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Rx for Health Care?: The Massachusetts Experience

Massachusetts' health insurance experiment illustrates the core issues in the national debate.

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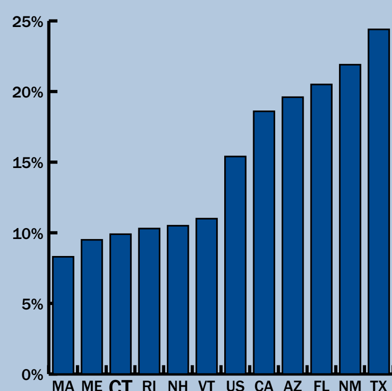
Fiscal crunch or not, people, pundits and pols would agree that one of our highest priorities is making health care more accessible for everyone. Neighboring Massachusetts has taken the lead, along with U.S. Senate Democrats like Max Baucus and Hillary Clinton. But is the Massachusetts plan the wave of the future? Or will we soon be waving goodbye to it instead?

The Bay State's plan, signed into law in April 2006, has attracted rapt attention, pro and con. Whichever way one comes at it, the Act Providing Access to Affordable, Quality, Accountable Health Care (APAAQAHC for "short") illustrates the core issues in the national debate over health insurance. For that reason, we Nutmeggers may be able to learn what to do, or what not to do, about health insurance from the experience of our neighbor to the north. And, come early 2009, the Massachusetts experiment will likely figure in the debate over national health insurance policy.

THE HEALTH INSURANCE GAP

The fundamental issue in the debate is the so-called health insurance gap—the proportion of the population who lack coverage, whether voluntarily or involuntarily. The bar graph shows the percentage of people not insured in 2005-2007, for the U.S. and selected states. (Census views the underlying survey data by state as too shaky to warrant relying on just one year.) Connecticut and the other New England states were well below the national average, but so were 24 of the remaining 45 states (including the District of Columbia). A handful of large states with big immigrant populations—especially California, Florida and Texas—pushed up the national average to 15.4%.



SOURCE: *The Connecticut Economy*, based on U.S. Census Bureau data

Massachusetts, at 8.3% uninsured, was tied for lowest with Hawaii. So the Bay State started its health insurance experiment with one of the lowest health insurance gaps in the nation. That could cut two ways, of course. Massachusetts could face the most challenging cases in its push to get everyone insured. But the Commonwealth also started its experiment with a relatively deep set of health insurance institutions, which should increase the chances for success.

Connecticut is probably similar enough to its neighbor to be able to learn valuable lessons from the experimental results. The rest of the country, of course, may be a different story.

APAAQAHC ESSENTIALS

The Massachusetts initiative is all about closing the health insurance gap. To do so, it envelops the existing patchwork of institutions and programs in a new structure of *subsidies*, *mandates*, *reorganization*, and *sweeteners*. Thus, the Bay State's experiment is highly complex, necessarily more so than what the state had before. (This section draws heavily on a State Law Libraries website, http://www.lawlib.state.ma.us/healthinsurance.html, and a more detailed summary to be found through an uplink from that site, "MA Health Care Reform Law of 2006, ACT".)

SUBSIDIES

The subsidy provisions of APAAQAHC include beefed up benefits and higher enrollment caps for

the poor and disabled, under the existing MassHealth program, and sliding-scale, below-cost premiums for low income uninsured persons, in the new Commonwealth Care plan. Under the latter, premiums are zero up to 150% of the federal poverty line (FPL) ($31,800/family of 4 in 2008), and the sliding-scale premiums apply from 150% up to 300% of FPL ($63,600/family of 4).

MANDATES

These provisions include individual and employer mandates.

Under the individual mandate, every Massachusetts resident (with minor exceptions having to do with "affordability") must be covered by health insurance. This mandate is enforced through a state income-tax surcharge equal to one-half of the cost of the lowest available yearly premium. One potential flaw here is that the penalties won't hit (poorer) people who don't file income tax returns. Another potential flaw is that (richer) young people may still choose to go uninsured, to avoid paying the other half of that lowest-cost premium. Of course, negligent poor people and truculent yuppies may now find ERs demanding upfront payment, because providers may not be reimbursed for their treatments out of "Safety Net" funds.

