IMPROVING HEALTH CARE

AFFORDABILITY, ACCESS, AND INNOVATION

GE BAI, DAVID A. HYMAN, AND CHARLES M. SILVER

The United States has long been Number 1 worldwide in healthcare spending. In 2023, U.S. healthcare spending totaled $4.9 trillion, or 18% of our nation's GDP. That translates into almost $15,000 per capita—double the average of other developed countries and two-thirds higher than Switzerland, the next highest spender (Centers for Medicare & Medicaid Services, 2024; Wager et al., 2025). The return on this massive investment is unimpressive, to say the least. At the population level, the U.S. consistently ranks at or near the bottom among developed nations in key health metrics, such as infant mortality, prevalence of chronic disease, life expectancy, and preventable mortality (Puthumana, Grogan, & Bai, 2025). In fairness, these metrics are affected by many factors beyond health care, and there are other performance measures on which the U.S. does better.

That said, at the individual level, many Americans are deeply dissatisfied with the healthcare system—and with the behavior of the insurance companies that pay the resulting bills. Stories about surprise medical bills, bureaucratic barriers to care, and denied claims are pervasive. When the CEO of United Healthcare was shot down on a Manhattan street, his (alleged) assassin quickly achieved folk hero status in some circles (Saric, 2024), a clear indication of the public's frustration with the healthcare status quo.

The U.S. obviously faces significant challenges in healthcare affordability and access, but opinions on how to address these challenges differ widely. Many argue that additional regulation is necessary, viewing it as essential for the protection of patients and treating it as a driver of beneficial innovation (Guterman, 2017; National Academies of Sciences, Engineering, and Medicine, 2024). Others contend that current levels of regulation are routinely counterproductive and argue that a dose of deregulation is the best path forward ((Puthumana, Grogan, & Bai, 2025; Silver & Hyman, 2018; Bai & Hoover Institution, 2020). This healthy debate is critical to our nation's search for strategic direction in a sector that affects the lives and wellbeing of every American, as well as patients around the world. In this article, we identify the ways the existing levels of regula-

tion have created barriers to affordability, access, and innovation in health care, and we then outline a roadmap for reform.

BARRIERS TO AFFORDABILITY, ACCESS, AND INNOVATION

Although multiple factors contribute to the suboptimal state of affairs in U.S. health care, excessive government regulation plays a central role (Silver & Hyman, 2018). Regulations, such as those that govern providers' charges for services, establish tax preferences for dollars spent on treatments and insurance, encourage or require the use of electronic health records, or mandate certain forms of insurance coverage, can discourage or prohibit innovations that many physicians and patients may prefer. Because existing health-care businesses possess considerable political muscle, lawmakers are especially likely to promulgate regulations that prevent new entrants from competing with them. The excessively burdensome and constrained regulatory environment in which U.S. health care operates has a major first-order negative impact on achieving the goal to which we all aspire: an affordable, accessible, and innovative healthcare delivery system.

More specifically, excessive regulation distorts both the supply and demand sides of the equation (Cochrane, 2015). On the supply side, excessive regulation suppresses competition, erects barriers to market entry, and routinely ends up serving the interests of incumbent providers instead of patients (Hyman, Letchuman, & Bai, 2024). For example, independent physicians and freestanding outpatient facilities (e.g., ambulatory surgery centers and imaging clinics) are essential sources of competition in the provider market. Their presence pressures all providers—particularly hospitals—to innovate, improve quality, reduce costs, and expand access to care. However, excessive government regulation has tilted the playing field in favor of hospitals, which are large incumbent providers that have political power. The list of particulars includes the 340B Drug Pricing Program (Bai, 2023); site-based payment differentials (Richman, Plummer, & Bai, 2024); provisions in the Affordable Care Act (ACA) that effectively limit the creation and expansion of

ABOUT THE AUTHORS

Ge Bai is a professor of accounting at the Johns Hopkins Carey Business School and a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health.

David A. Hyman is the Scott K. Ginsburg Professor of health law and policy at Georgetown Law School. He is an Adjunct Scholar at the Cato Institute and a non-resident Senior Fellow at the American Enterprise Institute.

Charles M. Silver is the McDonald Endowed Chair in Civil Procedure at the School of Law, University of Texas at Austin, and an Adjunct Scholar at the Cato Institute.

physician-owned hospitals; the Ethics in Patient Referrals (Stark) Law (Hyman, Letchuman, & Bai, 2024); certificate-of-need laws; Certificates of Public Advantage (Chen, 2024); and licensing requirements (Cato Institute. 2022).

