



BRIEF ANALYSIS

Insuring the Uninsured: Five Steps to Improve the Massachusetts Plan

by **Devon M. Herrick**

Massachusetts enacted an ambitious plan for near-universal health insurance coverage in 2006, the product of a compromise between then-Gov. Mitt Romney and the state Legislature. The cornerstone of the plan is mandatory health insurance. Individuals must purchase insurance directly or get it through an employer or Medicaid. Individuals who do not insure will lose a state tax deduction worth about \$200. Employers who do not offer health coverage will face a penalty of about \$295 per employee, called “pay or play.” These penalties will be used to subsidize private health coverage and fund “safety-net” hospitals. To make affordable private coverage available to individuals with too much income to qualify for Medicaid, Massachusetts will pay a portion of their health insurance premiums.

Following are five steps the Legislature could take to improve the plan’s chances for success.

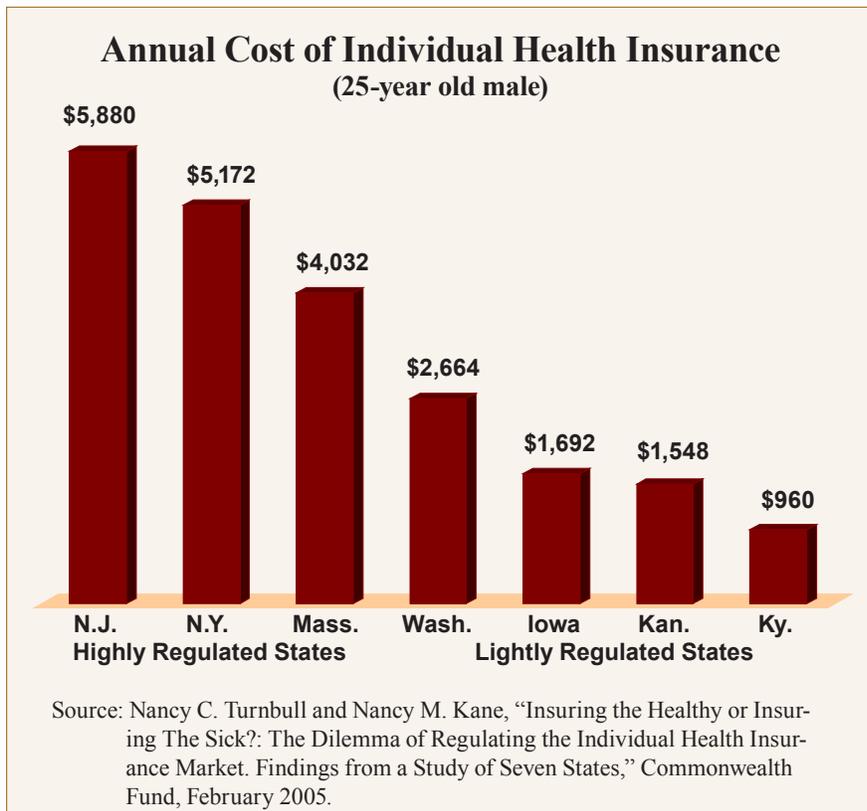
Step One: Request a Block Grant.

Massachusetts will subsidize private coverage for low-income families using more than \$300 million in funds it receives for care of the indigent, one of the many pots of federal health care money states get. A better way to fund such initiatives would be for Massachusetts to request a block grant for all federal Medicaid funds. This would give the state the flexibility to provide care in the most efficient way. For instance, the state could tailor its Medicaid benefits to meet the needs of different enrollees or subsidize employer health plans instead of charity care hospitals. In a system where most people have health insurance, the need for indigent care hospital subsidies should be zero. Hospitals would then compete for insured individuals’ business by providing efficient care or patient-pleasing services.

Step Two: Allow Consumers to Choose. Low-income families, workers in small firms and the self-em-

ployed will obtain coverage through the state-run Commonwealth Health Insurance Connector. Ed Haislmaier of the Heritage Foundation describes the Connector as a health insurance market designed to work like CarMax: one giant dealer selling numerous brands with a variety of makes and models. Unfortunately, the Connector Authority’s governing board has the power to specify what insurance policies must cover in order to satisfy the individual mandate. For instance, the board can require all state-regulated private health insurance — not just subsidized policies — to cover prescription drugs. It can set low limits on deductibles and out-of-pocket expenditures and prohibit ceilings on annual or lifetime coverage. An estimated 200,000 or more Massachusetts residents have health coverage that does not meet the board’s likely standards. Some individuals and employers will drop their insurance if they are required to purchase more costly plans.

