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AS I SEE IT

Quick ways to cut health costs

By Bill Randell

Sen. Richard T. Moore, D-Uxbridge, recently filed legislation to create the "Affordable Health Plan" to try and help small businesses with their health-care costs. Every day of the week at our firm, we work with small businesses trying to control their health-care costs, so we commend Mr. Moore's efforts.

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However, the bill as drafted simply shifts costs from one group to another, without making any reforms to control costs. The key component of the legislation caps reimbursements to providers at 110 percent of the rate paid by the federal Medicare program. (The current average reimbursement is now about 140 percent.) It's an open question, however, how many providers will agree to cut their reimbursements to participate in the "Affordable Health Plan." And as we've seen before, when rates are artificially capped for one group, costs get shifted to others.

Rather than add a new plan to the mix, the state should make some common-sense changes to the existing programs that would lower premiums for small businesses and others.

First, we must end the "open enrollment" loophole. Because of the Massachusetts Health Care Reform Law of 2006, small groups (one to 50 persons) and individuals can now obtain health insurance, regardless of pre-existing conditions, receive treatment the next day, and then cancel coverage the day after that. Unlike all large-group-sponsored health plans, which have a limited annual open-enrollment period, the 2006 law allows for health insurance on demand. In theory, it's a good idea; in practice, it's

a huge cost driver, because people are gaming the system.

Recently, Harvard Pilgrim reviewed a 12-month period and found that 40 percent of individuals who signed up during that time kept the coverage for five months or less. More importantly, they incurred on average of approximately $2,400 per person in monthly medical expenses during the short time they were enrolled, roughly 600 percent higher than average. In other words, because of the loophole, people can go without insurance until they face a major issue, buy in for a couple of months to get treatment, then drop out. This undercuts the whole theory of insurance, of spreading risk over time, over large groups of people.

Like Medicare or any private or public employer, we must limit the “open enrollment” period for health insurance for individuals and small groups to one month each year, unless there is a qualifying event (birth of a child, marriage, etc.) or a loss of coverage. Otherwise, they must be fully underwritten.

Second, the current penalty for not having health insurance is too low. An annual penalty of up to $912 may sound steep, but it doesn’t compare to the $12,000 a year it costs a family for health insurance. As a result, some people just pay the penalty because they know they can buy health insurance when they need it, because of the year-round open enrollment. By ending the continuous open-enrollment, and boosting the penalty, we’ll move more people into the insurance system, thereby spreading out costs even more.

Third, we need more flexibility in plan design. To avoid paying the non-coverage penalty, people must buy a plan that meets the state’s Minimum Credible Coverage standards, which includes prescription coverage. Making prescription coverage optional (like Medicare) would give small businesses a lower cost option that would prompt many to offer health plans for their employees.

Furthermore, Massachusetts imposes many costly mandates for coverage, such as in-vitro fertilization, which was determined to represent 6 percent of total premium cost by the state Division of Health Care Finance and Policy. Many large employers are able to avoid these costly mandates because they self-insure for health coverage and aren’t bound by the MCC standards. We should give smaller employers the same ability as large

self-insured businesses and offer an MCC plan that does not include state mandates.

Fourth, we should expand the Insurance Partnership, a premium assistance program that helps employees under specified household income limits pay for their group insurance. This program allows the underlying private insurance plans to compete against each other at the employer level, but steps in to help employees and employers buy or keep coverage.

Finally, the Connector Authority should add an asset test like Medicaid. Currently a multimillionaire can qualify for coverage as long as their earned income is below the income guidelines (300 percent of the federal poverty level).

The goal of health-care reform in Massachusetts is to get everyone covered, so instead of an uninsured person waiting until a condition spirals out of control, they would have access to treatment earlier, thereby improving their health and lowering costs. So far, the state has removed a lot of people from the uninsured rolls, but the system still has too many loopholes and is not controlling costs. Instead of a another new plan, let's implement the reforms above and lower the cost of health insurance for all employers, small and large, thereby promoting universal coverage.

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