Excessive regulation of pricing, quality, benefit design, care delivery, and technology has further stifled innovation. Examples include Medicare's highly prescriptive payment models (Blase, 2023), the ACA's community rating and essential health benefit mandates (Pope, 2023), and health technology rules (American Medical Association, 2024). These rules disadvantage new, smaller players and limit the options for innovators of clinical products, delivery systems, and insurance products.

On the demand side, regulation hides the true cost of health care, thereby inflating healthcare demand. Examples include employment-based private insurance coverage (Hyman, Letchuman, & Bai, 2024), certain aspects of the ACA that mandate premium structures and benefit designs, and various subsidies that are embedded in public and private programs (Silver & Hyman, 2018). By eliminating price signals, these arrangements increase spending and utilization while discouraging innovators from developing or pursuing more affordable alternatives (Cochrane, 2015).

These excessive and/or misguided regulatory interventions help explain why U.S. health care is so expensive. Regulation has resulted in misaligned incentives, reduced competition, inflated prices, and consolidation. The poor and disadvantaged have been harmed the most (Schwandt et al., 2025). Existing payment arrangements guarantee neither access to quality care nor improved health status. Coverage has expanded for low-income Americans (although it remains to be seen how the "One Big Beautiful Bill Act" will affect things), but enhanced coverage has not translated into access to consistent high-quality care (Hyman, 2024).

The conventional response to concerns about affordability and access is to double down on spending and regulation (Williams, Zima, & Miller, 2025). Because of entrenched financial and political interests, this approach has dominated U.S. health policy for decades. But more spending merely purchases more of the same, and doing more of the same simply gives the industry more opportunities to encourage already-captured regulators to do its bidding. As Nobel laureate Professor George Stigler (1971) observed, regulation is typically designed by incumbent industry interests and operated for their benefit. That simple insight helps explain the constellation of direct subsidies (when we are already spending too much on health care), entrance controls (when market entry is the key to innovation and lower prices), and price setting (which has never worked and will never work to improve access, lower prices, and promote innovation) that we see when we look at the healthcare system.

If we want something more than "*déjà vu* all over again," it is time to try something different. Below we spell out seven principles that should inform any attempt to reform our healthcare system. We then offer a road map for doing just that.

SEVEN PRINCIPLES GOVERNING HEALTHCARE MARKETS

We begin with some basic realities that past reforms have ignored or unduly discounted. These principles should serve as touchstones when designing and implementing reforms to promote affordability, access, and innovation.

1. Health care is far from the most important determinant of health, and it is health that we should care about and design our policies around.

A dollar spent on health care is a dollar not spent on other goods and services that may yield better health.

Although health care is important, it is not the primary determinant of health. Other factors—diet, exercise, education, income, housing, and personal behavior, etc.—have a far greater influence on long-term health outcomes than medical interventions (Hyman, Letchuman, & Bai, 2024). Over-investment in health care crowds out spending that may yield greater improvements in health. For instance, a dollar spent on improving education might have a greater impact on mortality and life quality than a dollar spent on excessive or unnecessary treatments. This principle highlights the need for a balanced approach to health policy, rather than one that puts health care (and ever more comprehensive insurance to pay for it) at the center of all discussion.

2. Health care is a complex, information-intensive personal service with elastic demand.

Health care is often treated as "special"—meaning that many people believe that market forces and economic principles do not (and should not) apply. This viewpoint has informed generations of health policy and helps explain why our healthcare system is not affordable or accessible.

In reality, health care is a complex, information-rich personal service that people consume when needed. This means that health care will inevitably be shaped by supply, demand, consumer knowledge, and consumer behavior (Cochrane, 2015). The complexity of health care means that it often requires specialized knowledge, but patients' willingness to pay varies with price, quality, and perceived necessity. For some things patients want "nothing but the best," while for others they will settle for "good enough" or go without, since they value other things more. The main thing that is "special" about health care is that many people persist in believing it is special, despite considerable evidence to the contrary. If we want to lower prices, expand access, and optimize resource allocation, we should stop treating health care as special.

