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Lessons from the Fall of RomneyCare

BY MICHAEL TANNER

When then-Massachusetts governor Mitt Romney signed into law the nation's most far-reaching state health care reform proposal, it was widely expected to be a centerpiece of his presidential campaign. In fact Governor Romney bragged that he would "steal" the traditionally Democratic issue of health care. "Issues which have long been the province of the Democratic Party to claim as their own will increasingly move to the Republican side of the aisle," he told Bloomberg News Service shortly after signing the bill. He told other reporters that the biggest difference between his health care plan and Hillary Clinton's was "mine got passed and hers didn't."

Outside observers on both the Right and Left praised the program. Edmund Haislmaier of the Heritage Foundation hailed it as "one of the most promising strategies out there." And Hillary Clinton adviser Stuart Altman

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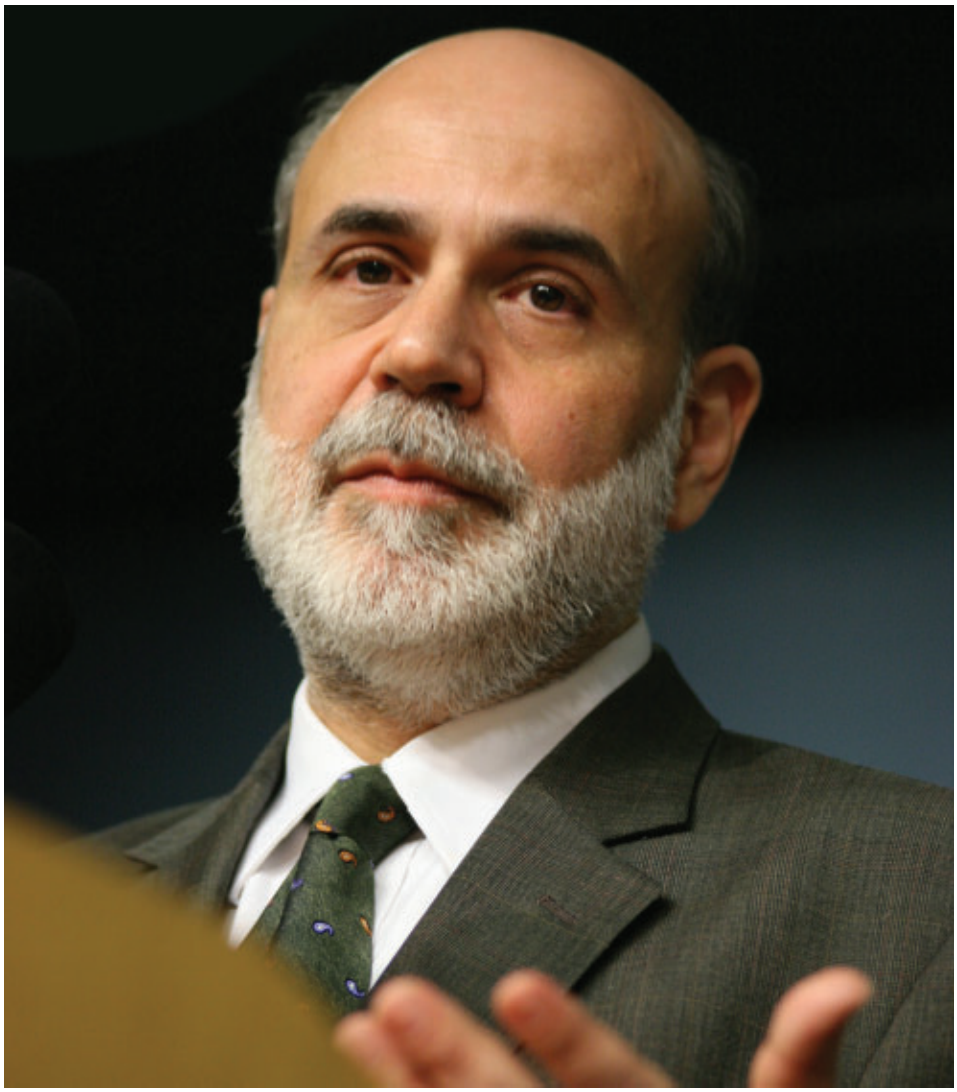

Federal Reserve Chairman Ben Bernanke unveiled a number of reforms aimed at increasing Fed transparency at the Cato Institute's 25th Annual Monetary Conference. The *Washington Post* characterized his speech as "the first major change to how the Fed communicates with the outside world that Bernanke has taken as chairman." **PAGE 14**

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said, "The Massachusetts plan could become a catalyst and a galvanizing event at the national level, and a catalyst for other states."

