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Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms

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Saving the AMERICAN DREAM

Abstract

As the Supreme Court ponders the constitutionality of Obamacare's individual mandate to buy health insurance, Congress should reflect on how to reform health insurance without such a mandate. Heritage Foundation health policy expert Edmund Haislmaier explains why the starting point for developing commonsense reforms for the individual health insurance market should be the rules that Congress established for employer-group coverage in 1996. Obamacare's radical changes to health insurance regulation were never necessary to address the remaining problems in the market. It is precisely Obamacare's new health insurance regulations that threaten to destabilize the market and make the present situation much worse.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2703**

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Congress established national health insurance market rules in the 1996 Health Insurance Portability and Accountability Act (HIPAA).[1] An examination of these HIPAA insurance rules, and their operation over the past 15 years, shows that radical changes to health insurance regulation under the Patient Protection and Affordable Care Act, popularly known as Obamacare were never necessary for addressing the remaining problems in the market. Rather, it is Obamacare's *new* health insurance regulations that threaten to destabilize the market and make the present situation much worse.

Indeed, the main reason why the authors of Obamacare included the individual mandate in the legislation was to counteract the significant adverse effects that *even they* recognized would result from their new health insurance regulatory scheme. Furthermore, as the constitutional challenge to the individual mandate made its way through the courts, the Administration's lawyers consistently and repeatedly argued that the individual mandate was necessary to prevent the health insurance market from collapsing once Obamacare's new insurance rules take effect, and allow people to wait until they need

Talking Points

- As the Supreme Court ponders the constitutionality of Obamacare's individual mandate to buy health insurance, Congress should reflect on how to reform health insurance without such a mandate.
- The starting point for commonsense reforms for the individual health insurance market should be the rules that Congress established for employer-group coverage in 1996 under the Health Insurance Portability and Accountability Act (HIPAA).
- Fifteen years of HIPAA have shown that Obamacare's radical changes to health insurance regulation were never necessary for addressing the remaining problems in the market. It is Obamacare's new regulations that threaten to destabilize the market and make the present situation much worse.
- Congress should pursue commonsense health insurance reforms that build on the balanced HIPAA rules. These insurance reforms, when coupled with the other health policy reforms outlined in The Heritage Foundation's Saving the American Dream plan, would result in a true consumer-driven health care system.

medical care before buying health insurance.

Clearly then, not only should the individual mandate be removed, but so, too, should the new Obamacare insurance rules. Past state experience with such regulations—unrestricted "guarantee issue," narrow "community rating," and a total ban on the imposition of "pre-existing-condition exclusions"—have proved that they do more harm than good. Indeed, just last year, Maine became the latest state to end its failed experiment when it rolled back the community rating and guaranteed issue rules that state lawmakers had imposed on Maine's individual health insurance market in 1993.[2]

The starting point, then, for developing alternative health insurance reform is the insurance rules previously established by HIPAA, since these rules will remain the applicable law if Obamacare is struck down by the Supreme Court or repealed by Congress.[3] Currently, 90 percent of privately insured Americans are covered by an employer-group plan. Over the past 15 years, the HIPAA employer-group coverage rules have worked reasonably well. Congress should simply extend those rules to the remaining 10 percent of the private market that consists of people covered by individual health insurance policies. These insurance reforms, alongside other health policy reforms, are also critical to achieving a consumer-directed health care system.[4]

Current Regulation of Private Health Insurance

America's private health insurance market consists of two basic submarkets: the employer-group-coverage market, and the individual insurance market. The most recent Census Bureau data show that enrollment in employer plans collectively accounts for 90 percent of all private coverage, while the remaining 10 percent of the market consists of policyholders and their dependents covered by individually purchased health insurance.[5] While those who have individual health insurance buy such coverage directly from commercial health insurers, employers who offer group coverage purchase it from a commercial insurer, or "self-insure" their own plans. In general, smaller employers tend to buy group plans from an insurer, while larger employers tend to self-insure their plans.

These distinctions are relevant because they are the basis for the current different regulation of each segment of the private health insurance market. Plans purchased from commercial insurers—whether individual or employer-group policies—are primarily regulated by state insurance laws. However, there are federal laws (such as HIPAA) that supersede state laws with respect to certain aspects of insurance regulation.