3. Government price controls don't work.

Governments have long tried to contain healthcare costs through price setting. These efforts sometimes work in the short term, but they are devastating in the long run. Price setting distorts incentives, suppresses supply, undermines quality, and leads either to regulatory capture or to shortages. In contrast, markets harness all of the decentralized knowledge that is necessary to establish prices that reflect both supply and demand. These market prices reward efficiency, signal scarcity, and stimulate innovation, thus fostering a competitive and dynamic healthcare ecosystem that benefit patients—rather than the alternative government-centric price-setting system that reflects the political power of the affected industry, the parochial interests of elected or appointed officials, and the accretion of decades of attempts to regulate the behemoth that is the American healthcare system (Smith, 1776).

4. Competition and market entry stimulate innovation that benefits patients.

When businesses compete, they must constantly innovate to attract and retain customers, by offering better products and lower prices. Market entry is one of

the most powerful forces for disrupting cozy cartels and complacent dominant firms. In health care, incumbents are routinely shielded from competition by a thicket of excessive regulation. Their incentive to innovate and improve fades, since excessive regulation has closed the door to innovators who might offer better value. In contrast, competitive markets put pressure on providers, insurers, and all other market participants to earn patients' trust—and their dollars. This fosters innovation that will better serve patients' diverse needs. Competitive pressure drives efficiency and improves quality in ways that bureaucratic mandates simply cannot replicate, and that excessive regulation largely precludes (Silver & Hyman, 2018).

5. Innovation benefits the poor the most.

Innovation is a great equalizer. It reduces the cost of formerly elite goods and services such as air travel, smart phones, and prescription pharmaceuticals, which makes them more accessible to all. Low-income populations, which might otherwise be excluded, benefit the most.

In health care, excessive regulation protects incumbents, limits experimentation, and impedes innovation in delivery models, technology platforms, and payment structures (Bai & Hoover Institution, 2020). Health care can become more affordable and accessible for everyone—especially those with the fewest resources—if excessive regulation is reduced and innovators are allowed to compete more freely.

6. Patient-focused subsidies work much better than subsidies to providers or insurers.

There will always be a need for subsidies to ensure that the most vulnerable have access to health care. But subsidies should directly follow patients rather than flowing to providers or insurance companies.

When patients control healthcare spending, providers compete to meet patients' diverse needs and preferences. This dynamic works much better than giving the funds to providers or insurers and then trying to write rules to ensure that most of the benefits ultimately flow to patients. When subsidies go to institutions, they prop up inefficiency and shield them from market discipline. In contrast, when patients control the money, every player must compete to deliver cost-effective, high-quality services that satisfy patients. Patient-directed subsidies promote choice, transparency, and accountability—essential ingredients for a healthy market that will deliver access to all comers, unlike our current over-regulated, dysfunctional non-market.

7. Insurance is a good way of paying for catastrophically expensive services that few patients will need, but a bad way of paying for everything else.

Health insurance is just that—insurance—which in every other sector of the economy is used to address the financial risk of rare, high-cost catastrophic events (Hyman, Letchuman, & Bai, 2024). We do not use car insurance to cover oil changes and car washes because premiums would be far higher if insurance covered these small, predictable expenses. Similarly, when we use insurance for routine care, such as primary care, visits to specialists, generic drugs, and minor treatments, we drive up healthcare costs and spending through higher administrative overhead, overutilization, and price inflation (Hyman, Uhlig, & Bai, 2025).

We should restore insurance to its rightful role—handling catastrophic risks. A hybrid approach, in which patients pay out of pocket for routine services using

earned or subsidized dollars while catastrophic risks are covered through insurance and/or reinsurance, would allow each payment mechanism to work as designed, maximizing efficiency and protecting patient interests.

THIRD-PARTY PAYMENT AND REGULATION: LESS IS OFTEN MORE

Our current healthcare system relies almost entirely on third-party payment (Cochrane, 2015). Providers understandably view private insurance companies and public programs as their customers—and behave accordingly. If we want a more patient-centric system, patients must be the central decisionmakers, and they must have ownership over their own healthcare dollars (Silver & Hyman, 2018; Bai & Hoover Institution, 2020; Cochrane, 2015). Making this change will encourage providers to focus on satisfying patients rather than on insurance paperwork and bureaucratic regulatory compliance. It will also help align incentives across the healthcare landscape.

A dose of deregulation, and of more sensible regulation will help encourage market entry and disrupt the cozy alliances between incumbents and regulators that have nurtured and sustained the status quo (Hyman, Letchuman, & Bai, 2024). This approach will also empower providers to innovate and to compete**,** if they choose to do so.