Under the employer mandate, firms with more than 10 workers must either provide "fair and reasonable" premium contributions towards health insurance coverage for their workers, or else pay the Commonwealth a "fair share" fine of up to $295 per employee per year. Here again, APAAQAHC seems to have a built-in flaw: Aren't "fair and reasonable" annual contributions for employee health insurance, even in a group plan, likely to exceed the fine of $295 per employee?

REORGANIZATION

Presiding over the whole construct just described is a new state authority, the Commonwealth Health Insurance Connector. The Connector will set the subsidy levels under MassHealth and Commonwealth Care, and decide what constitutes "affordability" under the individual mandate. And it also serves as a clearinghouse for the new non-subsidized "Commonwealth Choice" program offered to individuals and firms with 50 or fewer workers. Commonwealth Choice offers three levels of plans (Bronze, Silver and Gold), through six selected ("Seal of Approval") insurers, which eligible workers and their families may buy with pre-tax dollars. (Any Seal of Approval plan may also be purchased directly from one of the approved carriers.) The chosen six firms—which span 90% of the commercial health insurance market—must also offer a lower-priced Young Adults Plan for 18-26 year olds. Further,

The reorganization also requires that all Massachusetts-based health insurers (i) observe all state mandated coverages; (ii) extend family coverage of young adults for 2 years after they cease to be dependents, or until they reach age 25, whichever comes first; (iii) merge individual policies into their small-group products; and (iv) permit multiple employers to contribute to part-time workers' premiums.

SWEETENERS

Finally, to mitigate health-care providers' resistance to participating,

APAAQAHC deploys subsidies, mandates, reorganization and sweeteners.

"NEWLY-INSUREDS" IN MASS.
APRIL 2006 - MARCH 2008

State-Subsidized Plans		
MassHealth	72,000	
Commonwealth Care	176,000	
Sub-Total		248,000
Non-Subsidized Plans		
Commonwealth Choice	19,000	
Employer Plans	159,000	
Other Private Ins.	13,000	
Sub-Total		191,000
TOTAL:		439,000

SOURCE: Commonwealth Connector, "Facts & Figures, October 2008"

the state will pay hospitals and physicians $90 million more per year, for three years, than they would have received under the previous system. This will happen by increasing rates on state-provided services from 80% of costs to 95% of costs in three equal annual increments. To qualify for the higher rates, hospitals must meet quality benchmarks (presumably, administered by the Connector).

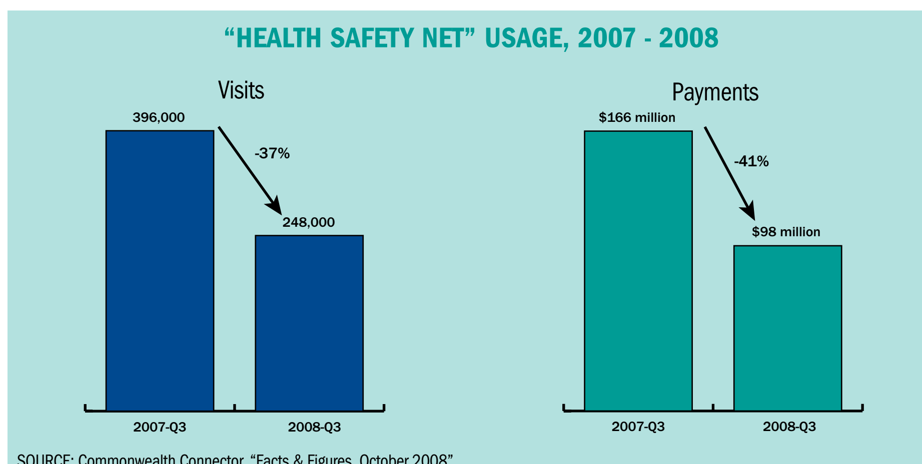
PAYING THE BILL

Closing gaps typically means an increase in services, and thus higher costs. Health insurance is no exception, at least if we're talking about tricking out the existing system as opposed (say) to switching to a single-payer plan, which could, according to its proponents, reduce total administrative costs.

