

Counter Point: What Massachusetts Should Do As Uncertainty Engulfs US Healthcare System

by Barbara Anthony

Introduction

If you are looking for a debate that embodies the sometimes-clashing values that have created American exceptionalism, look no further than the current debate around the American healthcare system. This debate brings into sharp contrast views of proponents of free market principles with those who believe in government interference in the healthcare marketplace. Both believe their approach is the best way to ensure that all citizens are able to obtain healthcare services. This debate takes place in a country which embraces both free market principles and government's obligation to create social welfare programs that "lift all boats" — think Social Security, Medicare, Medicaid and Unemployment Insurance. In economics courses, we learn that America is a "mixed economy" which uses both free market principles and social welfare programs to advance our common wealth. History teaches that no great nation (or great state like Massachusetts) can ignore less advantaged populations and remain economically and politically strong and secure. Thus, as we continue the debate around healthcare, it's helpful to remember that our national self-interest is in the preservation of a mixed economy that embodies both free market principles and the interdependence of our common welfare.

What's Happened in Massachusetts?

While the national debate around healthcare and the rhetoric about the so-called "horrors" of the Affordable Care Act (ACA or Obamacare) bombard the airways nightly, we in Massachusetts need to take a step back and separate the problematic issues in the Massachusetts marketplace from what some other parts of the country may be experiencing. With a healthcare uninsurance rate in 2015 of about 3 to 4 percent, Massachusetts has little to gain from a repeal of the ACA, or the adoption of any other plans that would create market disruption or inject uncertainty into our healthcare marketplace.

When RomneyCare (Ch. 58) was adopted in Massachusetts in 2006, its framers and supporters deliberately left healthcare cost control for another day. While Ch. 58 resulted in expanded coverage and access to healthcare, it was not until the passage of the ACA in 2010 and the state's



PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

Barbara Anthony, lawyer, economist, and public policy expert, is a Senior Fellow in Healthcare Policy at the Pioneer Institute. She is also an Associate at the Harvard Kennedy School's Center for Business and Government where she researches and writes about Massachusetts healthcare cost containment efforts. She served as Massachusetts Undersecretary of the Office of Consumer Affairs and Business Regulation from 2009 to 2015 and has worked at the intersection of federal and state commercial regulation and the business community for many years. Among other positions, Anthony served as the Director of the Northeast Regional Office of the Federal Trade Commission in Manhattan, and was a top deputy to the Massachusetts Attorney General. She began her career as an Antitrust Trial Attorney at the U.S. Justice Department in Washington, D.C. Anthony is a well-known consumer advocate and regularly appears as a media commentator on consumer protection and business regulation issues.

decision to expand MassHealth (Medicaid) that the state saw a very dramatic increase in its Medicaid budget and significant cost increases in the commercial healthcare market as well.

Despite cost control laws passed in 2010 (Ch. 288) and 2012 (Ch. 224), Massachusetts has continued to see annual increases in healthcare spending of between 2.1 and 4.2 percent. A big problem for Massachusetts is that its healthcare costs were already the highest in the country, and although growth has slowed, it continues on its upward trajectory from a very high base. Our commercial market in Massachusetts is characterized by huge variations in healthcare prices that cannot be explained, generally, by quality differences. Some observers believe our state's market is dysfunctional because price negotiations are dominated by some entities with the ability to extract from insurers and employers higher prices than would result in a more competitive market.

On top of high prices, over the past few years hundreds of thousands of low-income people, some of them employed either part-time or full-time, have swelled the state's Medicaid ranks because of the decision to opt into the ACA's Medicaid expansion. Currently, almost 2 million people of the state's 2015 population of 6.8 million are enrolled in the state's Medicaid program, which totals \$16 billion or 40 percent of the state budget. Sticky high prices in the commercial market, especially for small businesses, and a Medicaid budget that is indeed problematic — these are two of the major problems that Massachusetts faces as the national debate about whether or not to keep Obamacare swirls around us. While this debate occurs, what should we in Massachusetts focus on?

Retain Guaranteed Issue, No Exclusions Due to Pre-existing Conditions and Mandates

With the passage of RomneyCare, Massachusetts made its commitment to pursue universal coverage and access to healthcare services. This means that in Massachusetts one cannot be denied health insurance coverage, including anyone with pre-existing conditions. At the same time, in 2006, penalties were levied against individuals who opted against purchasing insurance, if available plans were deemed affordable. A small charge was also imposed on employers that did not offer health insurance. Penalties against employers for not offering coverage are always legally complicated because of a federal law, known as ERISA, that prohibits states from interfering with employer benefit plans. The employer "assessment" in Massachusetts was carefully structured and small enough so as not to provoke legal challenges from the employer community.