As in every other market under the sun, competition will help reduce prices and stimulate innovation, and make products and services available, intuitive, and more affordable (Silver & Hyman, 2024). Once freed from the administrative burdens created by third-party payment and excessive regulation, physicians will be able to focus more on patient care. The government's role would be limited to revenue collection and redistribution—not on setting prices, designing benefits, regulating quality, or managing healthcare delivery. Provider-driven innovation will lead to improvements in care delivery, operational processes, technology adoption, and procedure choices, which in turn will lead to a healthcare system that is more affordable and accessible.

The primary obstacle to a patient-centered healthcare system is the entrenched financial and political interests that are enriched by the status quo. Unsurprisingly, policymakers favor the interests of concentrated incumbent providers over a dispersed and unorganized group, such as patients. An obvious reason for this is that the incumbent providers are better able to provide political support and campaign contributions. Industry-protective policies are typically packaged as being patient friendly using slogans like "protecting access" or "helping patients." This enables policymakers to claim credit for seeming to solve constituents' problems without raising taxes. The true beneficiaries are not patients but the entrenched industry incumbents and policymakers themselves. Changing the politics that have given us our current dysfunctional system is a necessary precondition to durable reform. The best starting point to change the politics that gave rise to the status quo is to give patients control over their own healthcare spending. Once that happens, we will have created a giant interest group invested in treating healthcare like the market good that it is.

A ROAD MAP

So far, we have provided a view of the desired destination—a patient-centric healthcare system that is affordable, accessible, and innovative—but if it were easy to get there from here, we'd have done it already. Accordingly, we now offer a set of specific steps for doing so.

We start with Social Security. The elderly have many needs, including food, housing, and transportation. The federal government does not set prices for these goods and services and then reimburse the grocers, landlords, and taxi drivers who provide them. It instead sends out a specified amount of money every month to program beneficiaries, who make their own decisions about how to spend what is now their money. Social Security is not without its problems, but it works. In fact, it is so popular that it is referred to as the "third rail" of American politics—meaning that public officials who try to make even fundamental changes to the program put their elected positions at risk.

Social Security effectively functions as a defined contribution program, while Medicare and Medicaid function like open-ended defined benefit plans. We propose to make these two programs look more like Social Security (Hyman, 2024; Silver & Hyman, 2024). Instead of paying insurers, hospitals, physicians, nursing homes, and other providers to treat beneficiaries, these programs would simply deposit a set amount of money into each beneficiary's designated account. Each beneficiary would then use these funds to purchase medical services, and pay for them directly. They also would use the money to buy insurance to cover catastrophic medical needs.

We envision a parallel shift in the employer-sponsored market toward defined contribution arrangements (Silver & Hyman, 2018; Bai & Hoover Institution, 2020; White, Hyman, & Bai, 2024). Employers would fund accounts that their workers would use to purchase insurance to cover catastrophic medical costs and to help pay their out-of-pocket medical costs. Importantly, the insurance plans purchased through these arrangements and any balance in individuals' accounts would be portable over time, and if they changed jobs. This approach would help break the link between employment and insurance, unleash competition among insurers, and create more demand for affordable, customizable plans. The government would provide modest fixed subsidies and reinsurance for high-risk, low-income individuals. These subsidies could be supplemented with tax-deductible contributions.

Excessive regulation must also be addressed in order to facilitate market entry, competition, and innovation. Providers should be focused on serving their patients rather than on influencing the regulatory process or navigating regulatory mazes. This will enable patients to access quality medical care, judge its value, and make purchasing decisions using their own money. Innovations in medicine, care delivery, and insurance design will flourish, which in turn will enhance quality and affordability. Most medical services and products will become affordable enough for individuals to pay for them out of pocket using the federal funds they receive.

This approach will have several immediate benefits. First, it will turn everyone covered by Medicare and Medicaid, and those with employment-based coverage, into an army of bargain-seeking, self-paying customers. Second, it will align the interests of buyers (patients) more closely with those of the sellers (hospitals, physicians, nursing homes, etc.). This alignment will put pressure on healthcare providers to innovate and to improve healthcare quality and customer service. Third, this approach will lower administrative overhead for everyone involved. Fourth, insurance-based access restrictions, such as prior authorization requirements, will largely disappear. This will disproportionately benefit low-income individuals while enabling free markets to deliver their products to all. Fifth, this approach will be considerably harder for corrupt providers and fraudsters to game. The result will be improved health, lower prices, and less

wasteful spending, which will amount to hundreds of billions of dollars in savings every year.

