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*Lessons for Massachusetts
from State Health Care
Reforms in Other States:
What Chapter 58 Missed*

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Executive Summary

Through its individual mandate, mandated benefits, expansion of Medicaid and its health insurance exchange, the Massachusetts universal health care law, Chapter 58, dramatically expands state government's role in the delivery of health care. However, Chapter 58 represents the antithesis of free market or consumer-driven health care reform where choice, competition and transparency offer the potential for better alternatives. Chapter 58 rests on the tired, unsustainable and costly model of third-party payments and moves away from a model that should be based on a two-party transaction: Consumers (patients) and producers (physicians and health care providers).

The seminal model from which to judge all market-oriented reforms can be found in the Milton Friedman's often-cited 2001 *Public Interest* article, "How to Cure Health Care."¹ Friedman noted that as government became the primary purchaser of health care, per capita spending on as a percent of Gross Domestic Product (GDP) rose invariably.

The problem with health care insurance is that it relies on a third party payer that fails to serve the health care consumer. Friedman's "cure" came in the form Health Savings Accounts (HSAs) which enable the consumer to benefit from the same benefits as a subsidized employer-paid plan.

Although implemented at a rate far below their potential, HSAs have been, at best, shunned by policymakers who do not trust the market. Meanwhile, measures such as community rating reform, interstate sales and high deductible plans are other alternatives enacted by other states. The principles guiding real health insurance reform

¹ M. Friedman, "How to Cure Health Care," *The Public Interest* (Winter 2001).

should include the elimination of tax bias favoring Employee Sponsored Insurance (ESI), the enactment of tax credits to level the playing field for all workers, tort reform and portability.

Several states have moved toward incorporating these elements of competition and choice —at least one, Georgia, has taken Friedman’s outline for HSAs while other adapted HSAs for publicly provided Medicaid. Distinguishing its own model from the cumbersome federal plans for state exchanges, Utah has decided to establish a private health care exchange while deploying tax credits and enhancing portability. Maine has rewritten its reinsurance rules. Texas and Mississippi have instituted tort reforms, measures not directly involving health care provision themselves, but reforms that send a strong signal to the market by lowering barriers to physicians. These measures are not perfect, occasionally like Florida’s attempt to sell high deductible plans, they fail.

Massachusetts would be wise to look at other market based policies. These policies could include:

- More effective Health Savings which could provide affordable, high deductible policies which better suit consumer needs.
- Reforming guaranteed issue and community rating.
- Leveling the playing field between Employee Sponsored Insurance and workers who purchase their own policies by deducting non-reimbursed premiums from taxable income.
- The adoption of a private state exchange that promotes mandate free policies for consumers.

Massachusetts should also balk at expanding Medicaid and its new federal dollars. Subscribing more indigent users to Medicaid puts the state's competitiveness at risk by increasing the state's obligations.

Chapter 58 and the Patient Protection and Affordable Care Act (PPACA) despite the recent U.S. Supreme Court upholding it, will prove that government-run or government-directed health care will become unsustainable.² When the financial pressures are brought to bear, policymakers will have no choice but to turn to the discipline of the market, whether in the form of HSAs, consumer-driven health care or retail clinics or reforms that enables consumers to buy insurance policies across state lines

Health Care Reform in Massachusetts

Advocates of publicly-funded universal health care plans such as Chapter 58 have long argued that health care is a public good in which markets have failed to provide optimal level of provision, particularly to low-income, under-insured families and individuals.³ Thus, they argue, government should take an active role in expanding access to health insurance and regulating consumers, providers, hospitals and third-party payers such as private insurance companies. However, by intervening in the markets, governments impose distortions and additional costs. The patches to fix the market failure problem in turn call for more patches. By expanding coverage without

² J. Levitz and A. W. Mathews, "Same State, New Stab at Health Care," *Wall Street Journal*, May 5, 2012: A3.

