

# What Massachusetts Should Do in an Uncertain Healthcare World

By Josh Archambault

The debate over repeal and replacement of the Affordable Care Act (ACA) will continue even after the recent collapse of the American Healthcare Act (AHCA). There is likely to be another bill in the near future, and the Trump administration has already started to make changes administratively. These changes require serious soul-searching and clear thinking.

The same is true here in Massachusetts. Thoughtful reform could lower the Commonwealth's highest-in-the-nation premiums, but will also require a willingness to reexamine decades-old beliefs.

Massachusetts' Medicaid program (MassHealth) has expanded so much (mostly before the ACA) that the Bay State is closing in on a similar percentage of the population on Medicaid as significantly lower-income West Virginia. Roughly one in four residents in the Commonwealth are now enrolled in a taxpayer-funded safety net program and the financial fallout is huge. The state currently sets aside

\$16 billion annually, roughly 40 percent of its total budget, for this one "anti-poverty" program, crowding out additional investments in education, fighting the opioid crisis, or transportation.

Money is one thing, but the soul searching should start with these questions: Why do studies show that this massive spending results in health outcomes for Medicaid recipients that are at best mixed? What does an insurance card mean if the person holding it still struggles to access care? And in an environment of repeal and replace, is it worth trying to preserve the status quo or should Massachusetts aim to do better?

Here are three things for Massachusetts to remember as we plan for an altered ACA world:

## 1 - Don't Default to the Former Status Quo

Currently, Massachusetts' political and policy leaders seem to be asking if the Commonwealth can simply revert back to the RomneyCare framework. Such nostalgia glosses over two important questions: Did RomneyCare effectively contain costs? And can we afford that coverage system with fewer federal dollars?

While coverage rates did increase under RomneyCare, large unresolved issues persisted in our health system. Premiums remained the highest in the nation, there continued to be far too much emergency room utilization, wait times were long and may have gotten longer, reimbursed care for the uninsured still cost more than \$500 million annually, and the redirection of billions in federal dollars from supplemental hospital payments to underwrite the RomneyCare program never fully materialized. Bottom line: a flood of federal dollars made RomneyCare possible, and the reform did not slow cost growth. In an altered ACA world, Massachusetts needs to take a hard look at the real pressure points that are driving up costs and thereby limiting access. The Commonwealth's obsessive focus on coverage at all costs is a textbook example of focusing on the trees and overlooking the forest.



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## 2 - Put Everything on the Table

Current conversations in D.C. still suggest a “repeal” or alteration of some of the ACA’s financing with an effort to simultaneously change insurance regulations. The program-specific aspects of other “replace” efforts will likely play out over time and in smaller pieces. A sunset and staged repeal and replace strategy is politically smart. It increases the likelihood of gaining Democratic support on specific future program changes and provides states with a runway to determine how they will react to future changes.

### Focus on Access Instead of Coverage

In Massachusetts, everything should be on the table. To date, our health care policy discussions have focused too much on coverage or ineffective and misguided attempts at reducing costs that will have significant unintended consequences. The myopic focus on coverage that undergirds the ACA has actually left the truly needy behind — even in Massachusetts.

As an illustration, the Bay State has the most doctors per capita of any state, and yet Medicaid recipients often struggle to gain access to them. Surveys by the Massachusetts Medical Society have found that at times only 50 to 60 percent of internal medicine and 60 to 70 percent of family medicine offices accept Medicaid patients. Among Medicare and privately insured enrollees, that number is closer to 85 or even more than 90 percent. The problem for those on Medicaid gets worse depending on geography and whether specialists are needed. For example, in Barnstable County on Cape Cod, a 2012 Society survey found that only [14 percent](#) of family doctor offices accepted new Medicaid enrollees; similar issues were found in Bristol, Hampden and Norfolk Counties.

If access to health care, not just coverage, is a core goal, a more effective approach would be to focus on getting more individuals off Medicaid and into the private insurance market.

### Change Insurance Regulations

Fast-rising costs limit patient access. Unsexy as it may sound, one of the key ways to contain premium growth is to address insurance regulations. The two most costly regulations are called guarantee issue and community rating.