While critics may believe the state is too focused on providing insurance for its residents, the alternative to that focus is an acknowledgement that access to healthcare services will likely be denied to certain segments of the population who cannot

afford either insurance or the price of healthcare services, and that certain individuals will choose not to purchase insurance even if they can afford to do so. At the end of the day, lack of access to healthcare services leads to poor public health outcomes that we end up paying for, one way or another. (It is worth noting that Massachusetts passed guaranteed issue in the mid-nineties, but there was no mandate that people had to purchase insurance. The result was predictable: The small group market went into a so-called "death spiral" as mostly unhealthy people purchased insurance while too many healthy individuals opted to stay out of the market. The result was that premiums climbed dramatically and more and more people found it unaffordable.)

While healthcare policy can indeed be complicated, there is a fundamental principle concerning healthcare insurance that is pretty easy to understand. Health insurance works best when everyone — healthy, sick, young and old — is insured. The purpose of insurance is to spread risk, and the more people of varying degrees of health status who are included under the insurance umbrella, the lower premiums should be. Massachusetts should retain its statutory commitment to guaranteed issue, to no exclusions due to pre-existing conditions, and to the individual and employer mandates.

Do penalties need to be enhanced to incent greater participation in health insurance?

Despite the penalties that exist for not purchasing health insurance, there are some individuals who choose to "go bare" and take their chances. At a 3 to 4 percent uninsured rate, the number of holdouts is not huge, approximately 200,000 to 300,000 at most. In dealing with this population, one option is to stiffen penalties for individuals who can afford to purchase insurance but who do not do so. The penalties under Ch. 58 were less than the penalties under the ACA. Massachusetts should seriously consider a significant increase in such penalties.

What about dropping the mandates and adopting "high risk insurance" ACHA programs or "invisible risk sharing insurance" Maine-like programs?

Under recent amendments to the American Health Care Act (AHCA), which, effectively, would repeal the mandate to purchase insurance in Obamacare, states would be allowed, under a federal waiver process, to charge people with pre-existing conditions more for coverage provided that states set up high risk insurance pools or some other programs to mitigate risks to insurers with high-cost patients. A high risk insurance pool program would provide insurance coverage to individuals whom insurers deem unhealthy due to pre-existing conditions. While this AHCA provision does not contain many details, generally, insurers would cede high risks customers to the pool and losses would be covered by a combination of monies from

insurers and the government. High-risk pools are not new to health insurance markets. According to a May 3, 2017 New York Times article by Reed Ableson and Margot Sanger-Katz, before the ACA, 35 states had such pools. The article reports that the main problem with these pools is that they were underfunded, typically charged higher prices than the rest of the market, and often contained annual and lifetime caps. A May 3, 2017 online article in CNN Money by Tami Luhby reports that in 2011, high risk pools around the country covered 226,000 individuals which was only a fraction of those who were potentially eligible. (In general, the concept of high-risk pools in insurance is not new. Massachusetts has had a high risk pool for automobile insurance for many decades.)

A high risk insurance pool is similar but not identical to Maine's "invisible high-risk pool" (IHRP) discussed by Pioneer's Josh Archambault in the preceding policy brief. The idea of Maine's IHRP, is "a behind the scenes reinsurance program for higher risk subscribers whom insurers identify at the point of enrollment" through a detailed questionnaire eliciting information about health status.¹

In the Maine program, individuals in its invisible high-risk-sharing program did not know they had been designated as high risks and they continued to pay premiums as if they were part of the insurers' ordinary pool of customers. The pool would pay for losses incurred by these individuals over a certain threshold. However, this IHRP, similar to other high risk pools, would not pay anything for risks that were not identified prospectively.² Generally, any version of a high risk pool could serve as an incentive for insurers to be very conservative (when in doubt, cede the risk) in deciding which risks to yield to the risk pool unless there are mechanisms in place to prevent gaming the system. The AHCA amendment has some of those safeguards.

The high risk program approach contrasts with the approach that was in operation for the first three years of the ACA. Under Obamacare, insurers were reimbursed for enrollees who retrospectively turned out to have high claims, initially more than \$45,000 in a year. The idea behind both the ACHA's prospective and ACA's retroactive approaches is to reduce premiums in the individual market. The Brookings article previously cited concludes that "neither approach is inherently superior at reducing premiums."³ One thing that is clear is that both programs depend on the amount of funding in the pool which in turn influences the impact on premiums.

