Reformers' good intentions meet the law of unintended consequences

State Strategies to Reduce the Growing Numbers of People without Health Insurance

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AMONG DEVELOPED COUNTRIES, THE UNITED STATES has the highest proportion of people who lack private or public health insurance coverage: 16 percent of the U.S. populace in 1998. Further, many people *with* coverage are considered to be *underinsured* because they have insufficient coverage for a major illness or injury.

Health insurance, unlike some other forms of insurance, is on the public agenda because is not considered a purely private matter. For various reasons, including simple altruism, there is a shared sense of concern for fellow citizens who cannot afford essential health care. A person's ability to purchase health insurance is therefore a public issue, whereas the purchase of such other coverage such as life or homeowners' insurance is not.

WHY ARE SO MANY AMERICANS WITHOUT HEALTH INSURANCE?

IN VIEW OF THE BENEFITS OF HEALTH INSURANCE AND THE nearly $100 billion annual federal subsidy of employer-sponsored coverage, why are there so many individuals without any form of health insurance? There are several reasons:

First, there is the use of medical underwriting to prevent adverse selection. Medical underwriting identifies people with higher health risks (e.g., older people and people with chronic, preexisting conditions) and increases their rates or denies or limits their coverage. If an insurer did not medically underwrite, it would attract mostly higher risks and its premiums would rise, driving away the lower risks needed to maintain a stable and affordable risk pool. Fortunately, the fact that employers purchase coverage on behalf of a heterogeneous pool of workers greatly mitigates the problems of medical underwriting.

Employer sponsorship, however, leads to a second type of problem, known as moral hazard. In this case, widespread, subsidized insurance encourages health-care providers to deliver excess care or necessary care at excess cost. That drives up the cost of insurance, thereby deterring its purchase by employers. This effect is amplified by

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mandated benefits, which have been shown to reduce demand for coverage.

Third, where insurance is not available in the workplace, people face high premiums in the market for individual coverage. Insurance premiums include a loading factor for administrative expenses and risk. Both components of the loading factor increase as the number of people in the insured unit decreases. Individual health insurance typically carries a load of 30-40 percent, compared with a load of 10 percent or less for large groups.

Finally, the availability of public insurance in the form of Medicaid and other public programs probably has reduced the demand for ("crowded out") private health insurance coverage. Some households eschew private coverage when they are healthy or not as sick as they might become, reasoning that public coverage will be available for catastrophic illnesses. The availability of free services through private hospital emergency rooms also tends to crowd out private insurance coverage.

REFORM EFFORTS

THE MOST SWEEPING FEDERAL PROGRAMS TO EXTEND health-insurance coverage were enacted in the mid-1960s, with the establishment of Medicare and Medicaid. Medicare provides coverage to most senior citizens and many disabled individuals. In the late 1980s, Congress significantly increased the number of pregnant women, infants and children covered by Medicaid; the program now covers about half of those below the poverty line.

However, various efforts since 1912 to establish a system of universal coverage have failed at the national level—the most recent instance being the demise of the Clinton reform plan in 1994. The absence of a federal policy affecting all demographic and income groups has, in the past 10 years, caused states to take the lead in extending health-insurance coverage to more individuals.

Medicaid in the States Because the federal government provides 50 percent or more of Medicaid funding, state Medicaid programs have been the primary vehicles for expanding health insurance coverage. For instance, federal relaxation of Medicaid eligibility rules in the late 1980s and early 1990s has led to a doubling of the number of pregnant women covered by Medicaid and a 50-percent increase in the number of eligible children since 1987. States now must cover all pregnant women and children up to age 6 in households with incomes up to 133 percent of the poverty level; by 2002, all children under 18 in households with incomes below the poverty level will be Medicaid-eligible. Ironically, however, the near quadrupling of Medicaid expenditures between 1987 and 1998 has been accompanied by a steady increase in the number of uninsured people. There are at least twice as many and possibly four times as many uninsured people now as were reported 20 years ago.

Making Coverage More Affordable Beginning in the mid-1970s, some states established *high-risk pools* for medically uninsurable people (typically defined as having been rejected by one or more insurers). Those who qualify for a pool are able to obtain coverage at capped rates—typically 150 to 175 percent of standard rates. High-risk pools, of course, incur losses, which are covered by general revenues and assessments on insurers.