APAAQAHC does contain two measures intended to reduce costs by making better use of existing resources. First, requiring everyone to have health insurance is supposed to reduce the use of emergency rooms for routine and non-life-threatening ailments. Hospital ERs have higher costs per visit than regular physician offices, and non-emergency use of ERs imposes congestion costs. Waiting times for treatment, tantamount to unused labor services, are notoriously longer in ERs than in physician offices. Second, under a waiver negotiated with the Federal government, in the first year Massachusetts was permitted to transfer nearly $400 million in matching Medicaid funds intended to pay for health care for low-income residents, to help cover the cost of subsidized health insurance for those people. The Feds were persuaded to renew the waiver in 2008 for three more years.

Nevertheless, the total cost of Commonwealth Care—the principal net addition to the state budget under APAAQAHC—for the first year and the projected cost for the second year have both outpaced original forecasts, opening up a funding gap as the coverage gap has narrowed. According to a state source, "Health Connector Facts & Figures, October 2008", the projected first-year cost of $472 million turned out to be nearly one-third higher ($153 million) at $625 million. The original estimate for fiscal 2009 of $725 million has now become $869 million, up another $144 million. In response, the state has had to raise some fees and unrelated taxes (e.g., everyone's favorite, on cigarettes).

The explanation offered for the cost increases is higher-than-expected enrollments in the new program. The same source claims a total gain in "newly insured" of 439,000 since April 2006 (see table, page 15). Not all of the gain traces to the new law, but 176,000 participants, or 40% of the total gain, occurred in the new Commonwealth Care plan. It's likely, too, that a sizeable chunk of the 72,000 new enrollees in MassHealth (Medicaid) are the result of the expanded access to that plan under APAAQAHC.



A handy measure of how effective the Massachusetts health insurance experiment has been is its first-year impact on the number of provider visits and their total cost under the so-called Health Safety Net (HSN). This program, which predates APAAQAHC and was formerly known more mundanely as the Uncompensated Care Pool, pays for medical care if your income is less than 400% of FPL and you don't qualify for subsidized insurance. As the nearby bar graph shows, between 2007-Q3—the first quarter in which APAAQAHC began to take effect—and 2008-Q3, the number of visits under HSN fell by 37%, and total HSN payments fell by 41%.

Do the declines in HSN usage represent real savings? Assume that the reduction of 148,000 HSN visits is reflected in the 439,000-person increase in newly insureds claimed by the state, and that the formerly uninsured made only one trip to the ER per year. Then their share of the $869 million state health insurance tab comes to $293 million. In contrast, the avoided health safety net costs, $68 million, were less than one-quarter of that amount. Clearly, health insurance offers a broader range of care than does ER treatment. But it is also considerably more expensive.

"IT'S THE INCENTIVES, STUPID!"

One party missing from the discussion to this point is people—the consumers of all the health insurance and services. The key aspect of any health insurance reform for people is incentives.

APAAQAHC is big on mandates—that is, on negative incentives. It also offers subsidies, to make coverage more affordable for low-income people. And the Massachusetts experiment is built around the pervasive existing health insurance plans that provide a lot of "first-dollar coverage"—that is, relatively low co-pays and deductibles—and little coverage for preventive measures not provided by medical professionals (e.g., fitness

club memberships). The problem with such plans—which are to a great extent the product of the tax-exempt status accorded most employer-provided health insurance—is that they encourage overuse of health care services, thus pushing up costs, and discourage, or at least don't encourage, people from getting and staying fit. This set of incentives lies at the heart of the financial shakiness of virtually every single-payer, universal health insurance system, such as those in Canada and Western Europe. Cost pressures lead inexorably to rationing and unequal access to health care across income classes.