³ Most of the interventionist position is based on an article by Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care. *American Economic Review* (December 1963). (<http://www.who.int/bulletin/volumes/82/2/PHCBP.pdf>). For the latest thinking on the public provision of health care see C. Conaboy. "What patients pay: Dr. Don Berwick and Jim Capretta debate shifting health care costs," *Boston Globe*, April 10, 2012. <http://tinyurl.com/6n77jaz>.

the discipline of price signals, current federal and state plans will eventually have to undertake draconian measures often ascribed to the market. However, there is a history that competitive markets reduce prices and benefit consumers from cell phones, disk drives and cloud computing to elective surgical procedures and generic drugs.

The solution to some of these issues could rest in restoring the incentives of private markets. Private markets have been successful in driving down the costs of technology, making products and services ubiquitous. Private markets – which are effective in meeting consumers’ demands for such critical items as food, housing as well as electronics and automobiles, and even elective surgical procedures – can also provide cost-effective health services to consumers if only government would get out of the way.⁴ Even small steps such as providing choice among drug plans for seniors and cultivating and promoting generic drugs is an effective way of controlling costs within Medicare.⁵

Without the discipline of competition, government-mandated universal health care will remain costly and non-user friendly.⁶ Competition in non-insured medical services such as cosmetic surgery, laser surgery and other elective procedures has driven down prices.⁷

⁴ J. S. Flier and E. Maraot-Flier, “Health care reform: a free market perspective,” *Diabetes Review* 2, No. 4 (Fall 1994).

⁵ A. Roy, “George W. Bush, Health Reformer: Flat Medicare Drug Premiums Show That Choice and Competition Work,” *Forbes*, August 8, 2011. <http://www.forbes.com/sites/aroy/2011/08/05/flat-medicare-drug-premiums-show-that-choice-and-competition-work/>.

⁶ D. E. Schansberg, “Envisioning a Free Market in Health Care,” *Cato Journal* 31, no. 1 (Winter 2011): 27-58.

⁷ M. Cannon and M. D. Tanner, *Healthy Competition* (Cato Institute, Washington D.C., 2005): 7-8.

The failure of cost containment in Massachusetts

In April 2006, then Massachusetts Governor Mitt Romney wrote an enthusiastic opinion editorial in the *Wall Street Journal* praising the bipartisan effort to expand health insurance coverage in Massachusetts. He wrote:

I believe that we have [found a way to provide insurance to everyone]. Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced. And we will need no new taxes, no employer mandate and no government takeover to make this happen.⁸

The health care law that former Governor Romney signed included the following:

- an individual mandate, requiring all residents with the financial means to obtain health insurance;
- an employer mandate requiring all employers with 11 or more employees to make a ‘fair and reasonable’ contribution towards their employees’ health insurance;
- an expansion of Medicaid and creation of a health insurance subsidy program for residents with income up to 300 percent of the federal poverty level; and
- the creation of a quasi-public authority – the Massachusetts Health Insurance Connector (Connector) – that serves as an insurance “exchange” and merges the individual and small-group health insurance markets. The Connector also serves as a mechanism that allows individuals to purchase health insurance

⁸ Governor W. Mitt Romney, “Health Care for Everyone? We’ve Found a Way,” *Wall Street Journal*, April 11, 2006.

on a pre-tax basis, and provide a “seal-of-approval” to health insurance products that the Connector deemed to be of good value to consumers.

Chapter 58 has succeeded in lowering the number of uninsured in Massachusetts. But the Bay State was already one of the top states with residents covered under a private or public insurance plan. Yet Chapter 58 has done little to restrain costs. Per capita health spending is 15% higher than the national average.⁹ Massachusetts residents pay among the highest individual and family premiums. Rather than turning to the market, Massachusetts is turning to a global payment system which is nothing more than price controls. The latest legislative attempt to establish an intrusive payment panel pledging thousands of dollars in premium savings is far too optimistic.¹⁰

Mandated Benefits

As of 2010, Massachusetts legally required all insurance policies to offer 47 specific benefits.¹¹ Any insurance firm operating or entering the market in Massachusetts must offer benefits such as maternity care, contraception services, infertility treatment, chiropractic services, scalp-hair prosthesis (wigs) and more. There is no doubt that requiring these benefits, however desirable for all policies, increases the premiums that individuals and businesses pay. Moreover policy holders in Massachusetts enjoy one of

⁹ Kaiser Family Foundation, “Massachusetts Health Care Reform: Six Years Later,” Focus on Health Reform, (May 2012) <http://www.kff.org/healthreform/upload/8311.pdf>

¹⁰ J. Levitz, J. & A.W. Mathews, (2012, May 5) Same State, New Stab at Health Care. *Wall Street Journal*. A3.