Most states with high-risk pools retained them even after adopting small-group and individual-market insurance reforms. But by the late 1980s, states recognized that the pools covered only a small segment of the uninsured population and that the uninsured were by no means limited to the poor or near poor covered by the expansion of Medicaid. Given that three-fourths of the uninsured were either workers or dependents of workers, states began focusing on ways to encourage more employers—especially small employers—to offer health-insurance coverage.

A few states offered *subsidies* to entice more small employers to offer health coverage. The subsidies took the form of tax credits for employers and, in a handful of states, for individuals.

A far more common initiative has been *bare-bones coverage*. That is, small employers have been permitted to reduce the cost of coverage by offering plans that do not provide all mandated benefits (e.g., mental-health care, substance-abuse treatment, or alternative medicine). States had been adding mandates since the 1960s at such a rate that there were nearly 700 mandates by 1988. Some observers see mandates as a response to market failure caused by adverse selection; others see them as a response to political pressures. Critics claim that by driving up health-care spending such mandates make coverage less affordable, accounting for as much as one-fourth of the uninsured population.

Widespread, subsidized insurance encourages health-care providers to deliver excess care or necessary care at excess cost. That drives up the cost of insurance,

Medical savings accounts (MSAs) are an alternative vehicle for effectively bypassing the high costs of mandates. MSAs enable individuals to create a pool of tax-free funds to defray out-of-pocket medical expenses; additional expenses are covered by low-cost, high-deductible, catastrophic insurance. MSAs are seen as a way to avert the moral haz-

ard created by insurance because the individuals who benefit from MSAs fund them.

Purchasing cooperatives offer another way to make coverage more affordable. By grouping small employers (and in some cases individuals, such as the self-employed) into a single pool, states hope to provide them with some of the same economies of scale and purchasing power enjoyed by large employers.

Reforms in Small-Group and Individual Insurance Markets With the limited success of early efforts to subsidize coverage, and a perception that private insurance markets were beginning to "unravel," causing more people to become uninsured, many states began to explore ways to expand coverage by reforming private insurance markets. States have few options for regulating private insurance because of a federal law known as ERISA, which prevents states from regulating health benefits that employers self-fund rather than purchase. (Self-funding is common, especially among larger employers, and it has become more prevalent because of ERISA.) However, states are allowed to regulate the coverage, pricing, and underwriting of insurance that is voluntarily purchased by employers or individuals.

The absence of a federal policy affecting all demographic and income groups has caused states to take the lead in extending health-insurance coverage to more individuals.

The central aim of state reforms has been to increase insurance coverage and restrain insurance costs. It is especially difficult to increase coverage because of the practice of experience rating. In a system of voluntary coverage, it is not always easy to keep the healthy in the same pool as the sick because the healthy can obtain coverage far less expensively by finding a pool that excludes high-risk individuals. (For instance, 50 percent of the population generates only 3 percent of health-care spending, but only 1 percent of the population—with average annual expenses of more than $140,000—accounts for 30 percent of health-care spending.) Thus, many reform efforts have tried to encourage the pooling of risks in a variety of ways. States began such reforms in the small-group market in 1990. By 1992, some states had extended their reforms to individual health insurance. The reforms have two components: availability of coverage and rate compression.

Availability of Coverage Open enrollment (also called *guaranteed access*) requires insurers to offer enrollment to all applicants, regardless of their health. *Guaranteed renewability* further ensures that coverage will not be canceled because of poor health.

Limitations on exclusions for pre-existing conditions prohibit carriers from excluding anyone because of a particular health problem, but such limitations must be structured carefully to avoid adverse selection. If individuals knew that they could obtain coverage at any time, regardless of health, they might wait to purchase their coverage only when they were sick and drop it when they were well. Therefore, insurers are allowed to impose waiting periods (usually 6 to 12 months) before coverage begins, but insurers can limit benefits for a pre-existing condition for only a reasonable period (also typically 6 to 12 months).

However, so that a person does not have to satisfy an exclusion period each time he changes jobs or health plans, *portability requirements* allow workers and their dependents to continue their coverage through a new group or individual plan. (Portability rules should be distinguished from continuation-of-coverage requirements such as those enacted in the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [COBRA]. COBRA requires insurers of firms with 20 or more workers to continue, for up to three years, the coverage of a person who otherwise would lose coverage, at a premium not to exceed 102 percent of the group rate.)