Thus, APAAQAHC resembles the proposals advanced by most of the Democratic Presidential hopefuls, and most recently by Senator Max Baucus (D-MT). The proposals put forward by their Republican counterparts stress substituting private for public arrangements and paying for them with (what else?) tax cuts and credits. (Ironically, then-Governor, later-GOP Presidential hopeful Mitt Romney signed APAAQAHC into law in 2006.) But neither party's proposals had much room for "health savings accounts" (HSAs), which provide incentives to insureds to take better care of themselves, and (when they fall ill) to seek the most cost-effective treatments.

Instead of providing insurance that pays part of the cost of treating illnesses, HSAs give people money to spend on health care—but allow recipients to keep much if not all of any unspent funds at (say) the end of each "insurance year". To cover really big health care outlays, HSAs may be supplemented with high-deductible conventional health insurance—also known as "catastrophic" coverage—which is much cheaper than insuring first-dollar outlays. To confer the same income-tax status as employer health insurance contributions enjoy, HSA funds may be tax-exempt until spent on non-medical items.

Where such plans have been tried (e.g., among public school employees in northern California), they have worked well, been popular with employees, and saved employers money compared with more conventional types of coverage. HSAs, which replaced an earlier version known as "medical savings accounts", were introduced in the 2003 bill that extended Medicare coverage to prescription drugs. To this point, they have not proved very popular: as of January 2008, an estimated 6.1 million Americans (2.4% of those insured) were covered by HSA plans—some 4.6 million in employer plans and another 1.5 million in individual plans—according to a survey. Those figures may be low, according to an April 2008 report by the U.S. Government Accountability Office (GAO). The same study found that nearly half of the people with HSA-type coverage were paying for it with after-tax dollars. (Refer to Wikipedia, "health savings accounts", for more details.)

Why have HSAs not been more popular? One knock on them, especially among Democrats, is that insureds will put off getting needed health care and spend the money on other things (including income taxes!). Another reason, one suspects, is that it is difficult for many people to stay fit, or (once fallen from grace) to get fit again. But people will recognize, or may be educated to do so, that deferring needed health care often leads to worse, more expensive problems next year or the year after. Also, they may save all or part of their unused HSA against unexpected future medical costs. And a financial incentive to get and stay fit would make it less difficult for the less disciplined among us.

The best argument for HSAs is that they likely offer the best chance of providing universal health insurance coverage that won't break the bank because of excessive use of health care services and insufficient attention to health maintenance.

BOTTOM LINE

APAAQAHC seems to have shown that significant, rapid strides towards closing the health insurance gap are possible at manageable cost—in a relatively wealthy state with deep health-insurance institutions and one of the lowest rates of non-insurance to begin with. Connecticut fits the description, so we will want to keep a close eye on the Massachusetts experiment.

But APAAQAHC also personifies the worst of the incentives in the existing American health insurance system, writ large. Thus, there is a real risk that the Bay State's bold experiment will wind up with too much first-dollar coverage, too much treatment, too little individual responsibility for staying healthy—and unsustainable costs, unless we're ready to impose rationing, with all its problems of unequal access to health care.

John Kingsdale, executive director of the Connector, defends the mounting costs as part of the rationale for APAAQAHC, saying that "the state's first priority was to expand coverage, and then later address costs" (Healthcare News, July 2, 2008). Thus, the cost pressures would force "the political leadership … to make this affordable."

Worries that Kingsdale's optimism is little more than spin could induce other states to be wary of Massachusetts' sweeping reform of health insurance access. In fact, such worries may be behind the more piecemeal approach of the Rell administration, which has only gradually scaled up its controversial Charter Oak program for uninsured adults after adding it in 2006 to the existing Husky Care program for uninsured children.