Health Care Reform Without Obamacare Failure

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By: J.D. Tuccille - November 14, 2013

Advocates of free and spontaneous societies are at a bit of a disadvantage when asked by the opposition just what we propose as an alternative to some tottering example of the inadequacy of planned social order. After all, if we'd all spent the last few generations eating swill slapped in front of us at state-run cafeterias, who would feel comfortable describing a world of gourmet restaurants, fast-food drive-ins, greasy spoons, and ethnic food carts evolving all by itself if we just swept away the federal Department of Heartburn? Yet describe the alternatives, we must, when goggling at the current if-you-like-it-there-it-goes fiasco that doesn't even rate a description as the army-issue shit on a shingle of health care systems. We can't reliably describe what a free society would come up with for treating people's aches and pains given time to evolve and react to human needs, but Obamacare can be improved upon. A lot.

Aside from clearing away the spiderweb of mandates and regulations that have entrapped patients and providers in the United States, many health care experts have proposed less-coercive alternatives not just to President Obama's (not so) Affordable care Act, but to the system on which it's been grafted.

Job-based health insurance is an unintended artifact of World War II's wage and price controls. Employers offered benefits to hold or lure workers when they couldn't adjust paychecks. While the development made sense under the circumstances, it has since guaranteed that leaving a job also means changing health plans.

Such health coverage also means that consumers of health care—insured workers—have little incentive to comparison-shop for lower prices, since they don't pay out of pocket (this is a failing of any third-party-pays system). In a 2010 article for the Ludwig von Mises Institute, Vijay Boyapati described how elective LASIK procedures, which are usually paid out of pocket, declined in cost by 30 percent over a decade even as other covered medical procedures become more expensive. He also detailed his personal experience in shopping around for a dermatological procedure and finding prices ranging from $700 at a practice that accepted insurance down to $50 at a cash-pay clinic.

How to address these distortions?

Writing for the Cato Institute, Michael F. Cannon proposed that Americans gain more control over their pre-tax health dollars. Specifically, he suggested eliminating the tax preference for employer-sponsored health coverage in favor of very large, tax-free health savings accounts (HSAs) giving Americans direct control over their health expenditures.

Eliminating the tax preference for employer-sponsored insurance would therefore shift control over more than $532 billion each year, and $9.7 trillion over the next 10 years, from employers to workers. That effective $9.7 trillion tax cut would not increase the federal budget deficit, and it would more than swamp any small, explicit tax increases that altering the existing tax treatment of employer-sponsored insurance would impose on some insured workers.

Not incidentally, HSAs also put heath care consumers back in the position of paying with their own money, with an incentive to look at the price tag.

John C. Goodman and Peter Ferrara of the National Center for Public Policy Analysis have a similar idea. They propose giving people uniform tax credits to purchase health insurance. Once again, that approach would give individuals more control over their health expenditures, since they wouldn't be bound by employers' choice of insurers. It would also be more equitable, since current employer-based tax breaks vary widely depending on workers' income.

Goodman and Ferrara also want to "guarantee renewability" to address the problem of people being dropped by insurers. And they propose a safety net, funded up to the level of unclaimed tax credits, to cover the less-than-proactive segments of the population.

D. Eric Schansberg, a professor of economics at Indiana University Southeast, also likes tax credits, though within limits. He suggests they should be offered "only at a level to provide catastrophic insurance for substantial and unpredictable medical expenses. A variation on this theme would be to provide the subsidy on a means-tested basis, reducing it for those with higher incomes."

As with Goodman and Ferrara, Schansberg suggests health status insurance as a hedge against "the risk that one’s health status deteriorates in the current period—and thus, that future medical insurance premiums will increase."

Cannon and Schansberg both see a spiderweb of tight regulations on health insurers as limiting competition and driving increases in costs, which then squeezes many Americans out of the market for health care.

Pioneered by states seeking to satisfy every possible constituency with a heart-rending story to tell of illness and expense, mandated coverage of various ailments and treatments has inarguably elevated the cost of health coverage. While each individual mandate has a relatively small price tag, the Council for Affordable Health Insurance estimates that, in aggregate, "mandated benefits currently increase the cost of basic health coverage from slightly less than 10 percent to more than 50 percent, depending on the state, specific legislative language, and type of health insurance policy." The federal government, to much fanfare, now dictates "mental health parity," which raises costs by five to 10 percent, all by itself.

Those mandates have to go if we're to control costs, points out Cannon, and Schansberg agrees. Schansberg adds that insurers should be allowed to offer products across state lines to increase competition.

Cannon also points to provider-licensing as a limit on competition that drives costs higher. These laws restrict the entry of new physicians (a recent University of Virginia study concluded that "half of all US states could resolve their physician shortages within five years just by equalizing migrant and native licensure requirements"). Red tape also limits the scope of practice of non-physician providers, such as nurse practitioners, limiting options for consumers. Along the same lines, Schansberg would sweep away obscure but restrictive certificates of need, that require many medical facilities and providers to seek government (and competitors') permission before opening their doors. Making it easier for providers to offer their services, and expanding the range of provider choices from which consumers can pick, would certainly help to lower costs by increasing supply.

Schansberg also points to the escalating cost of medicines and suggests loosening the noose of FDA regulations to ease the path of drugs to the market and reduce costs. The FDA might abandon its gatekeeper role and move to issuing the equivalent of a Good Housekeeping Seal instead, so providers and consumers could make informed choices for themselves.

One way to compromise on the government's "nanny state" tendencies and bureaucratic conservatism would be to allow "dual tracking"—where the government continues to regulate but allows informed choice until a final decision is made (Madden 2010). A better alternative would be for the FDA to allow private certifiers to regulate these markets. The FDA could then play the role of "certifier of certifiers," rather than certifier of products (Miller 2000: 90). The FDA could allow certification, rather than treating its findings as a mandate for complete approval or disapproval. In other words, the FDA could merely provide information, instead of making a decision for those who might want to try a given drug.

None of these proposals are "pure" free-society solutions to the current health care mess, which several of the authors themselves admit. A truly free market in health services would evolve on its own to meet people's needs, rather than be designed and legislated. But these ideas constitute a step away not just from the Obamacare fiasco, but from the highly regulated, increasingly unsatisfactory situation that prevailed beforehand. They involve less coercion, fewer dictates from above, and more dynamism and choice.

Maybe someday we'll be able to pick and choose our health care in a world that offers all of the options and innovation that we find when we go out to eat. For now, though, let's just do our best not to end up with the medical equivalent of shit on a shingle.