Guaranteed access, guaranteed renewability, limitations on exclusions, and portability requirements collectively constitute an effort to replicate for individual and small-group markets the pooling of heterogeneous risks that occurs naturally in larger employer groups. By suppressing medical underwriting, those reforms also seek to force insurers to compete on their ability to promote efficiency in the delivery of medical care rather than on their ability to identify and segregate risks.

Rate Compression Reforms intended to guarantee access to coverage could not guarantee that it would be affordable. Proponents of rate compression argue that it does little good to ensure that high-risk individuals have access to coverage, because most of them could not afford the coverage if insurers are allowed to experience-rate their premiums.

Rate compression does not seek to reduce premiums, on average, but rather to reduce the variation in premiums across groups and individuals. One way to make coverage affordable for high-risk individuals is through *community rating*, that is, to charge everyone the same price regardless of health (although location and family size may still be used in setting rates).

But there are both efficiency and equity reasons to question a pure community rate. On efficiency grounds, individuals may be less inclined to use preventive care or to economize on treatment costs if part of the cost of failure to do

so is borne by everyone else. On equity grounds, a community rate may be objectionable insofar as it results in the subsidy of older and usually more highly paid workers by younger and relatively low-paid workers. Thus, most states have adopted *rating bands*, which require premiums to be within a certain range (e.g., plus or minus 25 percent) of the average premium for a given age or gender group.

Some states do not allow rates to vary with health status but do allow adjustments for demographic characteristics. That practice is known as *adjusted or modified community rating.*

With rating bands or modified community rating, insurers may set rates based on selected characteristics of enrollees. The resulting premiums will therefore vary somewhat with experience, but not nearly as much as they would if they were purely experience-based.

POSSIBLE UNINTENDED CONSEQUENCES OF REFORM

THE VARIOUS REFORMS THAT WE HAVE DESCRIBED ARE intended to increase the number of people with health insurance. But the interplay of those reforms with market complexities and other public programs and regulations may well have yielded no increase in coverage, or even a decrease. There are several plausible explanations:

- As noted above, public insurance may crowd out private coverage.
- Subsidies or other efforts to reduce health insurance premiums may not reduce premiums enough to cause meaningful increases in demand for private coverage, or they may target too small a segment of the relevant population.
- Similarly, risk pooling alone may not reduce premiums for high-risk individuals enough to entice them to enroll.
- Worse still, restrictions on medical underwriting may lead to higher premiums for people in low-risk categories, causing them to drop their coverage or causing insurers to withdraw from the market, particularly insurers who are unable to compete on cost.
- At the worst extreme, if too many low risks drop out and community rates rise sharply, higher risks may then drop out, causing rates to rise further. That process might lead to a "death spiral," that is, the complete collapse of the market. Or the market might stabilize at a new equilibrium, where those who most need coverage are among the smaller number of people who still have coverage.

These competing arguments cannot be weighed by a priori reasoning. Rather, we must look to empirical evidence about whether reforms have led to increased coverage or, in fact, have been counterproductive.

THE EMPIRICAL EVIDENCE

VARIOUS STUDIES, USING DIFFERENT DATA SOURCES AND methods, have assessed the effects of health insurance reforms. Most of the studies have quantified the probability that members of certain demographic groups have some form of health insurance. Such studies also have measured related outcomes, such as the probability of having private rather than public coverage, the probability of privately insured people having group rather than individual coverage, and the probability of an employer's offering coverage. Other, qualitative, studies have assessed more subtle issues, such as the effects of reforms on competitive dynamics and the interplay between the private and public sectors.

We base the following analysis mainly on two of the studies, one quantitative and one qualitative. Two of us (Sloan and Conover) conducted a quantitative, multivariate analysis of pooled Current Population Survey (CPS) data for adults for the years 1989-94. CPS is a large, nationally representative survey conducted by the Bureau of the Census, which annually collects information about the nature and source of insurance coverage. Information about state reforms was merged with CPS data to analyze the effects of specific reforms and other factors affecting the probability of coverage.

Health care reforms generally have had limited effects on heath-insurance coverage because the reforms have reached only a small fraction of the populace or have failed to address underlying problems.