The federal Employee Retirement and Income Security Act (ERISA) of 1974 also set federal rules regulating "employee welfare benefit plans" sponsored by employers and unions. The effect of ERISA is that states still regulate the commercial products that an employer might choose to purchase (such as group health insurance sold by commercial insurers) but are prevented from directly regulating the arrangement established by an employer for providing benefits to his workers. Thus, as a practical matter, a state can, for instance, require that group health plans sold by commercial insurers include coverage for particular benefits, but a state cannot require an employer to purchase that coverage, nor can a state even require an employer to provide health insurance to its workers.[6]

1. Health Insurance Portability and Accountability Act of 1996, P.L. 104–191.
2. Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite,'" Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, http://www.heritage.org/research/reports/2011/07/health-care-reform-in-maine-reversing-obamacare-lite.
3. While HIPAA included provisions affecting a number of other areas, some controversial and problematic in their own right, the focus of this paper is only on the HIPAA health insurance rules.
4. Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, May 10, 2011, http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity.
5. The Census Bureau's Current Population Survey data show that, of the 175 million Americans who had private health insurance coverage in 2010, 159.1 million (89 percent) had employer-group coverage and 18.9 million (11 percent) had individually purchased coverage. See Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 362, September 2011, Figure 1, p. 5.
6. Hawaii is the one exception. The state had already enacted the Hawaii Prepaid Health Care Act, *pre*-ERISA, requiring employers to provide health insurance to their workers; Congress "grandfathered" Hawaii's arrangement when it enacted ERISA later that year.

Because of these distinctions, Congress established two sets of federal health insurance rules under HIPAA: one for employer-group coverage, and one for the individual market.

HIPAA Group Health Insurance Rules

Under HIPPA, Congress set basic rules for employer-group health insurance in four key areas.

1. Guaranteed Issue of Coverage. HIPAA requires group health insurance to be "guaranteed issue" by health insurers for small employers (defined as two to 50 employees) and by any employer plan (regardless of size) for individuals eligible for coverage under the terms of the plan. This means that if a small employer seeks to purchase group coverage for its workers from a commercial insurer, the insurer may not refuse to sell the employer such coverage if the employer otherwise qualifies.

Similarly, if an employer offers health insurance to his workers, through either a policy purchased from an insurer or through a self-insured plan, the employer (and, when applicable, the insurer) may not refuse to cover a worker, or the dependent of a worker, who is otherwise eligible for coverage under the terms of the employer's plan.

These guaranteed issue requirements are not absolute, but are subject to reasonable rules. A company is, for instance, not required to offer coverage to someone who is neither an employee nor the dependent of an employee.

Nor do these rules preclude employers or insurers from making legitimate business decisions that may affect coverage. The following are examples of some typical business decisions that do not violate HIPAA's guaranteed issue requirements:

- An employer offers coverage to full-time workers, but not to part-time workers.
- An employer offers different plans to unionized and non-unionized employees.
- An insurer conditions the issuance of a group policy on the employer ensuring that a minimum share of workers enroll in the coverage (so that the insurer does not have to enroll only those employees who are in poor health).
- A health maintenance organization (HMO) declines to offer coverage in an area where it does not have contracts with enough doctors and hospitals to provide care.

Finally, HIPAA does not impose price controls, or otherwise regulate what an insurer charges an employer, or what an employer charges his workers, for coverage. However, in the case of coverage sold by commercial insurers, state insurance laws typically include "rating rules" for the small-employer market that govern how insurers calculate premiums to adjust for differences among employers in factors such as geographic location or past claims experience.

2. Guaranteed Renewability of Coverage. HIPAA also requires insurers who sell employer-group health insurance policies to renew the coverage at the end of a contract period if the employer purchasing the coverage wishes to continue it. As with guaranteed issue, this guaranteed renewal provision is not absolute, but subject to certain reasonable exceptions. Under HIPAA rules, an insurer may refuse to renew an employer's plan if (1) the employer fails to pay premiums; (2) the employer commits insurance fraud; (3) the employer fails to comply with terms of the contract that require a minimum share of enrolled workers, or that require the employer to make a minimum contribution toward the cost of coverage; or (4) if the insurer exits the market.

3. Limits on Pre-Existing-Condition Exclusions. A "pre-existing-condition exclusion" is a provision stipulating that the plan will not pay for the treatment of a specified medical condition that an individual had prior to obtaining the coverage.