¹¹ Council for Affordable Health Insurance, *Health Insurance Mandates in the State 2010*, http://www.cahi.org/cahi_contents/newsroom/article.asp?id=1037.

the lowest thresholds for deductibles for both single and family plans, \$1,472 and \$1,465, respectively.¹²

A 2008 report by the Massachusetts Division of Health Care Finance and Policy found that mandated benefits accounted for \$1.32 billion in spending, or 12 percent of premiums.¹³ A 2000 report by the Congressional Budget Office estimated that exemption from mandated benefits nationally would reduce premiums by 5 percent.¹⁴

Several states have realized that increasing the extending mandated benefits are a counterproductive. Why require a 25 year-old single male to carry maternity care and wig benefits if he does not want the coverage and is unlikely to need it? A viable and sustainable market would allow for consumer preferences. A high co-payment rate would send the appropriate signal about how much individuals are willing to pay.¹⁵

At the start of 2006, Massachusetts mandated 26 benefits, compared to 43 in 2007 and 47 in 2010.¹⁶ It is counterproductive to require and expand insurance mandates, while rejecting the expected price increases associated with them. Eliminating mandates would allow individuals to have various treatments covered, including maternity care,

¹² EHealthInsurance Services Inc. "The Cost and Benefits of Individual and Family Health Insurance Plans," (November 2011)

http://news.ehealthinsurance.com/pr/ehi/document/2011_Cost_and_Benefits_Report_FINAL.pdf

¹³ Division of Health Care Finance and Policy. Comprehensive Review of Mandated Benefits in Massachusetts.

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/070412-chapt58-update6.pdf>.

¹⁴ Congressional Budget Office, Increasing small-firm health insurance coverage through association health plans and healthmarts (January 2000); <http://www.cbo.gov/doc.cfm?index=1815&type=0>

¹⁵ M. Feldstein, "Balancing the Goals of Health Care Provision," *NBER Working Paper* 12279, National Bureau of Economic Research, <http://www.nber.org/papers/w12279.pdf>. 15.

¹⁶ For the years 2006, 2007 and 2010 respectively, see

<http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/070412-chapt58-update6.pdf>

<http://www.themeridiangroup.biz/library/employers/GeorgiaMandates.pdf>

http://www.cahi.org/cahi_contents/newsroom/article.asp?id=1037.

wigs or acupuncture, but they would have to pay for the expanded benefits. Instead Massachusetts has moved in the opposite direction.

Emphasizing Consumer Choice Not Mandates

Utah

Utah followed in 2009, allowing its exchange, Utah Exchange, a mechanism similar to the Massachusetts Connector, to provide insurance policies to policyholders who were free to opt for basic coverage that excluded state-mandated treatments. This move resulted in a reduction in premiums of 50 to 66 percent.¹⁷ Today Utah's private exchange offers 140 plans from the state's largest health insurance companies covering about 6,600 employees of 285 small businesses.¹⁸ Both employers and employees agree on insurance contributions employer determines in advance how much he will contribute to an employee's insurance, and the employee is presented with several options. The individual can select various metrics that appeals to them, such as high deductible or specific benefits and then shop for the best price from insurers. As the *Economist* notes, the Utah's response to mandates works like a defined contribution pension system with employers deciding how much they would like to contribute. Most of the plans are geared toward small businesses which often found it hard to find affordable insurance. The Utah Health Exchange is far different than the mandated exchanges of PACCA. It offers a better long term prospect for the state. The Governor believes that Utah Exchange which operates like a stock exchange, can ultimately be privatized.¹⁹

¹⁷ *The Heartlander*, "Utah Overhauls Health Care," The Heartland Institute (June 1, 2009)

http://www.heartland.org/publications/health%20care/article/25287/Utah_Overhauls_Health_Care.html.