The second study, conducted by Hall and colleagues, is an in-depth qualitative analysis of private market reforms in seven states. The Hall study consists of more than 150 expert interviews with agents, insurers, and regulators in 1997 and 1998.

We also summarize the results of more than 30 other quantitative studies. Those studies either used CPS data for years other than 1989-94, other data about households, or data from a series of surveys of *employers.*

All of the evaluations reach some consistent conclusions, but they also differ in important respects. Table 1 summarizes, for each type of reform, the number of studies that estimated positive, negative, or no effect on being insured or having access to insurance. For details, go to *www.hpolicy.duke.edu/cyberexchange/Regulate/Paregulate.html*

and click on "Insurance Regulation, State Health Insurance Market Reforms" for a complete list of the studies and links to their abstracts or full text (if available).

Overview Health care reforms generally have had limited effects, either positive or negative, on health insurance coverage. One must strain hard to find any effects because the reforms have reached only a small fraction of the populace or have failed to address underlying problems, and many other forces have been at work at the same time. Of the small effects that can be detected, some are positive—that is, they have led to greater coverage—some are negative, and others are ambiguous.

Medicaid Expansion Medicaid has been by far the most influential reform, but the news is not entirely good. There is evidence that Medicaid crowds out private insurance.

Sloan and Conover found that in states with a "medically needy" option—which allows recipients to subtract medical expenses from income for purposes of determining Medicaid eligibility—people are less likely to have private insurance. And those who have private insurance are less likely to have individual insurance than group insurance. Although pregnancy (which may make one eligible for Medicaid) has no effect on the probability of having coverage, it does reduce the probability of having private insurance, particularly individual private insurance. That is, increased

Table 1

Number of Studies of the Effects of State Health Insurance Reforms on Availability and Coverage

		NUMBER OF STUDIES ESTIMATING THE EFFECTS OF REFORMS ON THE PROBABILITY OF:												
		BEING INSURED			HAVING PRIVATE COVERAGE			SMALL EMPLOYER OFFERING HL PLAN				HAVING GROUP COVERAGE		
TYPE OF REFORM	Year first enacted	Lower	No Effect	Higher	Lower	No Effect	Higher	Lower	No Effect	Slightly Higher	Higher	Lower	No Effect	Slightly Higher
SCOPE OF COVERAGE														
Mandated benefits (number)		2	—	—	1	—	—	—	3	—	—	—	2	—
Alcoholism treatment	1973	—	1	—	1	—	—	—	2	—	—	—	1	—
Drug abuse treatment	1975	—	1	—	1	—	—	—	2	—	1	—	1	—
Mental illness	1975	—	1	—	—	1	—	—	2	—	—	—	1	—
Chiropractic services	1967	—	1	—	—	1	—	—	1	—	—	—	1	—
Psychologist	1971	—	—	—	—	—	—	1	—	—	—	—	—	—
AFFORDABILITY OF COVERAGE														
High risk pool	1976	—	1	—	—	1	—	—	2	—	—	1	—	—
No enrollment cap	1976	—	1	—	—	1	—	—	—	—	—	—	—	—
With enrollment cap	1987	—	1	—	—	—	1	—	—	—	—	—	—	—
Insurance premium rate regulation	Pre-1985	1	—	—	—	—	—	—	1	—	—	—	—	—
Bare-bones coverage	1990	—	1	—	—	1	—	—	1	4	—	1	3	—
Employer tax credits/subsidies	1987	—	1	—	—	1	—	—	2	2	—	—	1	—
Individual tax credits		—	1	—	—	1	—	—	—	—	—	—	1	—
Purchasing alliances	1992	—	1	—	—	—	1	—	—	2	—	—	2	1
MSAs	1993	—	1	—	—	1	—	—	—	—	—	—	1	—
AVAILABILITY OF COVERAGE														
Guaranteed issue (GI)														
Small groups, all products		—	3	—	—	1	—	—	3	—	—	—	1	—
Small groups, some products	1990	—	2	—	—	1	—	—	1	—	—	—	1	—
Industry redlining prohibited	1953	—	—	—	—	—	—	—	1	—	—	—	—	—
Individual market	1993	—	1	—	—	1	—	—	—	—	—	—	1	—
Guaranteed renewability (GR)														
Small groups	1990	—	2	—	—	1	—	—	1	—	—	—	1	—
Individual markets	1993	—	1	—	—	1	—	—	—	—	—	—	1	—
Pre-existing conditions waiting period														
Small groups	1955	—	2	—	—	1	—	—	1	—	—	—	1	—
Individual markets	1992	—	1	—	1	1	—	—	—	—	—	—	1	—
Portability	1990	—	—	—	—	—	—	—	—	—	—	—	—	—
Continuation of coverage requirements	1969	—	—	—	—	—	—	1	1	—	—	—	1	—
RATE COMPRESSION		1	—	—	—	—	—	—	—	—	—	—	—	—
Pure community rating (CR)	1992	1	—	—	1	—	1	2	—	1	—	1	1	—
Small group reform, rating bands	1953	—	2	—	—	1	—	—	—	—	—	—	1	—
Individual market reform, rating bands	1992	—	1	—	1	—	—	—	—	—	—	—	1	—
SMALL GROUP (SG) REFORM		—	—	1	—	—	—	1	—	2	—	1	—	—
All reforms (GI, GR, RR, Pre-ex, Port)	1990	—	1	2	—	1	—	—	—	1	—	1	1	—
All reforms except GI	1992	—	2	—	—	1	—	—	—	1	—	1	—	—
Only GR and RR	1991	—	1	—	—	—	—	—	—	—	—	—	—	—
Any other combination	1990	—	2	—	—	1	—	—	—	—	—	—	—	—
INDIVIDUAL (IND) MARKET REFORM		—	—	—	—	—	—	—	—	—	—	1	—	—
GI with rating restrictions	1993	2	—	—	—	1	—	—	—	—	—	—	—	—
All other types	1992	2	—	—	—	1	—	—	—	—	—	—	—	—

