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Obamacare in Practice - New England has already tried much of it, and the results are not encouraging

BYLINE: Stephen Spruiell

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The sales pitch for Obamacare is built on the following promises: The reforms will cut health-care costs. They will reduce the number of uninsured. You can keep your health insurance and continue to enjoy the same quality of care. And the plan will pay for itself.

There are plenty of reasons to doubt these promises -- the numbers just don't add up, for one. But we don't have to rely solely on CBO estimates and statistical projections to reach our judgment: We can simply turn our attention to New England, where most of the administration's proposals have been tried.

Vermont, Maine, and Massachusetts all force insurance companies to offer coverage to individuals regardless of health status, an arrangement known as "guaranteed issue." All three states also forbid insurers to charge different rates based on health status, a policy known as "community rating." Maine has a form of the "public option," a government-run insurance plan that competes with private plans and offers taxpayer-subsidized premiums, while Massachusetts has an "individual mandate" requiring everyone to purchase health insurance. Even New Hampshire -- sometimes held up as an island of individualism in a collectivist sea -- has, when it comes to health care, been swept along with the currents.

The result: Health care costs more in New England than it does anywhere else in the country. Insurance companies have fled the region, leading to less competition and higher premiums. The number of uninsured has gone down, true, but not by nearly as much as proponents of these reforms had predicted, while health-care subsidies eat up an ever-growing share of the states' budgets, with the consequences of higher taxes and -- yes -- rationed care.

Vermont: New England's adventure in government-run medicine began in the early 1990s, when Vermont, Maine, Massachusetts, and New Hampshire (and, beyond New England, the states of New York, New Jersey, Kentucky, and Washington) passed laws forbidding insurance companies to calculate prices on the basis of health status. New Hampshire, Kentucky, and Washington have since either repealed or partly repealed these laws.

Vermont was a trailblazer on this misguided path. In the spring of 1992, the Green Mountain State enacted the nation's first guaranteed-issue and community-rating mandates for individual coverage. According to an industry-sponsored study undertaken by Milliman, a consultancy, the passage of those laws led many insurance companies to stop offering individual coverage in the state; today, individuals can purchase plans from only two companies in Vermont.

To understand why that happened, consider the following well-worn analogy: Imagine you have no insurance and run your car into a tree. Now imagine that the law requires an insurance company to sell you a policy that covers the damage and forbids it to charge you a higher rate based on your driving record -- or the fact that your car is already wrecked. You can easily see why such a law, enacted on the state level, might prompt insurance companies to take their business elsewhere.

In 2006, the Vermont insurance department studied the effects of these reforms on the market for individual health insurance and reached the following unsurprising conclusions: "The individual market seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing."

Maine: Guaranteed issue and community rating are not the only ruinous reforms with which New England has experimented. In 2003, Maine created a state-run insurance plan called DirigoChoice (the state motto, Dirigo, means "I lead"), offering subsidized insurance to families earning up to 300 percent of the federal poverty level. Even with the

subsidies, enrollment has been far lower than expected. Approximately 10,000 people are currently enrolled in DirigoChoice. Of those, around 3,400 were previously uninsured, representing only 2.5 percent of Maine's uninsured population. The other 6,600 dropped out of private plans in order to take advantage of the subsidies.

Even though enrollment has fallen short of the state's goals, the cost of the program has exceeded the state's ability to pay. The economics are simple: The low-cost program immediately attracted the sickest patients, who ditched their more expensive private plans. The associated costs drove DirigoChoice premiums up by 74 percent, pricing out healthier Mainers. Earlier this year, a small-business owner told the Bangor Daily News that even with the generous subsidies -- and even though she offered to pay 60 percent of their premiums -- her eight employees still found DirigoChoice too expensive and declined its coverage.

The skewed economics of DirigoChoice have left it highly dependent on government financing, which has created a series of problems for policymakers. The program's initial funding mechanism was nothing short of bizarre: Each year, the Dirigo Health Agency had to come up with a number that (according to its experts) represented the amount of money DirigoChoice had "saved" the Maine health-care system; the law then required Maine insurance companies to pay that amount to the state. Needless to say, those calculations ended up being something less than rigorous, and the insurance companies objected. Employers argued that insurers were simply passing on the bill for these "savings-offset payments" to private policyholders. Last year, the furor over the payments led the agency to downgrade its savings estimate by $40 million, making the whole process look like an arbitrary sham.