¹⁸ *The Economist* "UnObamacare: A conservative state believes it has a better answer to the health-care (May 26, 2012) question <http://www.economist.com/node/21555956>.

¹⁹ *Ibid*.

The Massachusetts Connector spends more on administration than the Utah Exchange, (although the Connector no longer depends on an appropriation but on a surcharge on health care premiums) While unable to set prices, the Connector is also more intrusive in setting mandates “minimal credible coverage.” It should also be noted that Chapter 58 is able to shift costs to the federal government. Even with the cost shift, Massachusetts insured pay among the highest rates for insurance. Massachusetts could reap similar benefits if it were to follow Utah allow employers and employees to tailor their own health insurance plans. The Utah Exchange is not perfect it too relies on a heavy hand applied to insurance plans. But its ability to offer more high deductible plans while Massachusetts relies on subsidies and mandates make it a more sustainable.

Eliminating Tax Bias

The current tax system favors workers who receive employer-sponsored health insurance (ESI) over workers who do not have such an option offered by their employers, or who are unemployed. This form of tax discrimination is not only unfair but also inefficient, keeping workers tied to their jobs and encouraging wasteful spending as a result of low deductibles and low co-payments. Offering tax credits to workers who are unable to receive EHI would level the playing field significantly.

Market-oriented health care economists have suggested eliminating the deduction on EHI firms or extending tax credits to out of pocket medical expenditures.²⁰ Chapter 58 does not allow for any form of tax equalization. It rests on the inefficient premise that government can best be called upon to “contain costs.”

²⁰ J. Bankman, J. Cogan, G. Hubbard and D. Kessler, “Reforming the Tax Preference for Employer Health Insurance,” forthcoming Chapter in forthcoming NBER book *Tax Policy and the Economy*, 26, Jeffrey Brown, editor (October 27, 2011) http://www.nber.org/chapters/c12561.pdf?new_window=1.

Missouri: Portability and Tax Credits

Missouri, 'the show me state,' recently addressed the inconsistent tax treatment of worker health insurance. The "Missouri Health Insurance Portability and Accountability Act" decouples health insurance from employment and transferred it to the individual in two ways. First, it allows individuals to deduct all non-reimbursed qualified health insurance premiums from their taxable income. Second, Missouri allows employees to purchase an individual policy and have their employer put pre-tax dollars towards paying for it. This portability allows an individual to change jobs, without the risk of losing their insurance coverage.²¹

The portability of insurance coverage is a huge bonus for the employee. An individual can pick their insurance policy and have their employer pay part, while paying for the rest themselves, all with pre-tax dollars. They then have the option to leave their job, and have the same insurance policy, for which they have also paid with pre-tax dollars. When the worker is hired at a new company, the new employer can make a pretax contribution to the same insurance policy. This level of portability makes for fluid and efficient process, while reducing costs.

Utah: Portability

In 2009, Utah passed House Bill 188, which was designed in part to address this very issue. The bill used two solutions to address this problem. First, it allowed individuals to purchase their health insurance on the Utah Health Exchange.²²

²¹ State of Missouri SS#2 SCS HCS HB 818. "Establishes the Missouri Health Insurance Portability and Accountability Act and changes the laws regarding the Missouri Health Insurance Pool and small employer insurance availability," (June 1, 2007).

http://www.senate.mo.gov/07info/bts_web/Bill.aspx?SessionType=R&BillID=251793.

²² W. Smith, "Business pushing health care reform," *The Utah Pulse*, July 9, 2009, http://utahpulse.com/view/full_story/15733156/article-Business-Pushing-Health-System-Reform?