Today, however, Romney seldom mentions his plan on the campaign trail. If pressed he maintains that he is "proud" of what he accomplished, while criticizing how the Democratic administration that succeeded him has implemented the program. Nevertheless, he now focuses on changing federal tax law in order to empower individuals to buy health insurance outside their employer, and on incentives for states to deregulate their insurance industry. He would also use block grants for both Medicaid and federal uncompensated care funds to encourage greater state innovation. He encourages states to experiment, but does not offer his own state as a model.

A Double Failure

There's good reason for his change of position. The Massachusetts plan was supposed to accomplish two things—achieve universal health insurance coverage while controlling costs. As Romney wrote in the *Wall Street Journal*, "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced." In reality, the plan has done neither.

Perhaps the most publicized aspect of the Massachusetts reform is its mandate that every resident have health insurance, whether provided by an employer or the government or purchased individually. "I like mandates," Romney said during a debate in New Hampshire. "The mandate works." But did it?

Technically the last day to sign up for insurance in compliance with that mandate was November 15, though as a practical measure Massachusetts residents actually had until January 1, 2008. Those without insurance as of that date will lose their personal exemption for the state income tax when they file this spring. In 2009, the penalty will increase to 50 percent of the cost of a standard insurance policy.

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Such a mandate was, of course, a significant infringement on individual choice and liberty. As the Congressional Budget Office noted, the mandate was "unprecedented," and represented the first time that a state has required that an individual, simply because they live in a state and for no other reason, must purchase a specific government-designated product.

It was also a failure.

When the bill was signed, Governor Romney, the media, state lawmakers, and health care reform advocates hailed the mandate as achieving universal coverage. "All Massachusetts citizens will have health insurance. It's a goal Democrats and Republicans share, and it has been achieved by a bipartisan effort," Romney wrote.

Before RomneyCare was enacted, estimates of the number of uninsured in Massachusetts ranged from 372,000 to 618,000. Under the new program, about 219,000 previously uninsured residents have signed up for insurance. Of these, 133,000 are receiving subsidized coverage, proving once again that people are all too happy to accept something "for free," and let others pay the bill. That is in addition to 56,000 people who have been signed up for Medicaid. The bigger the subsidy, the faster people are signing up. Of the 133,000 people who have signed up for insurance since the plan was implemented, slightly more than half have received totally free coverage.

It's important to note that the subsidies in Massachusetts are extensive and reach well into the middle class—available on a sliding scale to those with incomes up to 300 percent of the federal poverty level. That means subsidies would be available for those with incomes ranging from $30,480 for a single individual to as much as $130,389 for a married couple with seven children. A typical married couple with two children would qualify for a subsidy if their income were below $63,000.

What we don't know is how many of those receiving subsidized insurance were truly uninsured and how many had insurance that either they or their employer was paying for. Studies indicate that substitution of taxpayer-financed for privately funded insurance is a common occurrence with other government programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP). Massachusetts has attempted to limit this "crowd-out" effect by requiring that individuals be uninsured for at least six months before qualifying for subsidies. Still some substitution is likely to have occurred.

The subsidies may have increased the number of Massachusetts citizens with insurance, but as many as 400,000 Massachusetts residents by some estimates have failed to buy the required insurance. That includes the overwhelming majority of those with incomes too high to qualify for state subsidies. Fewer than 30,000 unsubsidized residents have signed up as a result of the mandate. And that is on top of the 60,000 of the state's uninsured who were exempted from the mandate because buying insurance would be too much of a financial burden.

Billion-Dollar Overrun

According to insurance industry insiders, the plans are too costly for the target market, and the potential customers—largely younger, healthy men—have resisted buying them. Those who have signed up have been disproportionately older and less healthy. This should come as no surprise since Massachusetts maintains a modified form of community rating, which forces younger and healthier individuals to pay higher premiums in order to subsidize premiums for the old and sick.

