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# What to Do on the Day After ObamaCare

*The president's lawyer said 'Insurance has become the predominant means of paying for health care in this country.' But whose fault is that? Shouldn't we bring the cash market back?*

By JOHN H. COCHRANE

Last week, the Supreme Court heard arguments on the constitutionality of the administration's health law, aka ObamaCare. Opponents are giddy with the possibility that the law might be struck down.

But what then? Millions of uninsured, both those who choose not to purchase coverage and those who can't due to pre-existing conditions, will still be with us. The rising costs and inefficient delivery of health care will still be with us.

The country can have a vibrant market for individual health insurance. Insurance proper is what pays for unplanned large expenses, not for regular, predictable expenses. Insurance policies should be "guaranteed renewable": The policy should include a right to purchase insurance in the future, no matter if you get sick. And insurance should follow you from job to job, and if you move across state lines.

Why don't we have such markets? Because the government has regulated them out of existence.

Most pathologies in the current system are creatures of previous laws and regulations. Solicitor General Donald Verrilli explained as much in his opening statement to the Supreme Court: "The individual market does not provide affordable health insurance," he noted, "because the multibillion dollar subsidies that are available" for the "employer market are not available in the individual market."

Start with the tax deduction employers can take for their contributions to group health-insurance policies—but which they cannot take for making contributions to employees for individual, portable insurance policies. This is why you have insurance only so long as you stay with one employer, and why you face pre-existing conditions exclusions if you change jobs.

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A doctor in Rockville, Md., checks on a patient.

Continue with the endless mandates (both state and federal) on insurance companies to provide all sorts of benefits people would otherwise not choose to buy. It sounds great to "make insurance companies pay" for acupuncture. But that raises the premiums, and then people choose not to buy the insurance. Instead of these mandates, at least allow people to buy insurance that only covers the big expenses.

What about Medicare and Medicaid? Two words: premium support. The underlying point of premium support is simple. If insurance costs $5,000 and the government gives an individual a $4,500 voucher, that individual will still feel the correct economic signal to shop for cost-efficient health insurance and health care.

The main argument for a mandate before the Supreme Court was that people of modest means can fail to buy insurance, and then rely on charity care in emergency rooms, shifting the cost to the rest of us. But the expenses of emergency room treatment for indigent uninsured people are not health-care's central cost problem. Costs are rising because people who do have insurance, and their doctors, overuse health services and don't shop on price, and because regulations have salted insurance with ever more coverage for them to overuse.

If we had a deregulated, competitive market in individual catastrophic insurance, that market would be so much cheaper than what's offered today that we would likely not even need the mandate.

Meanwhile, staggeringly inefficient markets for health care itself need a thorough, competition-focused deregulation. Americans will know there's a healthy market when hospitals post prices on their websites, and when new hospital and health-care businesses routinely enter to challenge the old ones. Here too regulations keep competition at bay.

The number of new doctors is still restricted, thanks to Congress and the American Medical Association. Congress caps the number of residencies, the AMA has fought the expansion of medical schools, state tests make it difficult for foreign doctors to work here, and on and on.

There are hundreds of government impediments to competition. New hospitals? In my home state of Illinois, every new hospital, expansion of an existing facility or major equipment purchase must obtain a "certificate of need" from the Illinois Health Facilities Planning Board. The board does a great job of insulating existing hospitals from competition if they are well connected politically. Imagine the joy United Airlines would feel if Southwest had to get a "certificate of need" before moving in to a new city—or the pleasure Sears would have if Wal-Mart had to do so—and all it took was a small contribution to a well-connected official.

The result is a monstrous system in which insurance patients are gouged to subsidize Medicare, and cash patients are gouged most of all. Here's Mr. Verrilli again: "Insurance has become the predominant means of paying for health care in this country." Yes, the cash market has been badly damaged. Whose fault is that? Shouldn't we bring it back?

Group health plans in today's system may appear reasonable enough—they seem to resemble "buyers' clubs," where people pool together to get good deals from providers. But in a real buyer's club, each buyer still pays his own bill—you don't go into a Sam's Club and haul off whatever you can with only a fixed $20 copayment. And real buyer's clubs don't depend on where you work. Real buyers' clubs for health services could be a useful way to get competition going and revive the cash-and-carry market for individuals.

A deregulated health-care and health-insurance market can work. We can at least start by removing the obvious elephants in the room: all the legislation, regulation and interventions that needlessly keep prices up, keep competition and innovation out, shelter people from the economic consequences of their decisions, and prevent the emergence of real insurance that follows you from job to job and from health to illness and back.

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