House Bill 188 also changes the method individuals use to pay for the insurance policy once they select a plan. The employer deposits a specific total in a Utah Exchange account for each employee, allowing the employee to use this money, and additional pre-tax money if they choose to pay their premiums.

This allows individuals to have full control over their coverage, as well as the ability to carry their coverage to a new employer. The employer on the other hand has the advantage of being able to pass the control (and cost) of health insurance management to the exchange, while enjoying predictable costs in the future.

The Promise of Tort Reform

Studies often identify tort reform as a source of relief from increasing costs of health insurance. Rising malpractice rates deter the practice of medicine. Tort reform is another tool that other states have employed that could benefit Massachusetts. Stories abound about the cost of malpractice insurance for doctors, which is inevitably passed onto consumers of health care. The cost of this insurance is backed by actuarial analysis, in which malpractice judgments are a huge variable. Additionally, doctors order 'defensive' tests for patients to supply evidence to ward off possible malpractice judgments. These additional tests increase the consumption and costs of healthcare. Chapter 58 does little to address the need for tort reform.

According to a 2008 report by the Pacific Research Institute, Massachusetts ranks 41st in tort liability, in part due to a low ranking in the medical malpractice sub-index.²³

²³ Pacific Research Institute. *U.S. Tort Liability Index: 2008 Report*.

Massachusetts does have in place laws and policies to reduce the cost of lawsuits, but many are outdated, or ineffective. There is a non-economic cap on lawsuits of \$500,000, but the cap is considered a 'soft' cap, because it can be, and often is, overridden by a jury.²⁴ The Commonwealth also has a malpractice tribunal, which acts as a gatekeeper for spurious or frivolous cases. The tribunal reviews and decides if the case should proceed based on the evidence presented. However, the plaintiff can proceed against the tribunal's recommendation by posting a mere \$6,000 bond, which they forfeit to pay for the defense, if the defendant prevails.

This measure is merely a speed bump in trial cases. First, not only can a plaintiff proceed against the tribunal's recommendation, but the burden of proof for a positive recommendation is low. Second, although the state implemented the \$6,000 bond in 1986, and inflation has eroded its value as a deterrent, \$6,000 has never served as a meaningful deterrent in suits with possible payouts measured in millions of dollars.

While malpractice suits can serve as an important mode of justice, many argue that the current system goes far beyond that. Instead, malpractice suits are seen as an industry – one that unnecessarily creates higher costs for healthcare providers through higher malpractice insurance premiums. The U.S. Department of Health and Human Services believes that "if reasonable limits were placed on non-economic damages to reduce defensive medicine, it would reduce the amount of taxpayers' money the Federal

http://www.pacificresearch.org/docLib/20080222_2008_US_Tort_Liability_Index.pdf.

²⁴ C. E. Eibner, P. S. Hussey, M. S. Ridgely and E.A. McGlynn, "Controlling Health Care Spending in Massachusetts: An Analysis of Options Submitted to: Commonwealth of Massachusetts Division of Health Care Finance and Policy," (August 2009):222 Rand Corporation.

<http://archives.lib.state.ma.us/bitstream/handle/2452/58052/ocn498621633.pdf?sequence=1>

Government spends by \$25.3-44.3 billion per year.”²⁵ These savings would multiply if applied to private insurance plans.

Mississippi

Other states have implemented strong tort reforms laws that contrast with Massachusetts current weak system. Following its comprehensive tort reform effort, Mississippi moved to 7th place nationally in the medical malpractice sub-index.

By focusing on lawsuit abuse, Mississippi saw medical liability premiums fall by 42 percent and medical malpractice claims fell by 91 percent.²⁶ A reduction of that magnitude is unrealistic in Massachusetts, since Mississippi started from a lower base. But Massachusetts would be wise to follow Mississippi by “hard capping” noneconomic and punitive damages and constraints on judge shopping by plaintiffs.

