

The Nation.

No Rx in Massachusetts

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Senator Ted Kennedy, Governor Mitt Romney, the medical establishment of Massachusetts and the state's consumer advocacy groups could hardly resist congratulating themselves on passing a new health insurance law this past spring--a so-called individual mandate requiring the uninsured to buy coverage from private carriers under penalty of paying higher income taxes if they don't. The media called the law a model for states to replicate and praised such diverse groups for coming together to solve a seemingly intractable problem. A headline in the *New York Times* proclaimed, A HEALTH FIX THAT IS NOT A FANTASY.

A close look, however, reveals that the new law may well be a fantasy and a triumph for special interest politics after all. "It's absolutely worthless," says Dr. Marcia Angell, former editor in chief of *The New England Journal of Medicine* and author of *The Truth About the Drug Companies*. "There is no magic in Massachusetts."

The law is yet another patchwork attempt to dodge the main obstacle to reform--a fundamental lack of agreement about equity in healthcare.

Americans still don't share equity as a universal value, so every endeavor to cover more people results in a complicated, contorted and underfinanced scheme. Massachusetts's latest move is no exception. It pushes the country further away from national health insurance--with its essential ingredients of universal access, low administrative costs and limits on what medical providers can charge. Instead the law embodies much of the right's approach to health reform, which continues to make the world safe for big insurance, big hospitals, and Big Pharma while palming off on the working poor the task of covering themselves.

Indeed, a document distributed by Romney's staff says the organizing principles of the new law are "a culture of insurance" and "personal responsibility"--exactly the opposite

of what's needed if the United States is ever to join the rest of the world in providing medical coverage for all its people.

The law, on a speedy track for implementation next March, leaves the current dysfunctional system intact, tinkering around the edges with insurance market reform. In Massachusetts that means, among other things, no new coverage mandates for two years, merging the individual and small-group markets to enlarge the risk pool and encouraging more policies with health savings accounts--not what people need for really good coverage. The core of American health insurance--the principle of letting private carriers select those they will insure--is firmly in place. Advocacy groups signed on believing that more people would be covered, that the state would make sure insurance was affordable and that compromise would move the debate forward.

Hospitals and employers emerged in fine shape too. Hospitals will receive about \$500 million in higher Medicaid payments and a new revenue stream--in effect, they will be freed from the burden of offering charity care to the poor, who will now have insurance to pay their bills. Employers escaped without swallowing an employer mandate; that is, a requirement to cover all their workers. Those with eleven or more employees who fail to offer insurance will be assessed \$295 per worker per year--a pittance compared with what they would have had to pay for real insurance, estimated by Hewitt Associates, a benefits consulting firm, to be about \$9,000 per worker in 2006. For employers, the puny assessment was a far better deal than a real mandate, which had been headed for a ballot initiative this fall.

Rather than force employers who have deeper pockets to pay for coverage, the law requires the state's 550,000 uninsured to come up with the money. Recognizing that Massachusetts has the costliest medical care in the country--spending \$9,200 per person, compared with the national average of \$7,250--the legislature created an elaborate mechanism of subsidies to help the poorest folks, an arrangement the governor's press materials call a "glide-path to self sufficiency." For individuals with incomes at the poverty level, about \$10,000 (\$20,000 for a family of four), the state subsidy will cover all the cost; for single people with incomes between \$10,000 and \$30,000, it will cover some of the cost, more for those at the low end. Those with

incomes greater than \$30,000 will be on their own and subject to tax penalties if they don't spring for a policy.

It will be up to a new, \$25 million quasi-state agency, the Commonwealth Health Insurance Connector, a concept born at the Heritage Foundation, to certify whether new policies--likely with very high deductibles, high cost sharing and less comprehensive benefits--will be affordable and who can afford them. Determining affordability will be a difficult, politically charged job in a climate where there are more doctors per person than the national average and the state's hospitals spend 44 percent more on care than the national average. "The affordability standard is the most fragile part of the legislation. We don't know to whom it will apply," admits Nancy Turnbull, president of the Blue Cross Blue Shield of Massachusetts Foundation. (Blue Cross Blue Shield of Massachusetts and Partners HealthCare, a big hospital system, paid for a report by the Urban Institute, a Washington, DC, think tank, which became the road map for the new law.)

Imagine the shock to a worker at a Rockport clam shack when he realizes that his taxes are going up because he can't afford the state's "affordable" policy. The law does provide for appeal rights and a waiver of the penalty if people can prove that buying a policy is a financial burden. (Imagine the new bureaucracy and costs that will entail.)

Money for the estimated \$725 million in subsidies needed by the third year comes mostly from federal funds available through the state's Medicaid waiver. These waivers, available to all states, allow them to expand coverage by leveraging Medicaid dollars. Besides the federal dollars, Massachusetts expects to cover the subsidies with money redirected from the state's uncompensated care fund, which pays hospitals for serving the uninsured; \$125 million in new funds from general revenues; and the new assessment on employers. That may not be enough. A House-Senate conference committee report projects a deficit of \$162 million by the third year. Even John McDonough, executive director of Health Care For All, a strong supporter of the new law, worries about future funding. "At some point the program will require additional infusions of money to meet its promise," he says.

Where that money will come from is unclear. Relying on Medicaid is dicey; the state's Medicaid waiver expires in two years. The employer assessment may not stick. Romney vetoed the provision once, but the legislature overturned the veto. And there's virtually nothing in the law that will stem the rising cost of care, the greatest threat to the program. A new report by health policy researchers at Boston University shows that the state's healthcare costs will exceed \$62 billion this year, one-third above the national average. "Without cost control, they are bringing the uninsured into the same mess that the rest of us are in," says Dr. Mark Chassin, executive vice president at Mount Sinai Medical Center in New York.

Instead of strong cost controls, which would have kept the hospitals and insurance companies from agreeing to the bill, the law bets on market competition to bring down the price of medical care and thus the cost of insurance. It sets up a plan for collecting price information and data about quality of services so patients can become wise shoppers, and it contemplates that the new affordable policies with their higher deductibles and co-insurance will make people think twice about using medical services--approaches that don't touch the use of unproven technology, a major culprit in healthcare inflation. The law also envisions electronic medical records and computerized physician order systems in hospitals to address the cost problem. These may make healthcare safer, but the payoff on the cost side is a long way off, if it comes at all. Massachusetts led the way in healthcare reform once before, by passing a reasonable employer mandate in 1988 during the Dukakis Administration.

The plan, which would have required employers to pay nearly \$2,000 per worker each year for coverage, went nowhere in the state but later became a model for Clinton's pay-or-play plan. The state's individual mandate may suffer the same fate. If it becomes a national model, American healthcare, already on life support, will take a turn for the worse.