Note: For a list of the studies and links to their abstracts or full text (where available), go to www.hpolicy.duke.edu/cyberexchange/Regulate/Paregulate.html and click on "Insurance Regulation, State Health Insurance Market Reforms."

coverage under Medicaid seems to be offset by a reduction in the number of privately insured pregnant women.

These findings are consistent with other studies showing that declines in private coverage offset from 17 percent to one-half of the additions to Medicaid rolls under the broader eligibility criteria adopted in the late 1980s.

Affordability In contrast to the large effects of Medicaid expansion, Sloan and Conover found that high-risk pools do not have statistically significant effects on the probability of being insured. That finding is consistent with other studies showing that such pools do not affect the likelihood of insurance offers by small firms. The finding is also consistent with common sense: in most states with high-risk pools, coverage is measured in thousands whereas the number of uninsured often is measured in hundreds of thousands or millions. Sloan and Conover also found some evidence of "crowd-out," as risk pools were associated with a lower likelihood of having group coverage.

For benefit mandates, the results of the Sloan and Conover study imply that the elimination of 11 mandates (the sample mean) would decrease the proportion of adults without coverage from 18 percent to 14 percent. That is, of adults who lack coverage, between one-fifth and one-fourth lack coverage because of benefit mandates. That figure is consistent with other estimates. With one exception, other studies that have attempted to isolate the effects of the more expensive mandates (e.g., those for alcoholism or drug abuse treatment), generally have found no effects on coverage or, less frequently, negative effects.

Although much less studied, health insurance premium rate regulation also has been found to have no effects, or—as theory would predict—negative effects on coverage. Selective overriding of mandates through bare-bones plans does not increase the probability of being insured and has no effect on group coverage. Although a few studies have found that the use of bare-bones plans slightly increases the fraction of small employers *offering* coverage, Sloan and Conover found that the use of bare-bones plans has caused a statistically significant drop in the fraction of employees that *have* group coverage.

Similarly, employer tax credits and other efforts to subsidize coverage have not noticeably increased the probability of coverage, in part for three reasons: employers often were not aware of such programs, some efforts were geographically limited demonstration initiatives, and others were time-limited subsidies that employers evidently found insufficiently enticing. Some studies *did* find a slight increase in employer offers of coverage, but on the whole there was far less response to such incentives than reformers had hoped for.

Reformers' attempts to achieve greater efficiencies in the small-group market have met with little more success. There is some evidence that public purchasing cooperatives have had slight positive effects on the availability of plans among small employers and on the overall odds of having group or private coverage. However, because such cooperatives have minuscule enrollments—typically single-digit market-penetration rates for eligible groups—they have produced no measurable effect on the probability of being insured.