Texas

Texas implemented tort reform in 2003. According to the Governor Perry, Texas was facing a shortage of doctors, due in part to the difficult legal environment. The supply was crimped by an aggressive tort industry. Many areas were underserved, for example “24 counties in the Rio Grande Valley had no primary care doctors at all.”²⁷ Texas placed a “hard cap” of \$250,000 on non-economic damages while leaving easier-to-calculate economic damages uncapped. The state also expedited notoriously drawn-

²⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System," (July 2002) <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>.

²⁶ D. Freddoso, "Here's your 'demonstration project,' Mr. President – it's called Mississippi," *Washington Examiner*, September 2, 2009, <http://washingtonexaminer.com/blogs/beltway-confidential/here039s-your-039demonstration-project039-mr-president-it039s-called-missi>.

²⁷ Governor Rick Perry, "Tort reform must be part of health care reform," *Washington Examiner*, August 12, 2009 <http://washingtonexaminer.com/op-eds/2009/08/gov-rick-perry-tort-reform-must-be-part-health-care-reform>.

out trials – long incentives for ‘settlement hunters’ – by requiring plaintiffs to present expert testimony within four months of filing.

Since these reforms, 10 new insurance providers entered the Texas market. This increased competition, when combined with lower payout rates, led to a 27 percent insurance premium decline over five years.²⁸ Moreover, Governor Perry claims that as a result of reform, 15,000 doctors entered the Texas market. The size and the geographic reach of these estimates have been disputed but even critics acknowledge the number of practicing physicians has increased. This increased supply of doctors created more competition for patients, leading to lower health care costs, than a baseline policy of no tort reform.

Reform to State-Provided Insurance

In June 2012, the U.S. Supreme Court struck down a provision on the PPACA that put at risk a state’s entire Medicaid allotment if a state refused to expand Medicaid. By an overwhelming majority, the court ruled that such a provision was far too coercive. Attention to the expanded Medicaid provision was small compared to the arguments over how to interpret the commerce clause of the U.S. Constitution.

Medicaid continues to face funding problems. Enrollees continue to face poor health outcomes. There is a body of evidence that suggests that Medicaid fails to improve the health of the poor. Thus expanding Medicaid is hardly a solution. In Massachusetts, the average annual growth in Medicaid spending from fiscal year 2007 to 2009 is 10.1

²⁸ Ibid.

percent from —close to 3 percent higher than the national average.²⁹ While a large share of state Medicaid and SCHIPs spending is dictated by federal law, Massachusetts has sought —and received —federal waivers for several demonstration projects.

Utah: Tackling Medicaid

In Utah, Medicaid accounted for nine percent of state spending in 2001 and 18 percent in 2011. This share was expected to grow to 36 percent in 2020, but with the passing of the Affordable Care Act the state projected a spending increase of 46 percent. Understanding that this was an unsustainable path, state Senator Dan Liljenquist introduced a reform bill that is expected to save Utah \$770 million over 7 years.³⁰ The key reforms included the conversion to an “integrated managed care system, where physicians would be rewarded for positive health care outcomes instead of procedures.” It also established a Medicaid-only rainy day fund.³¹ The proposal, which has passed in both houses, and is currently awaiting a federal Medicaid waiver.

Indiana: Health Savings Accounts for Medicaid

Indiana Governor Mitch Daniels addressed his state’s crippling Medicaid spending growth rates by introducing reforms that would restore price signals within market mechanisms. By automatically covering a huge share of medical costs, consumers have no incentive to shop for most cost efficient products. There is no motivation to shop for low-cost products or turn down superfluous tests. To create these incentives, where

²⁹ Kaiser Family Foundation, “Kaiser State Health Facts,” StateHealthFacts.org

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=23&ind=181&sub=47>

³⁰ P. S. Edwards, “Utah’s thoughtful approach to Medicaid reform,” *Deseret News*, May 6, 2011

<http://www.deseretnews.com/article/700133018/Utahs-thoughtful-approach-to-Medicaid-reform.html?pg=1>.

³¹ Ibid.

consumers help regulators to control costs, Governor Daniels introduced the Healthy Indiana Plan.