HIPAA set reasonable limits on the application of pre-existing-condition exclusions in employment-based group health insurance coverage. Those restrictions apply both to employer self-insured plans and to employer-group policies issued by commercial insurers. Federal law specifies the following rules for employment-based coverage:

- **Limited "look back" period.** Only a medical condition that is diagnosed or treated within the six months prior to the enrollment date qualifies as a pre-existing condition.
- **Duration limits.** A pre-existing-condition exclusion may be imposed for no more than 12 months following the enrollment date, or 18 months in the case of a late enrollee (meaning someone who declines to enroll in the coverage when he or she first becomes eligible and who has no other coverage). Furthermore, the duration of a pre-existing-condition exclusion must also be reduced by the aggregate number of months of prior "creditable coverage."

This provision is particularly important because it means that an individual who maintains health insurance coverage faces *no* pre-existing-condition exclusions when he or she enrolls in new employment-based coverage. Thus, the majority of Americans who change coverage when they change employers do not, in fact, face pre-existing-condition exclusions.

- **Continuous coverage.** In determining whether an individual has prior "creditable coverage," employer plans and health insurers must disregard any gap in coverage that is not more than 63 consecutive days. Thus, no pre-existing-condition exclusion can be imposed on an individual who had a year or more of prior creditable coverage with any gap in coverage of two months or less.

- **Genetic information.** Genetic information may not be treated as a medical condition for purposes of imposing a pre-existing-condition exclusion in the absence of a diagnosis of the related condition. Thus, a pre-existing-condition exclusion for, say, colon cancer, cannot be imposed based simply on a genetic test that indicates an individual has an elevated risk for colon cancer. It can only be imposed if the individual was diagnosed with colon cancer.

- **Pregnancy, newborns, and adopted children.** Pregnancy may not be treated as a pre-existing condition, and pre-existing-condition exclusions may not be imposed for a newborn enrolled in coverage within 30 days of birth, or for an adopted child under age 8 if enrolled in creditable coverage within 30 days following adoption or placement for adoption.

4. Prohibition on Discrimination Based on Health Status. HIPAA also prohibits group health plans from discriminating against individual enrollees based on health status. Specifically, a group plan may not refuse to cover, or discontinue coverage of, an individual based on the enrollee's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. In addition, a group plan may not require an enrollee, "to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual."[7]

HIPAA's Rules for Individual Market Policies

As with group coverage, HIPAA requires that individual coverage be "guaranteed renewable" for the policyholder, with similar exceptions as those for group coverage. Specifically, the requirement to renew individual coverage does not apply if (1) the policyholder fails to pay premiums; (2) the policyholder commits insurance fraud; (3) the insurer exits the market; (4) the policyholder moves outside the plan's service area; or (5) if the coverage has been purchased thorough an association and the policyholder ceases to be a member of that association.

However, beyond the requirement to renew coverage, HIPPA does not generally impose on the individual health insurance market the rules that it imposes on employer-group coverage. The one exception is that HIPAA specifies a separate set of rules for workers who lose group coverage. Under those special rules, if a worker (1) loses group coverage; (2) has 18 months or more of prior creditable coverage; (3) further exhausts any available federal or state mandated employer-group continuation coverage; and (4) is not eligible for Medicare or Medicaid, then the worker is entitled to obtain individual coverage, with no pre-existing-condition exclusions. The same applies to any dependent of the worker who was also covered under the employer plan.

Furthermore, in such circumstances, a qualifying individual (commonly referred to as "HIPAA eligible") may obtain coverage under any individual policy sold in his or her state of residence *unless* the state has established one of two alternative mechanisms: HIPAA provides that a state may, alternatively, either assign HIPAA-eligible individuals to a particular insurer offering individual coverage or assign HIPAA-eligible individuals to the state's high-risk pool. Currently, 20 states use the "federal fallback" of providing choice of any individual market policy, three states use the "assigned carrier" option, and the remaining 27 states designate their high-risk

7. 42 USC 300gg-1 (2009).

pools to provide coverage for HIPAA-eligible individuals.[8]

Implications of the HIPAA Rules

In crafting the HIPAA insurance rules, Congress focused primarily on employer-group coverage, with the individual health insurance market a secondary consideration. Indeed, to the extent that HIPAA is concerned with the individual market it is mainly in the context of addressing a relatively narrow set of circumstances where the group and individual markets intersect—namely, workers transitioning from employer-group coverage to individual coverage.

Thus, health policy experts sometimes say that HIPAA provides "group to group" and "group to individual" portability of coverage, but not "individual to individual" portability.

With respect to employer-group coverage, Congress took a reasonable and balanced approach to setting rules under HIPAA.