Maine's, program, unlike the high risk pool provision in the AHCA, did not use tax dollars. There are articles, pro and con, about the reduction in premiums resulting from Maine's IHRP. Some proponents claim the IHRP cut premiums in half, while critics say that benefits were cut, including maternity coverage, 30 percent co-insurance was instituted and out of pocket maximums were doubled or more.^{4,5}

One troubling aspect of high-risk pools in general is that in

order for insurers to identify high risks, consumers will have to complete detailed questionnaires about their health status as part of the insurance application process. Under the ACA, and especially here in Massachusetts as far back as the mid-nineties, there has been guaranteed issue and no pre-existing conditions exclusions. To now require consumers to complete such applications is very likely to create confusion and anxiety. Questionnaires, such as those required by high-risk pools, are the products of a bygone era when medical underwriting was the norm.

While Massachusetts policymakers should be receptive to new ideas to reduce premiums, careful study of any version of a high risk pool is warranted before any consideration of implementation. As stated, previous to the ACA, about 35 states had adopted some version of high risk pools and the results were not very successful.⁶ The bottom line is that it is a complicated mechanism that generally requires significant government funding in order to make a significant difference in premiums and cover all those who are eligible.

So, what can Massachusetts do about reducing commercial healthcare costs?

In order for the state to address the problem of persistently high healthcare prices, there needs to be some consensus that our market is not functioning as a more competitive market would function. Thus, corrective action must not only make it possible for new competition to enter the marketplace, but there must be an acknowledgment that some form of corrective action with respect to the presence of market power is necessary — even as a short term intervention. Governor Baker started this interventionist conversation with a proposal to limit insurance company payments to payers, with high cost providers receiving no increases. This seems to be a circuitous route to reach providers who may be wielding market power without countervailing purchasing power on the other side. Perhaps a more direct approach to such conditions may be warranted by temporarily restraining pricing behavior on the seller (provider) side. This is not consistent with free market principles, but in a dysfunctional market, intervention may be necessary to correct what economists call supra-competitive pricing.

Medicaid Reforms Have to be Accelerated

After the ACA, Massachusetts made a decision to expand its Medicaid offering to include working and non-working people whose income was not above 138 percent of poverty. There is no question that this change resulted in a massive influx of new MassHealth enrollees. Some estimate that as many as 500,000 new members migrated to MassHealth as a result of this expansion, although Medicaid rolls had been growing steadily for many years. Massachusetts officials believe that a significant number of these new enrollees are low wage workers who are

making an economically sound decision to enroll in less costly MassHealth insurance rather than purchase insurance offered by their employers, or those whose employers do not even offer insurance. Regardless of the reason, one thing that does not seem feasible is that these low wage workers, many of which may be part-time workers, are not financially able to purchase commercial insurance.

This is a serious fiscal problem for the Commonwealth and one that would only worsen if federal Medicaid funding is cut under the ACHA. One potential source of state revenue to help offset this problem is from those companies who do not offer coverage at all, or who do not attract substantial numbers of their employees to their offering. There are also large companies which offer good coverage, but even they have a certain number of low wage employees who cannot afford their employers' coverage. This issue was discussed recently by Partners CEO and President David Torchiana in the April 27, 2017 edition of the Boston Business Journal. Dr. Torchiana recommended that employers above a certain size who have low income workers on Medicaid should be required to pay the state a per-employee fee for coverage in place of the commercial-premium contribution that would have been made. The amount of the employer contribution would still be less than the cost of employer-sponsored insurance, so the employer would still be ahead and the concept of employer responsibility embodied in Ch. 58 would be maintained. This proposal is worthy of consideration.

Another important component of MassHealth reform is the adoption of managed care and accountable care organizations to control costs. Under Ch. 224, MassHealth was mandated to initiate these serious cost control measures. At this point, we do not know the progress of these measures, or whether they are actually reducing costs once adopted. This is very important information. Are efficiencies and lower costs resulting from this overhaul? This information is a necessary part of any discussion regarding MassHealth reforms. MassHealth should report publicly on these efforts to reduce costs so that appropriate changes, including acceleration of managed care, can be made, if necessary.

For low wage workers and the unemployed, access to healthcare services remains a very serious challenge. Our options, unfortunately, are limited. First, of course, program integrity should be a matter of on-going review and those who are not eligible should be removed from the rolls; second, another option is to tighten eligibility requirements, thus limiting access in the first place; third, the state could opt out of the Medicaid expansion that it has adopted. Except for the first option, the other options would have undesirable public health consequences as well as tremendous public policy upheavals in a state that has been committed to universal coverage for over a decade. It seems that for Medicaid, greater contributions from employers and realizing cost savings from the directives to MassHealth in Ch. 224 warrant serious and immediate focus.

