5 painful health-care lessons from Massachusetts

by **Shawn Tully**, senior editor at large - June 15, 2010: 4:11 AM ET

FORTUNE -- The best guide to how President Obama's historic health-care legislation will reshape the nation's medical marketplace and fiscal future is the pioneering model in Massachusetts. The Bay State's reform program started in late 2006, and it shares virtually all the major features of the new federal plan.

Both programs greatly expand Medicaid coverage for low-earners, and provide heavily subsidized policies for a broad swath of the middle class. They tightly restrict the range of premiums for customers of different ages and medical conditions; they bar insurers from charging older patients, or even coach potatoes who abuse their health, anywhere near their actual cost. Both plans impose a long list of expensive benefits insurers must provide whether patients want to pay for them or not, ranging in Massachusetts from in-vitro fertilization to chiropractic services.

At the same time the plans offer lavish subsidies that swell the demand for health care, they do nothing to increase the supply of medical services in a market suffering from shortages of everything from family doctors to nurses to hospital beds. Two years after enacting health-care reform to rein in costs, Massachusetts strengthened "certificate of need laws" that prevent hospitals and other providers from competing with high-cost, entrenched suppliers. The state now requires that ambulatory surgical centers and outpatient treatment facilities get permission from regulators before they can enter the market. Their rivals invariably lobby the regulators to block competition, and usually win.

Thirty-six states, from Florida to Georgia to Washington, have similar price-inflating laws on the books. The Obama bill does nothing to eliminate regulations that effectively cartelize the market.

The combination of heavily subsidized demand and tight, over-regulated supply is a textbook formula for perpetuating the big, chronic price increases that bedevil today's health-care system.

Instead of attacking the real causes of the explosion in costs -- the combination of overly generous state aid and a dearth of competition among hospitals and physician groups -- Massachusetts is vilifying prestigious, non-profit insurers, and punishing them, believe it nor not, with price controls. In April, Governor Deval Patrick refused the request of carriers such as Harvard Pilgrim, the top-rated plan in the country, for premium increases of 8% to 32%. Instead, his administration is refusing all rate hikes over 7.7%; any rate requests the administration rejects are automatically held at 2009 levels.

In explosive emails released last week, Robert Dynan, chief of the financial analysis unit at the Division of Insurance, told Commissioner Joseph Murphy that the price caps would cause a "potential train wreck" and threatened "catastrophic consequences for the non-profit industry." Dynan warned that the non-profits, unlike national giants such as WellPoint (WLP, Fortune 500), operate on such slim margins that the controls could drive them into bankruptcy. Even now, four of the biggest insurers are threatening to stop taking new patients at rates so low they lose money on each new enrollee.

The battle in Massachusetts may foreshadow the results of the new federal law. It threatens to mirror precisely the cycle we're witnessing in the Bay State: Spiraling costs that make coverage unaffordable for both patients and businesses, followed by price controls that drive private providers from the market. "This could repeat itself on the national level, and become the beginning of government-run healthcare," says Lora Pellegrini, chief of the Massachusetts Association of Health Plans.

That disaster scenario may sound far-fetched. But an examination of the Massachusetts plan yields five important lessons that show the dangers ahead for the Obama healthcare blueprint.

Lesson 1: The Massachusetts plan does not control costs.

When Massachusetts launched its reform program in 2006, it already had the highest medical costs in the nation. Today, the burden is still rising far faster than wages or inflation, from those already lofty levels. A report from that state attorney general in March--remember, this is a Democratic administration--asked rhetorically "Can we expect the existing health care market in Massachusetts to successfully contain health-care costs?" The report concluded, "To date, the answer is an unequivocal 'no.'"

Costs are rising relentlessly for both families and for the state government. The median monthly premium for family plans jumped 10% from 2007 to 2009 to $14,300--again, that's a substantial rise on top of an already enormous number. For small businesses, the increase was 12%. In 2006, the state spent around $1 billion on Medicaid, subsidies for medium-to-lower earners, and other health-care programs. Today, the figure is $1.75 billion. The federal government absorbed half of the increase.

Hence, reform's proponents boast that expenses have risen only $354 million or around 6% a year. But the real increase is double that, including the federal share. And it's highly possible that the given the current budget pressures, the U.S. will reduce the contribution that has encouraged the state to spend so lavishly.

Lesson 2: Community rating, guaranteed issue and mandated benefits swell costs.

How did costs in Massachusetts get so big to begin with? A major reason is the adoption of guaranteed issue and community rating in the mid-1990s. The new federal bill would expand those rules to the entire nation. Under guaranteed issue, insurers must accept all enrollees regardless of their medical condition; under community rating, they must charge all customers similar premiums, even if their costs are far different. The result is that prices rise steeply for young, healthy customers, who must pay far more than their actual costs. It also give them a strong incentive to drop insurance; then, they can "game the system" by signing up anytime they need surgery or get diabetes.

Hence, the pool of insured people gets older and sicker as the healthy drop out. That's what happened in Massachusetts, and it contributed to soaring premiums. The 2006 reform plan was supposed to solve the problem by requiring that everyone buy coverage or pay a fine of around $1,000. It worked, but only in part: Of the 600,000 uninsured in 2005, around 450,000 are now covered. But a large share of 150,000 who still lack coverage are young residents who choose to pay the fine instead of high premiums. Insurers are also getting socked by people who sign up for insurance to get expensive care mandated under state law, including hospitalization for childbirth or hip replacements, and then depart once the procedure is completed.

