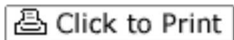

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Prescription for problems

Massachusetts' Obama-like reforms increase health costs, wait times

Michael F. Cannon

If you are curious about how President Barack Obama's health plan would affect your health care, look no farther than Massachusetts. In 2006, the Bay State enacted a slate of reforms that almost perfectly mirror the plan of Obama and congressional Democrats.

Those reforms reveal that the Obama plan would mean higher health insurance premiums for millions, would reduce choice by eliminating both low-cost and comprehensive health plans, would encourage insurers to avoid the sick and would reduce the quality of care.

Massachusetts reduced its uninsured population by two-thirds -- yet the cost would be considered staggering, had state officials not done such a good job of hiding it. Finally, Massachusetts shows where "ObamaCare" would ultimately lead: Officials are already laying the groundwork for government rationing.

The most sweeping provision in the Massachusetts reforms -- and the legislation before Congress -- is an "individual mandate" that makes health insurance compulsory. Massachusetts shows that such a mandate would oust millions from their low-cost health plans and force them to pay higher premiums.

The necessity of specifying what satisfies the mandate gives politicians enormous power to dictate the content of every American's health plan -- a power that health care providers inevitably capture and use to increase the required level of insurance.

In the three years since Massachusetts enacted its individual mandate, providers successfully lobbied to require 16 specific types of coverage under the mandate: prescription drugs, preventive care, diabetes self-management, drug-abuse treatment, early intervention for autism, hospice care, hormone replacement therapy, non-in-vitro fertility services, orthotics, prosthetics, telemedicine, testicular cancer, lay midwives, nurses, nurse practitioners and pediatric specialists.

The Massachusetts Legislature is considering more than 70 additional requirements.

Those requirements can increase premiums by 14 percent or more. Officials further increased

premiums by imposing new limits on cost-sharing.

"The effect," writes the Boston Globe, "has been to provide more comprehensive insurance than in most other states but also to raise costs." Premiums are growing 21 to 46 percent faster than the national average, in part because Massachusetts' individual mandate has effectively outlawed affordable health plans.

Massachusetts long ago adopted another feature of the Obama plan: price controls that prohibit insurers from varying premiums based on a purchaser's health status. Those price controls further increase premiums for the young and healthy.

They also eliminate comprehensive health plans. Obama adviser David Cutler found that in Harvard University's price-controlled health insurance exchange, "adverse selection" or the attraction of the sickest patients caused premiums for the most comprehensive plan to rise until insurers eventually canceled it. Those price controls also encourage insurers to avoid the sick. And who can blame them, considering that the government is forcing them to sell a $50,000 policy for just $10,000?

One way insurers can avoid the $50,000 patients is to drop benefits those customers find attractive. Shelby Rogers is a 12-year-old girl with spinal muscular atrophy, whose parents chose an Aetna plan through the price-controlled health insurance exchange for federal workers. Last year, Aetna announced it would drop coverage for Shelby's 12-hour-a-day nurse, who, among other things, helps Shelby avoid bedsores by turning her over at night. An Aetna spokesman explained the reason was to avoid offering a benefit that causes the sickest patients to flock to the plan.

Over time, as mandates eliminate low-cost options and price controls eliminate comprehensive options, both the Massachusetts and Obama reforms will march consumers into a narrow range of health plans.

As goes choice, so goes quality. Statistics on waiting times for specialist care in Massachusetts read like a dispatch from Canada. In 2004, Boston already had the longest waits among metropolitan areas. By 2009, waits had generally shortened in other metro areas (average wait: less than three weeks) but lengthened in Boston (average wait: seven weeks), according to the Merritt Hawkins survey.

Voters who believe the Massachusetts law reduced the quality of care outnumber those who believe it helped by nearly 3-to-1 (29 percent to 10 percent).

Massachusetts has reduced the share of its population that lacks coverage from an estimated 8.3 percent in 2006 to an estimated 2.6 percent by June 2008. Former Gov. Mitt Romney, a Republican who signed the Massachusetts reforms into law, boasts that "no other state has made as much progress in covering their uninsured."

Yet that achievement carries an exorbitant price tag: at least $2.1 billion this year, according to the Massachusetts Taxpayers Foundation, a figure that doesn't even include the cost of the additional coverage discussed above. Since Massachusetts has covered just 432,000 previously uninsured residents, the cost of covering a previously uninsured family of four -- at least $20,000 -- is well above the average cost of an employer-sponsored family policy (about $13,000).

Had state officials not done their level best to hide those costs -- the individual mandate pushed 60 percent of the cost off-budget, while expanding eligibility for Medicaid pushed another 20 percent onto the federal budget -- no one would be hailing Massachusetts as a model.

As it is, Massachusetts has fooled some prominent watchdogs. The Boston Globe editorializes that

the cost to the state taxpayer is "about $88 million a year," when the actual cost to state taxpayers is 19 times that amount, and the total cost is 24 times that amount.

The New York Times editorial page's account of the law's cost was only off by a factor of three.

Nevertheless, those costs are appearing in higher taxes and health insurance premiums. State officials have raised taxes on tobacco, hospitals, insurers and employers, as well as eliminated coverage for many legal immigrants just to scrape up their 20 percent share of the cost. They are also showing the nation where ObamaCare would ultimately lead: government-imposed rationing.

To cope with the cost of its reforms, Massachusetts created a legislative commission that has recommended moving the entire market to a single, Canadian-style payment system that would encourage doctors and hospitals to ration care.

The Legislature also plans to leverage its power under the individual mandate to require "evidence-based purchasing strategies," which is another way of saying government bureaucrats may soon be deciding who gets medical care and who does not.

When former Alaska Gov. Sarah Palin whipped people into a frenzy over "death panels," she was warning not only against a proposal for end-of-life counseling but plans that would make it easier for Medicare to use its existing power to try to ration care to the elderly and disabled.

Massachusetts shows that Obama's individual mandate would expand federal power by enabling it to ration care to patients under age 65.

Though initially popular, enthusiasm for the Massachusetts reforms may be on the wane. A recent poll found that more Massachusetts voters say the law has made health insurance less affordable (27 percent) than believe it has made coverage more affordable (21 percent). Voters who believe the reforms have been a failure outnumber those who believe the reforms have been a success by 37 percent to 26 percent.

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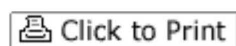

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