De-merging the Small Group and the Individual Markets Requires Careful Study

Ever since the small business (under 50 employees) and the individual markets were merged in 2006, there has been a strong desire in the small business community to decouple and return to its former status. When these two markets were merged, premiums for small businesses did go up, while those for individuals went down. The issue today is what would happen in each market if decoupling took place. There is widespread belief that small business rates would benefit, but we don't know what would happen to the individual market. This is an area where the state Division of Insurance should be able to provide current information that will better inform this issue. We need to know if there would be unintended detrimental consequences in the individual market and how such consequences would be addressed and that information should be made public.

Community Rating and the Review of Insurance Premiums

Community rating is the application of certain rating factors across broad portions of an insured population. Under the ACA, community rating includes factors that require insurers not to charge older enrollees more than three times what they charge younger customers.

There is a lot of conversation at the national level to change this ratio from 3-to-1 to 5-to-1. (In Massachusetts, the age community rating ratio is 2.1 to 1.) Under changes discussed at the national level, insurers would be able to charge older enrollees up to five times as much as younger enrollees. The rationale is that such a change will reduce premiums for younger people and entice more of them into the health insurance marketplace. In Massachusetts, we have an uninsured rate of about 3 to 4 percent of the population but we do not know the age distribution of these approximately 270,000 people. We also do not know the income characteristics of those in the 45-to-64 year old (pre-Medicare) age group. While a change to 5-to-1 might make sense in states with high levels of uninsured young people, the circumstances here in Massachusetts are not the same as Texas or Florida where uninsured rates generally are in the double digits. Before embarking on such a change in Massachusetts, the state should be asked to provide an analysis of how this change will impact the remaining uninsured in this market.

There is also another issue that receives too little attention, and that is the way the Division of Insurance reviews rate hike requests from insurance companies. There are some who believe that insurers price according to their least healthy enrollees. If this is true, there is something wrong with the state of health insurance regulation in Massachusetts. Insurance companies

submit to the Division of Insurance (DOI) rate hike requests that are a projection of what the carrier believes its future costs will be based on past costs and utilization. It is the statutory responsibility of the DOI to examine such rate requests and their underlying assumptions. The DOI has the authority to request as much additional data and information as it needs to determine if the carrier's request should be allowed or disapproved. If carriers are assuming that all their enrollees will mirror only their least healthy enrollees and they are basing their rate hike requests on that assumption, it is the DOI's responsibility to look carefully into such claims before allowing such rates to go into effect. While it is possible that carriers' pricing to their least healthy enrollees may be permissible in other states, it should not be the case in Massachusetts.

Health Connector

There are some health policy observers who argue that the Connector is in serious need of repair, and a reevaluation of its efficacy and reason for existence are in order. While there were very serious technical issues with the implementation of the Connector, the exchange now seems to be operating as intended and is an easy vehicle for tens of thousands of low income Massachusetts residents to shop for and obtain insurance coverage. The Commonwealth and the federal government have invested heavily in making the Connector work for state residents. Even in a tax credit system, the Connector would allow consumers to more easily navigate their options. If the Connector disappears or is "phased out," what will replace it for low-income residents? While it is true that not many unsubsidized people use the Connector, it provides a vital service to low income and subsidized populations.

It is also noted by observers that the Connector has been operating in the red for the past few years. While the Connector should be operating efficiently and state audits should determine this, the issue of turning a profit is another question. The Connector could raise its fees to insurers, but that will likely be passed on in higher premiums. The Connector could charge a user fee, but it seems counter-productive to charge a user fee to populations that need subsidies to purchase health insurance and may discourage use of the Connector.

It is a fair observation that the Connector has so far not attracted many unsubsidized enrollees. Certainly this calls for examination and a plan going forward to attract more unsubsidized enrollees. Such a plan would pit the Connector head to head with the existing healthcare broker industry and may complicate what should seem like an obvious marketing strategy to gain more customers and revenue. Regardless, a review of the Connector and a plan for improvements will eventually be necessary, but its elimination is unlikely to help address the most pressing issues facing the state's healthcare system.

Determination of Need Laws

Determination of Need (DON) laws were designed to prevent unnecessary overhead costs from being passed on to consumers and ensure that healthcare providers efficiently organize themselves. Too often, however, such laws have been used to prevent entry from new competitors and to preserve the status quo. The emergence of CVS Mini-clinics and urgent care centers not connected to major providers are examples of long overdue changes to the marketplace in Massachusetts that reduce costs, add to consumers' convenience and make healthcare services more available and affordable for all of us.