In the federal bill, the fines for going uninsured are even lower than in Massachusetts -- and anyone who can't find an inexpensive plan is exempted from all penalties. Hence, the "adverse selection" problem could prove far worse.

Lesson 3: Huge subsidies for low-to-medium earners could prove extremely expensive.

One of the most fascinating features of the Massachusetts plan is that it introduced a system of subsidized policies, sold through an insurance "exchange," that's extremely similar to the one in the new federal plan. Under Commonwealth Care, the state subsidizes plans¬¬--offered by private carriers--for residents who earn up to $66,150 who are not covered by employers. The aid is extremely generous. At $44,000, families pay around $1,000 a year in premiums. At the $66,150 maximum, they contribute around $3,000.

The problem is that the actual annual cost of these plans is around $10,000, so the subsides are enormous -- that's 90% for families earning $44,000. And while the costs keep going up, the share paid by the enrollee barely budges. Says Michael Tanner, an economist at the conservative Cato Institute: "It's a situation where the entire escalation in costs is paid by the government, not the people receiving the care."

The federal plan also subsidizes care provided through state-run exchanges. The patients' contributions are bigger than in the Mass plan: A family earning $66,000 would pay $6,300 a year. But the federal plan offers subsidies far higher along the income scale, aiding families of four making up to $88,200. And surprisingly, the federal plans would probably prove a lot

more costly than the ones in Massachusetts, where the state prides itself on restraining what they pay by squeezing providers, who then shift the added costs to private customers.

The big problem arises if far more people sign up for these exchange-offered plans than anticipated. That's been the case in Massachusetts. And as we'll see in a moment, it could still get a lot worse there. A potential disaster threatens the federal plan if employers staring dropping coverage, since a flood of newcomers would rush into the state-funded pools.

Lesson 4: The exchanges reward people for working less and earning less.

Data is lacking on how damaging these perverse incentives are in practice. But it's clear in Massachusetts that low-to-medium earning families often suffer financially if they get a raise, work overtime, move to a higher paying job -- or if a spouse rejoins the workforce. For example, a family earning $33,000 pays no premium at all under Commonwealth Care. But if their pay goes to $46,000, they're obligated to contribute about $2,400. That's an effective tax rate of 18.5% on that $13,000 raise. A pay increase of $44,000 to $46,000 is mostly erased by higher premiums alone.

The federal bill is plagued by the same weakness. For example, a $55,000 earner contributes $4,400 a year towards insurance. At $65,000, the bill is $6300; so the family is paying a "tax" of $1,900 or 19% on that $10,000 raise. After payroll taxes, those Americans would face a marginal rate of around 35%, a number that's heretofore been the territory strictly for high-earners.

Lesson 5: The generous plans and added mandates give employers an incentive to drop health insurance.

In charting the future of healthcare costs, the biggest danger by far is that companies will drop their coverage. It's also the one that's the most difficult to handicap, both for Massachusetts and the entire nation. The problem is simple: If employers stop paying for health care, employees will flood into the government-subsidized programs, enormously raising the cost to already fragile budgets.

Surprisingly, health reform in Massachusetts has actually increased the number of workers covered by employers. Over 100,000 more employees are covered by corporate plans today than when the program debuted in 2006. The main reason is that the plan imposed a $1,000 fine on employees who refused their employers' plans. Then, families were paying around $3,600 a year towards their company policies. Many decided that, when faced with a fine, the better choice was paying the extra $2,600 for full coverage. The plan was shrewdly calibrated by the administration of then-governor Mitt Romney to tilt the market towards company-provided care.

The Massachusetts plan also bans any employee from getting coverage from Commonwealth Care if his or her company offers coverage. Hence, it would appear that corporate coverage is solidly entrenched. But that's by no means certain, either in Massachusetts or under the Obama plan. The reason is the fast escalation in costs, for both companies and employees. From 2007 to 2009, the employee contribution for family policies rose a steep 17%, or $624 a year, to $4,200.

Employees can only move into Commonwealth Care if their employers drop their plans. The danger is that the incentives are tilting in that direction as the costs of coverage for employer, and the price of premiums to employees, keep climbing. The point is rapidly approaching where both will pocket big savings if employers drop their plans and workers buy their policies through the heavily subsidized exchanges.

In Massachusetts, the state government is pushing towards that tilt point by adding heavy mandates to a list of more than 40 already on the books. In 2009, it required insurers to cover prescription drugs. An expensive autism mandate is now being debated in the state legislature. The list of mandates under the federal plan is bound to mirror the ones in Massachusetts, and once again, the added expense severely weakens companies' incentive for providing coverage.

Cracks are already starting to appear. Part-time workers can get coverage under Commonwealth Care for a fraction of what they'd pay as full-timers. So they "game the system" by working ten or fifteen hours a week for two or three companies. Or they find that it pays to switch from full to part-time work. PHI, an organization that represents home healthcare workers, states that one-fourth of the home care agencies in Massachusetts are reducing workers' hours so they're eligible for state-subsidized care.

The federal plan will encounter the same problem -- perhaps a more acute one since its penalties are lower and its subsidies go much higher on the income scale.

Starting in 2017, the states will have the option of allowing companies that drop their plans to shift workers into the subsidized, state-run exchanges. That choice doesn't exist now in Massachusetts. It's not that employers are likely to dump their plans en masse. What's far more probable is a progressive erosion that relentlessly and systematically raises government spending.

The incentives are there, both in the federal plan, and its prototype in the Bay State. And when the incentives are that big -- and when subsidies inevitably get bigger, not smaller -- no amount of regulatory tinkering can stop America's employers and employees from taking the government's money, and saving their own. ■