Thus, between half and two-thirds of those uninsured before the plan was imple-

mented remain so. That's a far cry from universal coverage. In fact, whatever progress has been made toward reducing the ranks of the uninsured appears to be almost solely the result of the subsidies. The much ballyhooed mandate itself appears to have had almost no impact.

The Massachusetts plan might not have achieved universal coverage, but it has cost taxpayers a great deal of money. Originally, the plan was projected to cost $1.8 billion this year. Now it is expected to exceed those estimates by $150 million. Over the next 10 years, projections suggest that RomneyCare will cost about $2 billion more than was budgeted. And the cost to Massachusetts taxpayers could be even higher because new federal rules could deprive the state of $100 million per year in Medicaid money that the state planned to use to help finance the program.

Given that the state is already facing a projected budget deficit this year, the pressure to raise taxes, cut reimbursements to health care providers, or cap insurance premiums will likely be intense. Romney likes to brag that he accomplished his health care plan "without raising taxes." Unless something turns around, that is not likely to be the case much longer.

Moreover, the cost of the plan is also likely to continue rising, because the Massachusetts reform has failed to hold down the cost of health care. When Romney signed his plan he claimed "a key objective is to lower the cost of health insurance for all our citizens and allow our citizens to buy the insurance plan that fits their needs." In actuality, insurance premiums in the state are expected to rise 10–12 percent next year, double the national average.

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The Bureaucratic Connector

Although there are undoubtedly many factors behind the cost increase, one reason is that the new bureaucracy that the legislation created—the "Connector"—has not been allowing Massachusetts citizens to buy insurance that "fits their needs."

Although it has received less media attention than other aspects of the bill, one of the most significant features of the legislation is the creation of the Massachusetts Health Care Connector to combine the current small-group and individual markets under a single unified set of regulations. Supporters such as Robert E. Moffit and Nina Owcharenko of the Heritage Foundation consider the Connector to be the single most important change made by the legislation, calling it "the cornerstone of the new plan" and "a major innovation and a model for other states."

The Connector is not actually an insurer. Rather, it is designed to allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, which are currently enjoyed by large employers. Multiple employers are able to pay into the Connector on behalf of a single employee. And, most importantly, the Connector would allow workers to use pretax dollars to purchase individual insurance. That would make insurance personal and portable, rather than tied to an employer—all very desirable things.

However, many people were concerned that the Connector was being granted too much regulatory authority. It was given the power to decide what products it would offer and to designate which types of insurance offered "high quality and good value." This phrase in particular worried many observers because it is the same language frequently included in legislation mandating insurance benefits.

At the time the legislation passed, Ed Haislmaier of the Heritage Foundation reassured critics that "the Connector will neither design the insurance products being offered nor regulate the insurers offering the plans." In reality, however, the Connector's board has seen itself as a combination of the state legislature and the insurance commissioner, adding a host of new regulations and mandates.

For example, the Connector's governing board has decreed that by January 2009, no one in the state will be allowed to have insurance with more than a $2,000 deductible or total out-of-pocket costs of more than $5,000. In addition, every policy in the state will be required to phase in coverage of prescription drugs, a move that could add 5–15 percent to the cost of insurance plans. A move to require dental coverage barely failed to pass the board, and the dentists—along with several other provider groups—have not given up the effort to force their inclusion. This comes on top of the 40 mandated benefits that the state had previously required, ranging from in vitro fertilization to chiropractic services.

Thus, it appears that the Connector offers quite a bit of pain for relatively little gain. Although the ability to use pretax dollars to purchase personal and portable insurance should be appealing in theory, only about 7,500 nonsubsidized workers have purchased insurance through the Connector so far. On the other hand, rather than insurance that "fits their needs," Massachusetts residents find themselves forced to buy expensive "Cadillac" policies that offer many benefits that they may not want.

Governor Romney now says that he cannot be held responsible for the actions of the Connector board, because it's "an independent body separate from the governor's office." However, many critics of the Massachusetts plan warned him precisely against the dangers of giving regulatory authority to a bureaucracy that would last long beyond his administration.

