered and deliver the same physician and hospital coverage as Medicare Parts A and B. Medicare Advantage plan sponsors submit bids to the federal government to provide benefits to seniors in a certain area. Then they have to compete for seniors to enroll—and deliver those benefits below a benchmark set by the federal government. They must share the gap between their bid and the benchmark with seniors in the form of additional benefits.

This structure gives Medicare Advantage plans a strong incentive to keep costs down and to offer an appealing array of services to beneficiaries.

This competition works. The average bid from a Medicare Advantage plan in 2023 was 17% less than traditional Medicare would've spent to provide the same benefits. And Advantage plans don't compromise quality in order to control costs. Advantage enrollees report similar satisfaction rates as their counterparts in traditional Medicare plans.

The more retirees that enroll in Medicare Advantage plans, the more money Medicare will save the American taxpayer—and the better the program will be able to allocate funds across the board.

Thankfully, enrollment in Medicare Advantage is growing. Advantage plans are set to sign up a majority of seniors for the first time this open enrollment season.

The other way to fix Medicare will be much harder to accomplish. And that's raising the age at which people become eligible for benefits.

Americans are living longer and longer. At the same time, there are fewer workers to support each retiree than there were decades ago. And health costs, including in Medicare, have been growing faster than the rate of inflation for decades.

The difficulty here is not logistical but political. You've probably all heard Social Security described as the "third rail of American politics," because it carries the same warning as the electrified rail on subway tracks—touch it, and die.

Changing the terms of Medicare is at least as politically perilous as doing so for Social Security. But politics cannot trump math.

Americans are living longer and longer. At the same time, there are fewer workers to support each retiree than there were decades ago. And health costs, including in Medicare, have been growing faster than the rate of inflation for decades.

We're going to run out of money unless something changes. That "something" should be the current retirement age of 65.

When Democratic President Lyndon Johnson signed Medicare into law in 1965 as part of his Great Society program, the average American man's life expectancy was just under 67 at birth. For women, it was close to 74. Today, average life expectancy at birth is just over 73 for men and over 79 for women.

And those figures take into account the folks who die young. People who make it to age 65 can generally expect many years of health ahead of them. The average 65-year-old man today can expect to live another 17 years, while the average 65-year-old woman will hold on for another two decades.

Back in 1965, men and women who lived to 65 were only expected to live another 13 years and 16 years, respectively.

Raising Medicare's eligibility age would also reflect the reality of how people work today. As recently as 1991, the average American checked out of the workforce at 57. Today, the average American retires at 66 or later—that is, a full year after the official retirement age.

Raising Medicare's eligibility age would not necessarily mean taking benefits away from retirees. If people are working until they're 66 or more, there's a good chance they have employer-sponsored insurance—or the means to purchase insurance directly.

The case for raising Medicare's eligibility age will only grow stronger as medical science advances and keeps us alive longer.

The case for raising Medicare's eligibility age will only grow stronger as medical science advances and keeps us alive longer.

We can thank new drugs for many of those extra years of life. One recent study found that, thanks in a large part to new oncology drugs, the cancer death rate dropped 31% from 1991 to 2023. That's equivalent to nearly 4 million averted deaths.

Nor is this kind of lifesaving innovation limited to the oncology space. Pharmaceutical advancements were two-thirds of the reason the mean age of death increased from 2006 to 2018, Columbia University professor Frank Lichtenberg found in a 2022 study. Moreover, these developments were incredibly cost-effective, running just $36,000 for each life year gained.

Unfortunately, misguided policies are imperiling medical progress. As I mentioned at the start of my talk, the price controls on prescription drugs that are looming thanks to the Inflation Reduction Act are already crippling drug development.

It takes well over $2 billion to bring a drug from the lab to the patient. Some companies are calculating that they won't be able to recoup those kinds of investments with the threat of price controls looming. So they're pausing research into new therapies.

And things are only going to get worse. One study found that 139 fewer drugs will be developed in the coming decade as a result of the Inflation Reduction Act's price controls.

These price controls on branded medicines will also discourage manufacturers from investing in generic drugs. Why would they spend money building factories and seeking approval for a generic formulation of a branded medicine that's subject to price controls?

The result will be a more fragile supply chain, with just a single manufacturer of price-controlled medicine that has little incentive to invest in production improvements. A natural disaster or manufacturing snafu could lead to widespread supply shortages.

And who's to say that the government-dictated price will be lower than robust generic competition would yield? Today, generic drugs cost on average between 80% and 85% less than their brand-name competitors. The IRA's price controls are short-circuiting the kind of market competition that eventually yields lower prices, more choices, and better value.

To make matters worse, price controls could even make it harder for American patients to access drugs developed in other countries. Drug companies generally launch their medicines in countries where they have the best chance of earning a return while they have the exclusive rights to manufacture and sell their drugs.

Because drug companies want to launch their drugs where they can earn their money back, they tend to seek out countries with free markets.

At the moment, that works to American patients' advantage. One 2019 study found that patients in the United States had access to 89% of all new drugs released between 2011 and 2018. By comparison, patients in the United Kingdom had access to just 60% of new drugs released in that period. Canadian patients had access to just 44%.

Developing new drugs to slow, ameliorate, or cure those chronic diseases will save the country money—and help patients live longer, happier, more fulfilling lives.

If we follow the lead of Canada and the United Kingdom by embracing price controls, American patients will have to wait longer for access to innovative therapies—if those therapies come about at all.

Access delayed or denied is costlier in the long term than any savings that price controls may deliver in the short term.

The Centers for Disease Control and Prevention estimates that chronic disease and mental health account for 90% of the country's annual healthcare costs, about $3.7 trillion per year. Developing new drugs to slow, ameliorate, or cure those chronic diseases will save the country money—and help patients live longer, happier, more fulfilling lives.

CONCLUSION

Free markets are the cure to what ails the American healthcare system. Compared to government regulations and subsidies, competition and transparency bring about higher-quality goods and services at lower cost to patients and taxpayers alike.

From doctors and drug companies to insurance plans and federal benefit programs, we need to bring free-market principles back to American health care. We need to empower doctors and hospitals, not the government.

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