The Healthy Indiana Plan provides an alternative to Medicaid, by offering high deductible insurance policies coupled with health savings accounts. The first \$1,100 of medical expenses will be paid for using the health savings accounts, with the Plan covering the remaining expenses. The savings account is funded from various sources. State and federal money that normally would pay for Medicaid coverage was instead used to fund these savings accounts. Additionally the individual, dependent on their income levels, would contribute between zero and five percent of their total income.³²

Florida: A Medicaid Opt-Out

Florida faces huge future Medicaid liabilities which continue to claim an ever larger share of state spending each year. The Florida reform plan allows individuals to opt out of Medicaid, and use the premiums to instead purchase employer-based health insurance. Individuals that shop for their own insurance plan with deductibles, and hopefully better coverage, will be more careful of their spending decisions.³³

The second, more original, aspect of Florida's Medicaid reform is the implementation of reverse health savings accounts. These accounts begin with no balance, and the state adds funds if the individual performs defined healthy behaviors, such as weight management, or not smoking. This is meant to strengthen already existing incentives to be healthy, but begs the question, if people are uncaring about the effects of smoking,

³² Kaiser Family Foundation, "Healthy Indiana Plan: Key Facts and Issues," (June 2008)

http://www.kff.org/medicaid/upload/7786_S.pdf.

³³ Center for Medicaid Studies, "Florida Medicaid Reform: Fact Sheet," April 8, 2009,

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf>.

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html>

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/florida.html>

for example, on their body, will a few dollars in an account change their preferences? The system as a whole is unproven, and could be open to corruption and abuse, but it is a novel approach to a difficult issue that should be watched.

Georgia: Health Savings Accounts

In May 2008, Georgia enacted health care legislation that eliminates all state and local taxes on individual and group HSAs. Moreover individuals purchasing insurance can deduct x percent of the cost of HSAs from their tax liability. The legislation also allows for more flexible plan design, a move that will save between one percent and two percent. Individual health insurance HSAs are expected to cost 15 percent to 35 percent less.³⁴

Maine: Reforming the health insurance market

Since 2003, the state of Maine endured the failures of Dirigo Health, the state's attempt at universal health care. Dirigo included elements that would soon be emulated in PPACA. These included regulations on private health insurance, the expansion of Medicaid and a set of subsidies for private insurance. The program cost \$183 million over six years and failed to meet its objective to cover all residents.³⁵ When Dirigo was passed, the state's individual market plummeted as a result of guaranteed issue that caused younger residents to drop coverage.

³⁴ R. E. Bachman, "Georgia Passes HRA/HAS Health Insurance Reforms," Center for Health Transformation.

³⁵ T. Bragdon and J. Allumbaugh, "Health Care Reform in Maine: Reversing "Obamacare Lite." Heritage Foundation Backgrounder 2582. (July 19, 2011).

Upon taking office, the new Republican administration and legislature began reforming the state's insurance system with a package that limited guaranteed access to reinsurance funding for only high-risk individuals, more affordable individual plans, and the ability to purchase insurance across state lines and new short-term options for unemployed workers. The reform also included association-like plans for business known as "captive" health plans.³⁶

While it is too early to fully evaluate the results of Maine's health care reforms, there are some indications that the reinsurance program may lower premiums in the individual market.³⁷

Conclusion: Why market-based reforms are inevitable

Despite his pronounced pragmatism, President Obama has little faith in the private market ability to deliver the optimal amount of health care. In 2009 during the build-up for his reform package, he boldly declared "We've got to admit that the free market has not worked perfectly when it comes to health care." With government paying for more than half of all medical bills on one hand and a heavily-regulated regime on the other hand, the current system is clearly not based on any notion of a free market. Rather it is one in which consumers are trapped by mandates and fewer choices.

With Chapter 58, Massachusetts continues to base its reform on the same flawed critiques of the market, opting for a health care reform law that stifles consumer choice

³⁶ Ibid, 9.