In particular, HIPAA rules on the application of pre-existing-condition exclusions with respect to group coverage encourage good behavior (buying health insurance before it becomes necessary) and discourage bad behavior (waiting to obtain health insurance until medical care becomes necessary). Good behavior is thus rewarded with what could be called an earned right to obtain future coverage on favorable terms. All an individual needs to do to earn such favorable treatment is to have at least one year of "creditable coverage" (defined as any public or private major-medical plan), with no gaps in coverage of more than 63 days. Furthermore, even if an individual does not have sufficient creditable coverage, employer-group coverage is still "guaranteed issue," and any pre-existing-condition exclusion is time-limited.

This balanced approach to setting rules and incentives explains why, for the past 15 years, pre-existing-condition exclusions have not been a barrier to coverage for the vast majority of privately insured individuals who are covered by employer-group plans. It also explains why that market has been able to function with a guaranteed issue requirement, but without the need to mandate that individuals obtain coverage.

However, with respect to the individual market, Congress only applied that kind of balanced approach to those limited cases where a worker loses group coverage and obtains individual replacement coverage. It was the failure of Congress to apply a set of reasonable rules to the entire individual health insurance market that has resulted in continued inequities in that market. It also thwarts efforts to shift to a true consumer-directed health care system where individuals, not employers or the government, own their health insurance.

Specifically, under HIPAA rules a person who purchases individual market coverage, and later needs or wants to change individual coverage, can be refused the new coverage, or the new insurer can impose pre-existing-condition exclusions on the coverage or charge the individual a higher rate based on past medical history. Unlike the rules for group coverage, HIPAA does not require individual market insurers to credit applicants with prior coverage.

Thus, in the individual health insurance market, people who buy health insurance before they need it are treated the same as those who wait until they need medical care before buying insurance. Aside from being inequitable, such rules are contrary to the public policy goal of encouraging people to buy health insurance before they need to use it. This flaw in HIPAA also left an opening for supporters of more government intervention to push for a blanket prohibition on the use of pre-existing-condition exclusions, which Congress then included in the Obamacare legislation.

Rather than simply extending HIPAA's sensible employer-group rules to individual health insurance coverage (the remaining 10 percent of the private market), in Obamacare Congress replaced HIPAA's balanced approach with a complete ban on pre-existing-condition exclusions under *any* circumstances, and then attempted to limit the damage caused by that policy blunder by adding an individual mandate to buy coverage.

Establishing Sensible Rules for Individual Health Insurance

Obviously, the better policy solution is for Congress to first repeal the damaging Obamacare insurance rules (thus reverting to HIPAA's balanced and proven rules for group coverage), and then remedy HIPAA's remaining deficiencies by extending the same balanced approach to individual market coverage.

Congress can remedy HIPAA's defects by extending to the individual health insurance market the same type of reasonable and balanced rules that it applied 15 years ago to employer-group coverage. The effect

8. Statehealthfacts.org, "Non-Group Coverage Rules for HIPAA Eligible Individuals, 2011," Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?ind=356&cat=7 (accessed June 14, 2012).

of the reforms would be to provide the individual-to-individual coverage portability that was left out of the original HIPAA legislation. In particular, Congress needs to ensure that the rules provide the right incentives so that the system can work fairly and effectively without the need to impose an individual mandate to buy coverage.[9] The components of the reform legislation should follow two basic principles:

Principle #1: No discrimination against those who buy their own coverage. As noted, the biggest flaw in the current rules governing individual health insurance is that they do not appropriately credit consumers who voluntarily purchase health insurance coverage before they need it and continue paying premiums while they are healthy. Unlike in the employer-group market, a person who purchased individual health insurance for years and then needs or wants new coverage can still be denied coverage for a medical condition that he developed while covered by his previous policy, or charged a higher premium than similarly situated individuals, or refused new coverage entirely.

The solution is to establish rules for the individual market that permit someone who has purchased and maintained coverage to obtain, in certain circumstances, new individual health insurance coverage at standard rates, regardless of the individual's health status or past medical history. Similar to the existing group market rules, the individual market rules should specify that:

1. If an individual health insurance applicant has sufficient prior creditable coverage (e.g., 18 or 24 months), then the insurer would be required to accept that applicant, could not impose any pre-existing-condition exclusions on the new coverage, and could not charge the individual more than the applicable standard rate for the coverage.

2. The definition of "creditable coverage" and the rules for counting periods of creditable coverage, treating gaps in coverage, and issuing certificates of coverage would be those already specified in HIPAA.