Industry participants' views of public purchasing cooperatives are instructive. Agents, who fear being driven out of business if the cooperatives are successful, are hostile to them. Also, both agents and insurers have an innate antipathy toward government-sponsored organizations. Many cooperatives have been operated in a way that makes them magnets for higher-risk people, which discourages insurers from participating, thereby reducing the possibility of competitive bidding. Finally, it is difficult to achieve substantial administrative efficiencies through cooperatives, for two reasons: they duplicate many of the functions performed by insurers and agents, and they usually require individual selection of insurance by employees rather than group offerings through employers.

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Small-Group and Individual Market Reforms The many provisions of small-group and individual market reforms intended to expand access to coverage have had no detectable effect—positive or negative.

Sloan and Conover found that the probability of being insured has not been affected by changes in underwriting rules (e.g., guaranteed issue, guaranteed renewability, limitation of waiting periods for pre-existing conditions waiting periods, and portability). Nor have those changes affected the probability of having private coverage, or the probability of having group coverage. Others who have analyzed the effects of the same reforms, in the same detail, have reached the same conclusions.

Studies of the effects of less-stringent underwriting rules on small employers' decisions to offer coverage similarly have found no detectable effects. Likewise, a number of quantitative studies of the small-group market have found that open enrollment and community rating have little or no effect on the probability of being insured, whether the rating restrictions are loose or strict.

The only discernable effect of underwriting reform has been in the market for individual insurance. Sloan and Conover found that the imposition of modified community rating has had a negative effect on private coverage but no detectable effect on the odds of being insured. Interestingly,

for the insured population, community rating increases the fraction of people who have public rather than private insurance. That finding points to a "reverse crowd out," in which some people who apparently are driven out of the private market by higher premiums are able to join public programs.

Interviews with industry sources suggest two reasons for the neutral or negative effects of underwriting rules. First, medical underwriting was less effective than had been believed; therefore, most employer-sponsored groups that had wanted insurance before restrictions on underwriting were able to get insurance, and most of those that had not been able to afford coverage still cannot. Second, insurers can still tailor the risks they accept by the ways in which they package benefits, market policies, and work within allowable rating structures.

All of the evidence from the few available aggregate studies indicates that individual market reform has *decreased* the odds of being insured.

Industry sources also explain why the effects of underwriting reforms have not been as negative as predicted by many in the industry. The sources observe that the greatest potential for harm lies in the individual market, where adverse selection is much more likely. (That observation is consistent with quantitative findings of Sloan and Conover cited above and with accounts from the states of New York and Washington, where reforms to the individual market have created many more problems than group-market reforms.) In the small-group market, even pure community rating has not been severely disruptive because enough insurers have been willing to compete on those terms.

Indeed, since reform, price competition for small-group business has been more intense, in part because of the movement to managed care, in which insurers have vied aggressively for market shares large enough to justify investments in provider networks. But the movement to managed care may itself have been precipitated by reform laws, which were intended, in part, to force insurers to adopt the management techniques of HMOs. Indeed, some studies have found that even though small-group reforms have not have their intended effects on coverage, they have changed the market by accelerating a trend toward HMOs. Conversely, small-group reforms generally have been more effective in areas that have higher concentrations of managed-care plans.

The Collective Effects of Reform Perhaps we have focused on the trees and have failed to see the forest. Even if no particular state reform has had a noticeably positive effect on coverage, it is possible that state reforms have been collectively effective.

Several studies attempted to aggregate small-group reforms into clusters on a continuum from "stringent" to "weak." The results are not encouraging. Although the studies, on average, indicate that small-group reform has increased slightly the propensity of small employers to *offer* coverage, the studies also collectively indicate that, if anything, small-group reform *reduces* the odds that an individual worker will have group coverage.

These seemingly paradoxical findings mirror a current, nationwide trend. There are now more small firms offering coverage than there were a few years ago, but many of them are shifting more of the premium costs to employees. As a result, enrollment rates have declined by more than enough to offset the increase in the number of employers offering insurance. Employees may decline insurance for themselves or their dependents under an employer's plan because they consider their share of the premium too high or have access to more suitable or less expensive coverage from another source (e.g., a spouse's employer). The net result has been declining group coverage for employees of small firms.