³⁷ B. Gorman, D. Gorman, J. Smagula, J., *The Impact of PL90 on Maine's Health Insurance Markets*, Prepared for the Maine Bureau of Insurance. Gorman Actuarial, LLC (December 2011):4
<http://www.maine.gov/pfr/insurance/PL90/GormanActuarialReport.pdf>.

and innovation while offering little fundamental cost containment. Moreover, the health care law is putting the state's long-term competitiveness at risk as the share of health care spending overwhelms public and private budgets alike. Medicaid continues to be a major concern. And while talk of states pulling out of Medicaid is growing louder, the prospect is nonexistent politically. Few studies have examined the potential for PPACA to crowd out private insurance, a trend confirmed by past experience of government intervention in the market. On the other hand, large private insurance companies may be very happy to be in the "regulatory capture" of PPACA, which mandates the purchase of a privately produced product.

Were it not for the generous federal subsidy Massachusetts could not pursue universal coverage. Despite the best intentions, insurance costs in Massachusetts continue to soar. More government micromanagement of insurance markets only adds to the complexity and with the false promise of cost-containment. The recent emphasis on global payments offers little relief because, like all price controls, they come at the expense of consumer and provider.

Chapter 58 has set Massachusetts on a path of unsustainability, a path that will threaten its prosperity and ability to grow.

Chapter 58, through the Connector, provides only a small opening for the next wave of consumer-driven health care. But even a little opening might be critical to any measure of sustainability. One sure way to open up the system at the margins would be to allow more "minute clinics" where services are delivered more cost-effectively than

emergency rooms.³⁸ Recently, the Rand Corporation called for actively deregulating the emerging retail clinic market by relaxing physician oversight for nurse practitioners and expediting applications for new clinics.³⁹ A re-examination of licensing laws that serve as a bar to entry will be necessary.

Few policymakers have acknowledged the power of America's largest retailer, Wal-Mart, which plans to do for health care what it has done for retailing, namely cut prices.⁴⁰ States should also find ways to encourage medical tourism which usually simplify transactions between individual consenting consumers and providers leaving out third party payers all together.⁴¹ Yet these are small, marginal measures large health care system that consumes 17% of the gross national product.

The measures taken in other states as Massachusetts was crafting Chapter 58 are piecemeal steps in the right direction toward sustainability. They will lessen the pressure to cut other public services or raise taxes, two measures that are certain to hurt economic growth. To be sure the reforms in other will require of the same economic analysis Chapter 58 has undergone since 2006.⁴² Market reforms described above must also meet the goals of long shared goals of universal access to health care.⁴³ The fundamental critique that the "standard competitive market model" does not apply to

³⁸ A. Mehrotra, H. Liu, J. Adams, M.C. Wang, J. Lave, N. M. Thygeson, L.I. Solberg, E.A. McGlynn "The Costs and Quality of Care for Three Common Illnesses at Retail Clinics as Compared to Other Medical Settings," *Ann Intern Med.* September 1; 151(5): 321–328.

³⁹ Rand Corporation, 2.

⁴⁰ S. Pipes, "Wal-Mart's entrance into health care is great news for American consumers," *Forbes* (November 28, 2011) <http://www.forbes.com/sites/sallypipes/2011/11/28/wal-marts-entrance-into-health-care-is-great-news-for-american-consumers/>

⁴¹ For an example of a web based marketplace where consumers can find competitive pricing see www.medibid.com.

⁴² See Beacon Hill Institute studies on Chapter 58 available at www.beaconhill.org.

⁴³ See National Center for Policy Analysis, "Five Steps to a Better Health Care System" based on testimony by John C. Goodman before Congress. "Cash and Counseling" pilot programs where Medicaid patients manage their budgets are showing some promise.

health care is less defensible today.⁴⁴ The time to trust the consumer to make his own health insurance decisions on prices and services has arrived.

⁴⁴ A. Roy, "Yes, Virginia, There Can Be a Free Market for Health Care," *Forbes*, March 18, 2012, <http://www.forbes.com/sites/aroy/2012/03/18/yes-virginia-there-can-be-a-free-market-for-health-care/>

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