ClintonRomneyEdwardsCare

Despite the problems being encountered in Massachusetts, the Romney plan continues to receive a surprising amount of support as a model for reform. The health

care plans advocated by all three of the leading Democratic presidential candidates—Hillary Clinton, John Edwards, and Barack Obama—are all substantially the same as Romney's. They are all variations of a concept called "managed competition," which leaves insurance privately owned but forces it to operate in an artificial and highly regulated marketplace similar to a public utility. All of their plans include an individual mandate (only for children in Obama's case, and for everyone in Clinton's and Edwards's plans), increased regulation, a government-designed standard benefits package, and a new pooling mechanism similar to the Connector.

Romney denounces Senator Clinton's plan as "government run health care," but there really is very little difference between the Romney and Clinton plans.

In addition, several states have been seeking to use Massachusetts as a model for their own reforms. In California, Gov. Arnold Schwarzenegger added an employer mandate to a plan that otherwise looked very much like the Massachusetts plan. Other states considering similar proposals include Alaska, Kansas, Louisiana, Maryland, Michigan, New York, Oregon, and Washington, as well as the District of Columbia. Although none of these proposals has made it into law, several remain under active consideration.

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No one can deny that the U.S. health care system needs reform. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes. Given these pressures, the temptation for a quick fix is understandable.

But, as Massachusetts has shown us, mandating insurance, restricting individual choice, expanding subsidies, and increasing government control isn't going to solve those problems. A mandate imposes a substantial cost in terms of individual choice but is almost certainly unenforceable and will not achieve its goal of universal coverage. Subsidies may increase coverage, but will almost always cost more than projected and will impose substantial costs on taxpayers. Increased regulations will drive up costs and limit consumer choice.

The answer to controlling health care costs and increasing access to care lies with giving consumers more control over their health care spending while increasing competition in the health care marketplace—not in mandates, subsidies, and regulation. That is the lesson we should be drawing from the failure of RomneyCare.

Briefs Defend Habeas Corpus, Religious Freedom in Supreme Court

The war on terror has presented U.S. courts with many thorny legal issues relating to civil liberties and national security. On one hand, what right does the president have to hold people indefinitely without recourse to judicial review? On the other, does the Constitution really require that everyone picked up by our military in wartime have access to our courts? Tim Lynch, director of Cato's Project on Criminal Justice, acknowledges the difficult tradeoff confronting policymakers during the war on terror but says that now more than ever is the time to defend the distinctly American right to a safe and speedy trial. On December 5, the Supreme Court took up *Boumediene v. Bush,* which centers on the right of "enemy combatants" held in Guantanamo Bay to have their detention reviewed by American civilian courts. In question is the Military Commissions Act of 2006, a Bush-spearheaded bill which holds that if prisoners are housed on foreign soil, then federal courts lack jurisdiction to consider habeas corpus claims of wrongful imprisonment. But this right cannot be abrogated in the absence of a "rebellion" or "invasion," according to the Bill of Rights, and thus the Military Commissions Act is unconstitutional, Lynch argues in Cato's amicus brief on the case. This isn't the first time Lynch has lent his pen to defend habeas corpus rights. He has also written briefs in the cases of Salim Ahmed Hamdan (2006), Jose Padilla (2004), and Yaser Esam Hamdi (2004).

For decades the Supreme Court has repeatedly held that religious speech is, like other types of speech, protected by the Free Speech Clause. Accordingly, the Court has consistently held that the government may not silence such speech simply because it expresses a religious viewpoint. Despite this well-settled law, local officials in Contra Costa County, California, specifically barred religious speech from a forum that the county had opened broadly for expressive activities: although the county opened library meeting rooms for every manner of educational, cultural, or community-related meetings or programs, it expressly excluded from those forums any speech that amounted to a "religious service." In Cato's brief on *Faith Center Church Evangelistic Ministries v. Glover,* a team of lawyers from Gibson, Dunn & Crutcher urge the Supreme Court to review a decision of the Ninth Circuit ratifying this blatant viewpoint discrimination. Cato's brief also highlights the need for the Supreme Court to clarify its public-forum doctrine, a doctrine that, although fundamental in a large swath of free-speech cases, has led to widespread confusion among the Courts of Appeals as to the amount of protection the Free Speech Clause provides when speech occurs on public property.