Of course, there will always be a need for protections against force, fraud, duress, and other sharp practices. We do not underestimate the creativity of fraudsters and scam artists. But those same fraudsters and scam artists also seek to rip off those who receive Social Security. We respond to that risk by criminalizing and imposing strict penalties on those who exploit the elderly—not by replacing Social Security with a program that reimburses those who provide the elderly with food, housing, and clothing. Anyone who proposed doing so would face the wrath of tens of millions of elderly Americans.

Low-income patients have much to gain from these changes. By liberating coverage from restrictive insurance plans, these patients will gain access to broader provider networks. A safety net, funded through reinsurance, charitable contributions by the altruistic, and targeted subsidies, will help protect these patients from financial ruin when they need care. Despite these improvements, the taxpayer burden will be slashed by the unforgiving competitive force of markets.

Technology will be an essential ingredient. Innovations in artificial intelligence (AI) have the potential to substantially improve the quality and efficiency of healthcare delivery while reducing information barriers and transaction costs. Technology offers incredible opportunities that our current system, which focuses on protecting incumbent interests, prevents.

More specifically, on the supply side, accurate diagnoses, precision treatments, targeted therapies, and shorter recovery times will deliver better results at lower cost. Many treatments no longer require hospital stays. Outpatient and at-home care are often better, faster, and cheaper. AI will also help accelerate drug development, potentially increasing choices, competition, affordability, and access. Innovative providers and new entrants will leverage technology to deliver care more efficiently, which will incentivize them to undercut incumbents and push to lower anti-competitive regulatory barriers.

On the demand side, patients will have access to considerably more information about the cost and quality of care than was previously available. That information—which some patients will need help interpreting, will help patients make more informed choices. Over time, better information will also encourage patients to become an interest group in their own right. Technology has democratized access to goods and services in nearly every other sector, and it can help do the same in health care—if we let it.

CONCLUSION

The failures in the U.S. healthcare system stem from excessive regulation that distorts demand, suppresses supply, and stifles innovation. Unsurprisingly, these policies reflect and are driven by incumbent interests and political expediency. A patient-centric healthcare system that relies on competition will reduce prices, promote access, and unleash innovation. That system will deliver better care to all—especially the most vulnerable. If more Americans are able to experience the benefits delivered by innovative, affordable, and accessible healthcare markets, their demands for more of the same will become too strong to be denied.

Achieving this vision will require a dismantling of excessive regulatory barriers and the modeling of a new approach on Social Security. If we do that, we can make patient-centric health care—that is, a system in which patients have the power—into another "third rail" of American social policy.

ACKNOWLEDGMENTS

We thank Dr. Philip Auerswald and Dr. John Cochrane for their comments and suggestions.

REFERENCES

American Medical Association. (2024). *7 EHR Usability & Safety Challenges and How to Overcome Them*. American Medical Association. https://www.ama-assn.org/practice-management/digital-health/7-ehr-usability-safety-challenges-and-how-overcome-them

Bai, G. (2023). "Testimony before the U.S. Senate Committee on Health, Education, Labor, and Pensions." https://www.help.senate.gov/imo/media/doc/b89fe0f1-9e63-13b1-7746-d56bc2116816/Bai%20Testimony.pdf

Bai, G. (2020). *Patient-centered health care.* Hoover Institution. https://www.hoover.org/research/patient-centered-health care

Blase, B. (2023). "How Medicare Is Hindering Health Care Innovation—and the Way Forward." Policy Brief. Mercatus Center. https://www.mercatus.org/research/policy-briefs/how-medicare-hindering-health care-innovation-and-way-forward?utm_source=chatgpt.com

Cato Institute. (2022). "Health Care Regulation." In *Cato Handbook for Policymakers* (9th ed). Cato Institute. https://www.cato.org/cato-handbook-policymakers/cato-handbook-policymakers-9th-edition-2022/health-care-regulation

Centers for Medicare & Medicaid Services (CMS). (2024). "Historical national health expenditure data." CMS.gov. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical

Chen, L. (2024). "The unintended and anti-competitive consequences of laws to control health care costs." *Journal of American Medical Association: Health Forum*, 5(6), e242470. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2820716