Our DON laws are in need of major overhaul to permit easier entry by low cost, innovative providers. However, given the dysfunction that our current marketplace is experiencing, there is an anomaly that would take place if all DON laws were eliminated. We already see major providers opening urgent care centers competing with newer entrants unaffiliated with major providers. Eliminating all DON laws will apply equally across the board both to those with existing market power and new innovators trying to gain a toehold in our state. Instead of wholesale elimination, a more refined approach could be developed that would benefit new entrants while limiting the power of existing players of a certain size to expand into certain markets. Such an approach could be temporary and work to phase out DON.

Make Healthcare Price Transparency a Reality

Although the state has strong laws requiring healthcare price transparency by carriers and providers, consumers and employees alike woefully underutilize these laws. Pioneer has conducted **multiple surveys** that demonstrate that providers simply do not take price transparency seriously and carriers do not invest in promoting their cost estimator tools to employers or enrollees.

The result is that in an age of high-deductible health plans, and in a state with huge variations in healthcare prices, consumers have no idea what their healthcare costs are, even when they are paying for it themselves. There is ample opportunity for the state and business communities to exert leadership and take steps to reward consumers for making high-value, lower cost provider choices. Paying patients to reduce costs is one way to drive patronage to lower cost providers. And, there are plenty of innovative programs scattered around the state that serve as examples, such as the Group Insurance Commission's pilot to financially reward state enrollees who choose high value providers, or the Polar Seltzer company which educates its workforce about the cost of care and how it impacts both workers and the company's bottom-line.

The state executive branch needs to employ its regulatory agencies, such as the Department of Public Health, the Boards of

Medicine and Dentistry and the DOI, to require greater adherence by healthcare regulated entities to the state's transparency laws. There is also an opportunity for the Attorney General's Office to let providers and carriers know that adherence to the state's transparency laws fall under the umbrella of the state's consumer protection laws. There is much leadership that the Commonwealth can exert to promote greater innovation and utilization of the state's transparency laws. Price transparency in healthcare is fully consistent with a free market approach that will help consumers make better choices with their and their employers' healthcare dollars.

Conclusion

Regardless of what takes place at a national level, Massachusetts has its own set of challenges to continue pursuing the state's commitment to universal coverage at affordable prices. Here is a ten point program that the state should vigorously focus on in the days ahead:

1. Retain guaranteed issue, no exclusions for pre-existing conditions, and mandates to purchase insurance.
2. Consider significantly increasing penalties for failure to purchase affordable and available insurance.
3. Consider temporary direct intervention to tamp down provider prices that are not responding to competitive pressures.
4. Accelerate Medicaid reforms, including an assessment for employers whose low wage employees are on Medicaid and cost savings resulting from adoption of managed care principles as mandated by Ch. 224.
5. Carefully examine the feasibility and potential fallout of uncoupling the merged individual and small business market, and focus on any unintended consequences for individuals.
6. Retain community rating and the current age band unless data shows moving to a 5-to-1 age band will really make a difference in our already low uninsured rate without hurting middle-aged consumers
7. Scrutinize carrier filings at the Division of Insurance to ensure that proposed rates are not based on overly pessimistic claims projections.
8. Audit the Commonwealth Health Connector Authority to ensure it is operating as efficiently as possible, and the Connector should explore plans to capture a greater share of the unsubsidized market.
9. Revise the state's DON laws to permit easier entry for new entrants or expansions by healthcare entities below a certain size, while putting in place temporary restrictions on expansions or entry into new markets by entities above a certain size.
10. Take leadership through the Executive Branch and the Attorney General's Office by playing a larger role in incenting both compliance with state law and the creation of innovative programs around our state's transparency laws.

Endnotes

1. "Making Sense of 'Invisible risk sharing.'" *Brookings* (online) Mark Hall and Nicholas Bagley. April 12, 2017.
2. Ibid.
3. Ibid.
4. Ibid.
5. For an article describing the benefits of IRSPs and the Maine program, see "Correcting Misconceptions About Invisible Risk-Sharing." *Health Affairs Blog*. Josh Archambault, Joel Allumbaugh and Tarren Bragdon. April 25, 2017.
6. "Extra Billions for Health Bill? Researchers Say It's Still Not Enough," *New York Times*. Reed Abelson and Margot Sanger-Katz, May 3, 2017.

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📍 185 Devonshire Street, Suite 1101 Boston MA 02110 📞 617.723.2277 📠 617.723.1880
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