The Democratic legislature tried to replace this funding mechanism with a tax on beer, wine, and soda, but Mainers exercised a "voters' veto" and repealed this tax via referendum. Running out of money, the legislature went back to taxing Maine insurance companies (and, by extension, private policyholders), enacting a 2 percent tax on all paid insurance claims. The state also has capped enrollment in order to keep costs from spiraling further out of control. The program's supporters are now looking to Washington for help. "We have a very limited capacity because of limited resources," Maine Office of Health Policy and Finance director Trish Riley said recently. "With federal money, more people would become eligible and the federal government would require people to have coverage."

Massachusetts: Requiring people to buy coverage is often touted as a solution to "adverse selection" -- the problem created when sick people opt in to an insurance plan while healthy people opt out. But mandated coverage also has been tried in New England, and, while it did bring down the number of uninsured, it did not help contain costs. Under Commonwealth Care, individuals in Massachusetts are required to purchase health insurance, and employers with more than ten employees are required to offer insurance to their workers; anyone failing to comply with these mandates is subject to penalties. As in Maine, families with incomes of up to 300 percent of the poverty level are eligible for subsidies.

Forcing the healthy to buy coverage was supposed to diversify the risk pool, subsidizing the sick and lowering premiums for everyone. But that hasn't happened. Since the enactment of Commonwealth Care in 2006, premiums have gone up significantly faster than has the national average, primarily because requiring everyone to purchase a "minimum" level of coverage empowers the state to define "minimum" -- and, inevitably, health-care providers and other interest groups have worked hard to make sure that "minimum" actually means "quite expansive."

As Michael Cannon of the Cato Institute has noted, lobbyists in Massachusetts have successfully pushed for the inclusion of prescription drugs, preventive care, drug-abuse treatment, hospice services, fertility treatments, prosthetics, telemedicine, and numerous other mandates in the definition of "minimum." So even if you already had insurance you were happy with, the new rules forced you to upgrade to a more expensive plan that the state ruled acceptable. So much for Obama's promise that you can keep the simple, affordable plan that you like.

As in Maine, health-care subsidies in Massachusetts are proving far more expensive than proponents of the plan predicted -- 20 percent higher for FY2009. Revenue sources are falling short in Massachusetts as well, so state officials are turning to new taxes to cover their losses. The state has added $1 per pack to its cigarette tax and imposed $89 million in new fees and assessments on health-care providers and insurance companies. And since no taxpayer-funded health-care program would be complete without a special commission to control costs, Massachusetts created one in 2008. The commission has already recommended "exclud[ing] coverage of services of low priority/low value." Translation: The government will exclude the services of those providers who aren't as good at lobbying as, say, the fertility-treatment guys.

New Hampshire: Though New Hampshire had the good sense to repeal its guaranteed-issue and community-rating laws for individuals in 2002, it is hardly a model of intelligent health-care policy. Here's why: Federal law already imposes guaranteed issue and community rating for small groups (businesses with two to fifty employees). Adverse selection isn't a big problem when it comes to group coverage. But some states -- including New Hampshire -- have redefined "small groups" to include groups of one, giving self-employed individuals an incentive to postpone buying insurance until they need expensive care. Predictably, New Hampshire small-group premiums have shot up -- the state now has the second-highest

employer-based premiums for individual purchasers, and the highest "employee plus one" premiums, in the country.

The implementation of Obamacare would represent a subversion of federalism: Rather than acknowledge that their preferred policies have failed in a handful of Justice Brandeis's little laboratories, the Democrats would disguise those failures by forcing all 50 states to adopt the policies. Their imposition on a national scale would, not coincidentally, rescue the strongly Democratic states of New England from the consequences of their failure. In a way, Obamacare would function as yet another Washington bailout, and, as with the other bailouts, the responsible would pick up the tab for the reckless.

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