Guarantee issue requires health insurance plans to sell to all individuals, regardless of their health status, and community rating restricts the difference in premiums that insurers can charge to the young and old. These restrictions penalize young people, who generally earn less, and benefit older workers at the peak of their earning potential. In addition, insurers price premiums as if everyone is sick. This results in high premiums that only those with generous government subsidies or employer assistance can afford, making younger adults much less likely to sign up for insurance due to the cost.

Consider Massachusetts’ decision to merge the individual and the small business market under RomneyCare, which drove

up premiums for small businesses. The Commonwealth did it because these two regulations had driven most of those who were healthy out of the individual market. In a post-ACA world, the state should reconsider this move. The Department of Insurance has already done the important [analysis](#) of how many small businesses would be helped by decoupling the market. Massachusetts needs to look outside its borders for an alternative that helps all age groups.

### Take a Hard Look at the Future of the Connector

The Commonwealth should reexamine the Connector. The conversation in Washington is to allow tax credits outside of an exchange, unlike under the ACA. In that new world, the state should ask how much value the Connector is still able to provide. It has operated in the red even after plan assessments, has relied on taxpayer funds, and struggled to attract a significant number of unsubsidized enrollees. Maybe that means the exchange’s structure changes, or perhaps it should be phased out.

## 3 - Adopt Successful Reforms from Other States

In a post-ACA environment, the best advice is not to look backward, but to instead look sideways at other states.

### Embrace an Invisible High-Risk Pool to Help Those with a Pre-Existing Condition, but also Drop Premiums

As mentioned above, guarantee issue, which Massachusetts and the ACA employ, is a very expensive means of insuring those with pre-existing conditions because it allows a person to wait until they need a significant amount of medical care before signing up for insurance. Of the eight states that used to do it **the way we do**, five had largely abandoned **the old method** before the ACA was passed. Pre-ACA, other states had developed far more creative solutions.

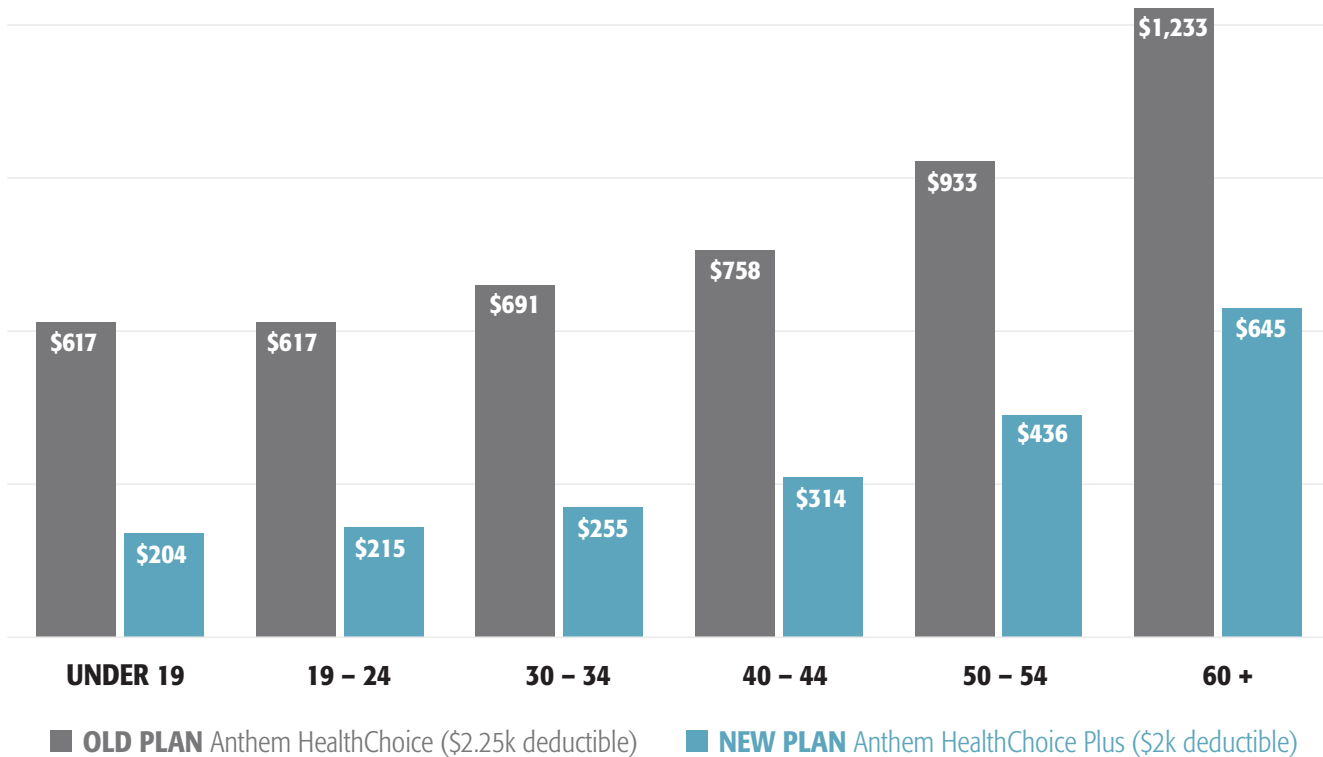
Maine, for example, switched to an efficient program that can be thought of as an [invisible high risk pool](#). The program did not function like a traditional high-risk pool as it did not segment individuals out or charge them a higher premium. Instead it was targeted risk-sharing. The program operated under guaranteed issue regulations, did not require any taxpayer money and resulted in significant premium decreases for all age groups in the individual market. Premiums of the state’s largest issuer fell by about 70 percent for the young and around 50 percent for older residents. The plans also came with lower deductibles that attracted more young people to sign up.