Instead of regulating insurance, the Connector should simply be a clearinghouse, providing information on the numerous plans for sale. Any minimum standards



should be set by law, rather than left to the discretion of bureaucrats. Participants should be allowed to choose the coverage they want — including health savings accounts (HSAs), limited benefit plans with deductibles as high as \$10,000 (higher for people who show financial responsibility) and benefit packages that have yearly caps as low as \$100,000. This would be more than enough to cover the medical bills for all but the sickest patients.

Families receiving health insurance subsidies should also be allowed to choose their coverage. Comprehensive plans with first-dollar coverage and little cost sharing require extensive subsidies and do not give consumers incentives to ration their use of medical services. Low-income families would be able to benefit financially if they controlled some of the dollars spent on their health care and could roll over unused funds into an HSA for future health care needs.

Step Three: Remove the Employer Mandate. The “pay or play” provision of the Massachusetts plan is a roundabout way to require employers to offer health insurance. However, employee health benefits are a form of nonwage compensation; workers pay for health coverage by forgoing wages. If employers do not offer health insurance, it is likely because their workers prefer cash wages. Since workers ultimately bear the cost of health benefits, forcing employers to provide coverage when workers prefer cash is essentially a tax on labor that inhibits job growth. At the very least, the mandate should only apply to individuals.

Step Four: Eliminate Costly Insurance Regulations. Massachusetts’ highly regulated health insurance market makes private coverage more expensive. The inability to pay premiums is one of the primary reasons people lack health insurance. Two costly regulations are guaranteed issue and community rating. Guaranteed issue requires insurers to sell policies to all state residents who apply, regardless of their health status or pre-existing medical conditions. While guaranteed issue sounds like a way to protect consumers, it actually harms them by driving up prices. When insurance companies are forced to accept all applicants, they raise premiums to guard against the increased risk of losses. As a result, insurance is a poor value for everyone except those with serious health conditions.

In Massachusetts and other states, guaranteed issue is combined with a modified form of community rating. Community rating forces insurers to charge every policyholder similar prices, allowing very little adjustment for age, sex or any other indicator of health risk. For example, although medical costs are typically three to four times as high for a 60-year-old male as for a 25-year-old male, both pay the same premium. Under community

rating, therefore, healthy people must be charged more so sick people can be charged less.

As premiums rise, lower-income and healthy people are driven out of the individual market. The pool of insured people grows smaller and less healthy, driving up premiums even more. While proponents claim this cannot happen when everyone is required to have insurance, a tax penalty of \$200 is unlikely to entice young, healthy people into buying expensive coverage.

A recent study by the Commonwealth Fund illustrates how insurance rates are far higher in states with these two regulations than in states that do not have them. The policies have similar coverage and a deductible of about \$500. As the figure shows:

- A healthy 25-year-old male could purchase a policy for \$960 a year in Kentucky but would pay about \$5,880 in New Jersey.
- A similar policy, available for about \$1,548 in Kansas, costs \$5,172 in New York.
- A policy priced at \$1,692 in Iowa costs \$2,664 in Washington and \$4,032 in Massachusetts.

Massachusetts should establish a state-subsidized, high-risk pool to help high-cost individuals obtain affordable coverage. Instead of community rating and guaranteed issue, it should allow insurers to charge risk-based premiums.

Step Five: End Costly Benefit Mandates. Forcing insurers to cover benefits that many consumers may not want (or need) also drives up premiums. For instance, Massachusetts is one of only seven states to mandate coverage for hair prostheses (hairpieces). It is one of only 14 states that mandate coverage for in vitro fertilization — adding 3 percent to 5 percent to the cost of premiums. Proponents often argue that their particular mandate costs little; but when all 40 of Massachusetts’ mandated benefits are added together the costs are significant. Nationwide, as many as one-quarter of the uninsured may have been priced out of the market by costly mandates. Insurers rather than states should design health plans.

Conclusion. Mandated benefits and regulations have driven up the cost of health insurance in Massachusetts. Deregulating the market to allow competition in the design of health plans would make more affordable coverage available. Requiring people to buy additional insurance is likely to lead to a rise in the number of uninsured and an increase in the cost to taxpayers to subsidize their coverage.

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