Cochrane, J. H. (2015). "After the ACA freeing the market for health care." In *The future of health care reform in the United States*, Anup Malani and Michael H. Schill (eds.), p 161-201. Chicago IL: University of Chicago. https://static1.squarespace.com/static/5e6033a4ea02d801f37e15bb/t/5edfd93d3d4c397cb6df2720/1591728445952/after_aca_published.pdf

Guterman, S. (2017, August 3). "Making health care markets work better: The role of regulation." The Commonwealth Fund blog. https://www.commonwealthfund.org/blog/2017/making-health-care-markets-work-better-role-regulation?utm_source=chatgpt.com

Hyman, D. A., Letchuman, S., & Bai, G. (2024). "Health insurance coverage: Is broader always better?" *Journal of American Medical Association: Internal Medicine*, 184(3), 243-44. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2814226

Hyman, D. A., Uhlig, B., & Bai, G. (2025). "Should primary care be covered by insurance?" *Journal of General Internal Medicine*. Volume 40, pages 2416–2417. https://link.springer.com/article/10.1007/s11606-025-09541-3

Hyman, D. A. (2024). "Quality health care: Getting there from here." *University of St. Thomas Journal of Law & Public Policy*, 18(1), 111. https://researchonline.stthomas.edu/esploro/outputs/journalArticle/Quality-Health-Care-Getting-There-From/991015300234203691

Hyman, D. A., Letchuman, S., & Bai, G. (2024, February 27). "Rationalizing physician regulation." *Health Affairs Forefront*, online. https://www.healthaffairs.org/content/forefront/rationalizing-physician-regulation

National Academies of Sciences, Engineering, and Medicine. (2024). *Envisioning a transformed clinical trials enterprise for 2030: Proceedings of a workshop—in brief.* The National Academies Press. https://nap.nationalacademies.org/read/27184/chapter/6

Pope, C. (2023). *Aiding insurance without inflating premiums.* Policy brief. Manhattan

Institute. https://media4.manhattan-institute.org/sites/default/files/Aiding-Insurance-Without-Inflating-Premiums-Chris-Pope.pdf

Puthumana, J., Grogan, J., & Bai, G. (2025, April 7). "A patient-centered approach to improving the return of investment in US health care." *Georgetown Journal of International Affairs*, online. https://gjia.georgetown.edu/2025/04/07/a-patient-centered-approach-to-improving-the-return-of-investment-in-us-health care/

Richman, B., D, Plummer, E., & Bai, G. (2024). "The curious persistence of site-dependent payments." *Journal of American Medical Association: Health Forum,* 5(11), e243616. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2825383

Saric, I. (2024, December 10). "How the internet cheered the UnitedHealth shooting suspect as a folk hero." *Axios*. https://www.axios.com/2024/12/10/luigi-mangione-unitedhealth-ceo-internet

Schwandt, H. et al. (2025). "The failure of life expectancy to fully rebound to prepandemic levels." *Journal of American Medical Association*. doi: 10.1001/jama.2025.10439

Silver, C., & Hyman, D. A. (2024). "Leveraging Medicare: How to deliver affordable specialty care to all Americans." *University of St. Thomas Journal of Law & Public Policy,* 18(1), p.128-163. https://researchonline.stthomas.edu/esploro/outputs/journalArticle/Leveraging-Medicare-How-to-Deliver-Affordable/991015300234003691

Silver, C. & Hyman, D. A. (2018). *Overcharged: Why Americans pay too much for health care.* Cato Institute. https://www.amazon.com/Overcharged-Americans-Much-Health-Care/dp/1944424768

Smith, A. (1776). *An Inquiry into the Nature and Causes of the Wealth of Nations.* W. Strahan and T. Cadell.

Stigler, G. J. (1971). "The theory of economic regulation." *The Bell Journal of Economics and Management Science,* 2(1), 3-21. https://doi.org/10.2307/3003160.

Wager, E., McGough, M., Rakshit, S., & Cox, C. (2025, April 9). *How does health spending in the U.S. compare to other countries?* Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries

White, J., Hyman, D. A., & Bai, G. (2024, November 25). "Reforming HSAs to expand gig workers' access to affordable health care." *Health Affairs Forefront*. https://www.healthaffairs.org/content/forefront/reforming-hsas-expand-gig-workers-access-affordable-health-care

Williams, D., Zima, S. C., & Miller, B. J. (2025). Reforming drug price regulation: Using tools that work." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing,* 62, 1-10. https://doi.org/10.1177/00469580251335844.