The beauty of Maine’s invisible high-risk pool is that it operated behind the scenes, out of sight of consumers. All applicants completed a health statement with their application.

Insurers used the data provided to determine who to designate for the invisible pool, but the individuals are not treated

## INVISIBLE HIGH-RISK POOL & EXPANDED AGE BANDS

### Individual Insurance Premiums Before & After Maine Reforms



differently. They are enrolled in the same plan they applied for at the same rates whether tagged for the invisible high-risk pool or not. The pool simply helps defer expenses of the highest cost policyholders so those costs don't raise premiums for all. In effect, everyone is priced as if they were healthy. By contrast, under the Massachusetts and ACA systems, everyone is priced as if they are unhealthy driving up premiums. Additional changes will also be needed that embrace innovative new care options.

### Welcome Innovative Care Options

The state's Determination of Need (DON) laws are antiquated, prevent competition, and stifle innovation for smaller companies. DON laws set in place a bureaucratic and regulatory legal process that requires approval before the creation of new health facilities, expansions or acquisitions. The research is clear: laws like ours [hurt patient care](#) and [drive up costs](#). Which is why most states with similar laws have repealed them. The Massachusetts market may require some additional consumer protections due to market consolidation concerns and monopoly-like behavior, but additional flexibility should be considered.

### Pay Patients to Reduce Costs

Finally, Massachusetts policymakers have come to recognize that the Commonwealth's healthcare prices vary wildly and that there is no correlation between those price variations and quality of care. Currently the Group Insurance Commission,

which serves state and some local employees, is piloting a program to reward patients when they pick a high-value provider that charges less. The state could build on this work by passing a law that provides a rebate to patients who choose a high-value provider. This kind of reform has already proven wildly successful in New Hampshire, where the state has saving over [\\$12 million for the state and patients](#) have received over \$1.2 million in incentive payments. If unleashed statewide, costs would drop and innovative providers would be rewarded with more patients. In turn, insurance premiums could drop as they reflect underlying healthcare costs.

### Conclusion

Regardless of what happens in the debate over repealing and replacing the ACA in D.C., Massachusetts has to tackle health care costs intelligently. We need to do more than provide insurance; we need to increase access to care. That means thinking seriously about the role of private market insurers, insurance regulations and the regulation of medical providers. If we address these issues, Massachusetts could end up with far less expensive premiums and a more efficient healthcare system, instead of simply fearing what federal action might mean for our state budget. Employers would be able to steer more money to middle-class wage increases instead of endlessly dumping it into healthcare benefits, and the state could free up resources to dedicate to non-healthcare purposes.