3. The term "applicable standard rate" would be defined as the rate charged for the same policy to other applicants with the same characteristics with respect to rating factors established in state law. Insurers would not be permitted to use health status or employment criteria as rating factors, but states would retain authority to establish their own rules for the use of other rating factors, such as age or geographical location.

4. In order to ensure stability in the market, these federal rules for insurers would be made subject to state laws, limiting their application to certain circumstances. Specifically, states could limit the applicability of these provisions to only open-season periods specified in state law, provided that any open season established by a state was not less than 30 days, and that any period between scheduled open seasons was not more than 24 months. The exception: If a state opts to restrict the application of these provisions to open season, the rules would still apply outside of the open periods in cases where (1) the applicant lost prior coverage under an individual or group plan due to change in employment, or because the employer or insurer discontinued coverage; (2) the applicant ceased to be eligible for coverage under a public program, such as Medicaid or the Children's Health Insurance Program (CHIP); or (3) the policyholder had reason to add a dependent to his coverage due to marriage, birth, adoption, or a custody order requiring the policyholder to provide dependent coverage. Furthermore, in order for the rules to apply in these special circumstances, the individual would have to apply for coverage within 60 days of the qualifying event.

Principle #2: Pathway for earning the right to more favorable coverage terms. The rules should also provide a pathway for those who have not always maintained coverage in the past to *earn* the same right to obtain coverage on more favorable terms in the future. Specifically:

1. Insurers would be required to make individual market coverage available to applicants with less than the minimum required prior creditable coverage—but the insurer would also be allowed to impose pre-existing-condition exclusions for a period of up to 24 months, reduced by the number of months of prior creditable

9. For a similar, though more conceptual, discussion of these issues and reform principles, see James C. Capretta and Tom Miller, "How to Cover Pre-existing Conditions," *National Affairs*, Issue No. 4 (Summer 2010), pp.110–126, http://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions (accessed June 19, 2012).

coverage. In addition, insurers would be allowed to charge such an individual a higher premium (e.g., 150 percent of the applicable standard rate) for up to 24 months. Insurers would also be allowed the flexibility to extend the rating surcharge period to 36 months if the insurer waived its right to impose pre-existing-condition exclusions, or at their discretion, to entirely waive their right to impose such exclusions or a rating surcharge.

2. The definitions of "creditable coverage" and "applicable standard rate" would be the same, and states would retain the same authority to limit the applications of these provisions to open seasons established in state law.

These changes will address the problems facing the majority of uninsured individuals, as many of them, particularly young adults, are relatively healthy. Once these rules are established, lawmakers might consider other possible steps to address the situation of any remaining uninsured individuals with pre-existing medical conditions. Given past success in covering uninsured individuals with expensive medical conditions through state high-risk pools, the remaining uninsured likely have less costly medical conditions. If Congress is concerned with covering that remaining population sooner, one option might be an initial, one-time open season during which applicants could obtain individual health insurance without pre-existing-condition exclusions, regardless of the applicants' prior coverage histories, so that everyone would have an equal opportunity to start earning creditable coverage under the new rules.

The Benefits

This kind of balanced and reasonable approach to setting coverage rules for individual health insurance offers a number of advantages.

First, this approach remedies one of the two main disparities in current federal law that bias the present system toward employer-sponsored coverage, and consequently inhibit the growth of a more consumer-driven health system. Currently, both federal tax policy and federal insurance market rules treat employer-sponsored coverage more favorably than coverage purchased in the individual market. Applying rules to the individual market that are consistent with those for employer-group coverage would eliminate one of those regulatory disparities. Such a change would also strengthen the case for Congress to address the other major disparity (the unequal tax treatment of health insurance) by reforming federal tax law to provide the same tax treatment of health insurance for all coverage options—a key reform that numerous health policy experts have long advocated, and which is outlined in The Heritage Foundation's *Saving the American Dream* plan.[10]

Second, these rules would pave the way for federal and state policymakers to make other important and overdue reforms to Medicaid and CHIP, also outlined in *Saving the American Dream*. Specifically, these rules would make it easier for policymakers to "mainstream" lower-income, able-bodied individuals and families now covered by Medicaid and CHIP into better-quality private coverage. Providing assistance to those individuals through "premium support" to help pay for private coverage would also better enable recipients to achieve self-sufficiency over time. Instead of losing coverage when an enrollee earns too much to qualify for Medicaid or CHIP, under the premium support approach, public assistance gradually tapers off as an individual's earnings increase. Furthermore, these reforms would enable recipients to use their premium-support contributions to obtain individual market coverage if their employer does not offer a plan—as is often the case with firms that employ primarily lower-wage workers.

