President Obama said earlier this year that the health-care bill that Congress passed three months ago is "essentially identical" to the Massachusetts universal coverage plan that then-Gov. Mitt Romney signed into law in 2006. No one but Mr. Romney disagrees.

As events are now unfolding, the Massachusetts plan couldn’t be a more damning indictment of ObamaCare. The state’s universal health-care prototype is growing more dysfunctional by the day, which is the inevitable result of a health system dominated by politics.

In the first good news in months, a state appeals board has reversed some of the price controls on the insurance industry that Gov. Deval Patrick imposed earlier this year. Late last month, the panel ruled that the action had no legal basis and ignored "economic realities."

In April, Mr. Patrick’s insurance commissioner had rejected 235 of 274 premium increases state insurers had submitted for approval for individuals and small businesses. The carriers said these increases were necessary to cover their expected claims over the coming year, as underlying state health costs continue to rise at 8% annually. By inventing an arbitrary rate cap, the administration was in effect ordering the carriers to sell their products at a loss.

Mr. Patrick has promised to appeal the panel’s decision and find some other reason to cap rates. Yet a raft of internal documents recently leaked to the press shows this squeeze play was opposed even within his own administration.

In an April message to his staff, Robert Dynan, a career insurance commissioner responsible for ensuring the solvency of state carriers, wrote that his superiors “implemented artificial price caps on HMO rates. The rates, by design, have no actuarial support. This action was taken against my objections and without including me in the conversation.”

Mr. Dynan added that "The current course . . . has
the potential for catastrophic consequences including irreversible damage to our non-profit health care system" and that "there most likely will be a train wreck (or perhaps several train wrecks)."

Sure enough, the five major state insurers have so far collectively lost $116 million due to the rate cap. Three of them are now under administrative oversight because of concerns about their financial viability. Perhaps Mr. Patrick felt he could be so reckless because health-care demagoguery is the strategy for his fall re-election bid against a former insurance CEO.

The deeper problem is that price controls seem to be the only way the political class can salvage a program that was supposed to reduce spending and manifestly has not. Massachusetts now has the highest average premiums in the nation.

In a new paper, Stanford economists John Cogan and Dan Kessler and Glenn Hubbard of Columbia find that the Massachusetts plan increased private employer-sponsored premiums by about 6%. Another study released last week by the state found that the number of people gaming the "individual mandate"—buying insurance only when they are about to incur major medical costs, then dumping coverage—has quadrupled since 2006. State regulators estimate that this amounts to a de facto 1% tax on insurance premiums for everyone else in the individual market and recommend a limited enrollment period to discourage such abuses. (This will be illegal under ObamaCare.)

Liberals write off such consequences as unimportant under the revisionist history that the plan was never meant to reduce costs but only to cover the uninsured. Yet Mr. Romney wrote in these pages shortly after his plan became law that every resident "will soon have affordable health insurance and the costs of health care will be reduced."

One junior senator from Illinois agreed. In a February 2006 interview on NBC, Mr. Obama praised the "bold initiative" in Massachusetts, arguing that it would "reduce costs and expand coverage." A Romney spokesman said at the time that "It's gratifying that national figures from both sides of the aisle recognize the potential of this plan to transform our health-care system."

An entitlement sold as a way to reduce costs was bound to fundamentally change the system. The larger question—for Massachusetts, and now for the nation—is whether that was really the plan all along.

"If you're going to do health-care cost containment, it has to be stealth," said Jon Kingsdale, speaking at a conference sponsored by the New Republic magazine last October. "It has to be unsuspected by any of the key players to actually have an effect." Mr. Kingsdale is the former director of the Massachusetts "connector," the beta version of ObamaCare's insurance "exchanges," and is now widely expected to serve as an ObamaCare regulator.

He went on to explain that universal coverage was "fundamentally a political strategy question"—a way of finding a "significant systematic way of pushing back on the health-care system and saying, 'No, you have to do with less.' And that's the challenge, how to do it. It's like we're waiting for a chain reaction but there's no catalyst, there's nothing to start it."

In other words, health reform was a classic bait and switch: Sell a virtually unrepealable entitlement on utterly unrealistic premises and then the political class will eventually be forced to control spending. The likes of Mr. Kingsdale would say cost control is only a matter of technocratic judgement, but the raw dirigisme of Mr. Patrick's price controls is a better indicator of what happens when health care is in the custody of elected officials rather than a market.

Naturally, Mr. Patrick wants to export the rate review beyond the insurers to hospitals, physician groups and specialty providers—presumably to set medical prices as well as insurance prices. Last month, his administration also announced it would use the existing state "determination of need" process to restrict the diffusion of expensive medical technologies like MRI machines and linear accelerator radiation therapy.
Meanwhile, Richard Moore, a state senator from Uxbridge and an architect of the 2006 plan, has introduced a new bill that will make physician participation in government health programs a condition of medical licensure. This would essentially convert all Massachusetts doctors into public employees.

All of this is merely a prelude to far more aggressive restructuring of the state's health-care markets—and a preview of what awaits the rest of the country.

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