The real issue is not what has happened to group or private coverage but whether reform generally has led to increased coverage. Most of the studies of reform packages found no detectable effect. Two such studies show that small-group reform—stringent reform, in particular—*has* made it more likely that a small-firm employee will be insured. However, because of the inconsistency of findings it is difficult to make a strong case in favor of reform from the evidence at hand.

Interviews with insurers and agents help us understand why small-group reform has been relatively ineffective. Insurers and agents explain that most insurance sales are to people who already have coverage. Such individuals are price-sensitive; that is, slight differences in price will cause them to switch plans or insurers. That effect that has been heightened by reforms that foster portability and continuity of coverage. In sum, market reform has precipitated intense price competition, which has helped to keep people in the market but has not drawn large numbers of previously uninsured people into the market.

Moreover, low-cost policies with relatively few benefits have not sold well, for three reasons:

- Subscribers have become accustomed to, and continue to demand, comprehensive coverage.
- Insurance agents, who mostly work on commission, are reluctant to offer bare-bones plans.
- Insurers are reluctant to embrace policies that do not match the structure of their current portfolios or their automated claims and actuarial systems.

In contrast to the weak or inconsistent findings about small-group reform, all of the evidence from the few available aggregate studies indicates that individual market reform has *decreased* the odds of being insured. The negative effect of community rating for the individual market is confirmed by Hall's qualitative study. He documents large numbers of insurers dropping out of the market, insurers declining to offer indemnity coverage, premium increases, covert risk selection, and circumvention of market and regulatory borders.

However, there is no evidence of market collapse or anything like a death spiral. Even under stringent community rating, markets for individual insurance in most states (possibly excepting Kentucky) have reached new equilibriums at higher prices. Fewer people are covered but those who are covered are generally older and sicker.

It seems, for the moment, that empirical evidence has soundly trounced the worst fears based on theory.

CONCLUSIONS

THE GENERALLY INCONCLUSIVE EVIDENCE ABOUT THE effects of state reforms may reflect the inherent difficulty of measuring complex and subtle phenomena. Although some studies drew on small, state-level samples, those based on the Current Population Survey had ample statistical power. And although some studies included only a limited number of variables—and thus were unable to detect or control for complex interactive and confounding factors—Sloan and Conover included a full slate of reforms and many demographic, income, and disability variables, which had statistically significant effects on coverage in anticipated directions.

More troubling is the possibility that state reforms may be endogenous; that is, states with large numbers of uninsured people may have been more likely than other states to adopt reforms. In that event, the effectiveness of reforms may have been masked. That possibility is difficult to test or correct for because there are so many reforms and states to consider. Some assurance comes from the fact that the studies we have surveyed here used a variety of statistical techniques, which suggests either that endogeneity is not a significant factor or that the studies yielded similar findings despite some endogeneity.

Of course, it may simply be too soon to know the effects of state reforms. As one actuary explained in 1998, market reforms were then only "four years young"; even a "slow trickle" of better risks leaving the market might signal the start of a protracted death spiral.

Other observers note that market reforms were, by happy coincidence, enacted at a low point of cyclical underwriting profitability, during an intense battle among managed-care firms for market share. Now that insurers are consolidating and making up for past losses, vulnerable groups may bear the brunt of inevitable cost increases.

Yet other observers are hopeful that a new generation of reforms, focused on particular market segments and designed with greater sophistication, will prove more effective. Such new reforms might include subsidies for uninsured children and private associations for individuals or small groups.

What does seem clear is that it is hard to construct a reform that has a measurable effect without making things worse. If subsidies are too small, they have no effect. But if they are large enough to have an effect, they cause crowding out; that is, people drop private coverage to move to subsidized programs. Similarly, reforms in the private market stabilize enrollment, at best, but also make insurance more accessible to higher-risk individuals. If that insurance proves too attractive to higher risks, however, rates will go up, lower-risk individuals will drop out, and total enrollment will decrease.

Such dilemmas are intractable in a system that maintains both public and private insurance, has a skewed risk distribution, and leaves it to the individual to chose (or decline) coverage. Perhaps, with more empirical study, it will be possible to determine whether future reforms can overcome those daunting odds.

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