Third, in any consumer-driven system, it is the ability of consumers to vote with their feet that induces insurers and other health care providers to compete for their business by offering customers better value for their money. Thus, in order to have a well-functioning consumer-driven health insurance system, individuals must have periodic opportunities to choose another health plan on predictable terms, as is typically done in the group market. Without such opportunities, consumers would find themselves locked into past decisions and health plans would be insulated from much of the normal competitive pressure to offer better service and value to their customers. By limiting the opportunity for consumers to change coverage to specified open seasons—and the occasional occurrence of clearly defined exceptional circumstances outside of open season—these rules would spur competition, while preventing people from "gaming the system" by constantly changing coverage. Thus, the rules would strike a reasonable balance between the interest of consumers in being able to change coverage and

10. Butler et al., *Saving the American Dream.*

the interest of insurers in market stability.

Fourth, with respect to group-to-individual portability, these reforms would be an improvement to the current HIPAA rules. As noted, HIPAA requires individuals who are losing employer-group coverage to first exhaust any available continuation coverage (which is often expensive) before being allowed to obtain an individual market policy on favorable terms. Furthermore, only 20 of the 50 states currently allow such individuals a real choice of coverage. The other 30 states direct them to either a state high-risk pool or a designated insurer, which can also be more expensive. These reforms would eliminate those obstacles and allow individuals who lose employer coverage to obtain new coverage directly in the individual market on fair terms that credit them for their history of prior coverage.

Fifth, these rules would allow greater labor mobility, and thus complement other health reform proposals, such as equalizing the tax treatment of health insurance and allowing the purchase of health insurance across state lines, that would also have the same effect.

States Can Act Now

States do not need to wait for Congress to enact such individual market reforms. States can enact this same reform design on their own. Indeed, doing so would be consistent with the prior evolution of employer-group coverage rules. By the time that Congress enacted group coverage rules in HIPAA, many states had already adopted similar rules for group coverage sold by insurers. What Congress did in HIPAA was to apply those group coverage rules nationally to all insurers, and more importantly, also to self-insured employer plans that states were preempted from regulating under ERISA.

However, state lawmakers interested in pursuing such reforms should be mindful of the lessons of past state experience. In the late 1990s, 10 states enacted guaranteed issue and community rating requirements for their individual health insurance markets, and none of those changes turned out well.[11] Indeed, most of the 10 states have since repealed those laws, most recently, Maine.[12] The reason those laws caused problems can be traced to two sets of design flaws.

First, like Obamacare, those states imposed blanket guaranteed-issue requirements that did not appropriately distinguish between applicants with and without prior coverage. They also failed to include reasonable limitations, such as restricting the applicability of the provisions to periodic open seasons, and all but two states barred insurers from applying pre-existing-condition exclusions in any circumstances.

Second, and again like Obamacare, several of the states imposed standardized coverage designs while most of them also included in their reforms community-rating provisions. Those provisions limited the extent to which insurers could vary premiums based on factors such as age, geographical location, and family composition. The most harmful community-rating provisions are ones that restrict the ability of insurers to vary premiums by age.[13]

Conclusion

Obamacare got it wrong. Its radical approach to health insurance regulations threatens to destabilize the market and requires an individual mandate to counteract the adverse effects.

Congress should instead pursue commonsense health insurance reforms that build on balanced rules that have been in effect for employer-group coverage for over 15 years. Coupling sensible individual health insurance market reforms with appropriate tax and Medicaid reforms would be a fair and fiscally sound strategy for expanding coverage to the currently uninsured. The Heritage Foundation's *Saving the American Dream* provides such a plan, and puts health care reform on a course toward a true consumer-based health care system.

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11. Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets," Milliman, Inc., March 2012.
12. Bragdon and Allumbaugh, "Health Care Reform in Maine."
13. The natural variation in medical costs by age is about 5 to 1—meaning that the oldest group of (non-Medicare) adults normally consumes about five times as much medical care as the youngest group. Thus, if 64-year-olds consume, on average, five times as much medical care as 20-year-olds, stipulating that an insurer cannot charge a 64-year-old more than, say, three times what it charges a 20-year-old (the limit imposed by Obamacare and several of the state reforms), that will have the effect of artificially "compressing" normal age-related premium variations. Mandated "rate compression" forces insurers to underprice coverage for older people and to overprice coverage for younger individuals, significantly increasing the likelihood that young, healthy adults will not buy coverage.