

## **Local Cooperatives Will Not Work for Rural America**

### **Timothy Stoltzfus Jost**

#### **What does public plan choice offer to rural America?**

- Driving cost control by controlling administrative costs, introducing plan competition, and bargaining with providers.
- Offering rural Americans a choice of insurers.
- Encouraging delivery system reform.
- Bringing transparency and accountability to health care financing and delivery.
- Offering a national strategy for a national problem.

#### **The cooperative alternative**

- One compromise proposal that has been offered to ideological opponents of public plan choice is that of consumer cooperatives.
- But would they work for rural America?

#### **The uninsured in rural America**

- Rates of uninsurance are high in rural America, and higher in remote areas. The rural uninsured also remain uninsured longer than the urban uninsured.
- Insured rural Americans have worse coverage than urban Americans. They are less likely to have preventive or drug coverage, have higher deductibles, and pay higher out-of-pocket costs.
- Farmers are generally covered by high-cost, low-value, non-group policies.
- Rural hospitals and other health care providers are in financial crisis because they must provide care to un- and underinsured residents of their communities.

#### **Insurance markets in rural America**

- Insurance markets in rural America are not competitive. One or two dominant insurers hold over 90% or more of market share in many rural communities.

#### **Can rural cooperatives compete?**

- Cooperatives, such as electrical cooperatives, are common in rural America, but were formed under completely different circumstances from those that would face health insurance cooperatives.
- Forming a viable, competitive health insurance company is a complex, difficult, and expensive task that requires specialized expertise and massive resources.
- There is no reason to believe that providers would offer cooperatives competitive rates, much less rates that would contribute to cost control.
- Local cooperatives are likely either to be the victims of risk selection or to engage in it themselves. Either way, they will not provide a viable alternative to private health insurance.
- We have tried rural health insurance cooperatives before in the U.S., and they failed.

**Rural America needs public plan choice.**

## **Local Cooperatives will not Work in Rural America**

**Timothy Stoltzfus Jost**

One of the most hotly debated health care reform proposals to emerge during the past two weeks has been the concept of health insurance consumer cooperatives. The cooperative has been offered as a potential compromise by Senator Conrad to overcome Republican resistance to the concept of public health insurance plan choice offered by the proposals of President Obama and most Democratic leaders. This memorandum explores in particular the suitability of consumer cooperatives to serve as an alternative to public health insurance plan choice in rural areas.

### **What does public plan choice offer to rural America?**

Before we can examine the potential impact of a cooperative on rural areas, we must first consider the likely effects of a public plan. The public plan choice alternative addresses each of the key problems that must be solved if we are to have true health care reform.

**Cost control.** Health reform cannot happen unless we can control the continual upwards spiral of health care costs. The public plan would control costs in three ways. First, it would be able to keep its costs down by not having to make a profit and by avoiding many of the administrative costs incurred by private insurers. Second, it would introduce competition into the health insurance industry. Health insurance markets are segmented into the large group, small group, and non-group markets and within each of those categories competition is exceedingly local. In 36 states, 65% of the small group market is controlled by 3 insurers; in 16 states one insurer controls half of the market. Private insurers generally do not compete; they simply take prices from providers and pass them on to consumers, driving the health care cost spiral. A national public plan would have the capacity to introduce vigorous competition into every part of the country that other insurers, be they for-profit or non-profit, have for the most part been unable or unwilling to achieve, forcing private insurers to compete for business and to bring down their premiums. Third, a national public plan would also have the bargaining clout and determination to make providers moderate the increase in their prices, bringing down the cost of health care itself.

**Choice.** Right now the only choice available to most Americans is private insurance. In many markets, small businesses have only a choice of one or two insurers. Even when more than one choice of insurer is available, it is difficult to distinguish among them based on value, since plan provider rates and coverage policies are largely proprietary and objective outcomes data is unavailable. Americans want to have alternatives to choose among to best meet their needs. A public plan offers this.

**Delivery System Reform.** A national public plan could drive delivery system reform and improve the quality of care, as Medicare has been doing through its demonstration projects, payment reforms, and consumer information initiatives.

**Transparency and Accountability.** One of the most important developments in the health care reform debate over the past decade has been the data that has emerged from the Dartmouth

research group on variations in health care spending. This data, discussed by Atul Gawande in his widely noted recent New Yorker article on health care costs and the President in his speech at Green Bay, could only be collected because Medicare data are available to researchers. No comparable research can be done on the under-65 population because private insurers regard whatever data they have to be proprietary. Private insurers are also much more secretive about their coverage and utilization review policies. A public plan could make anonymized data available to researchers and be open with its subscribers about coverage and utilization policies.

***A National Strategy.*** We have waited for decades for the states to make affordable health care available to Americans. None have found a way to foster competition in the insurer and provider markets. Rather, over time, most have allowed increased consolidation in the insurer and provider markets, which is driving up costs. All Americans are experiencing the same problems with health care—lack of access, high costs, and uneven quality. We need a national strategy for health care reform that will help all Americans, not just some. We also need a national public plan that offers uniform benefits to all Americans and national bargaining power.

### **The Cooperative Alternative**

Because of strong ideological resistance to public plan choice on the part of Republicans, there have been a series of attempts to find an alternative to the public plan that would allow bipartisan legislation to go forward. The cooperative has emerged as one such alternative.

In the one-pager Senator Conrad released originally mooted the cooperative concept, he proposed several alternatives: state-based cooperatives, a nationwide approach, or a hybrid approach. In previous working papers, I have examined what a national cooperative might look like, contending that if it were given enough federal support, bargaining power with providers, and protection from adverse selection, it might be able to make a meaningful contribution to health care reform.<sup>1</sup> In recent days, however, proposals have been discussed that contemplate much more limited and local cooperatives—essentially a few small town business leaders getting together over breakfast at the Perkins to form a health insurance cooperative in their town.

While this proposal seems romantically attractive, it will never work and is doomed to failure. Before explaining why this is the case, however, let us take a look at uninsurance in rural America.

### **The Uninsured and Underinsured in Rural America**

The problem of the uninsured in rural America is real. Census data show that the level of uninsurance is approximately equal to the level found in metropolitan areas, slightly higher in some years, lower in others. Research shows, however, that the proportion of the population with private health insurance in rural states drops the further one gets from urban areas, and drops dramatically when one reaches remote “frontier areas.” In 2002, for example, 24% of residents of remote rural areas were uninsured, compared to 18% of residents of urban areas or rural areas adjacent to urban areas.<sup>2</sup> Rural residents are also much less likely than residents of urban areas to be offered insurance by their employers; 59% of workers in remote rural areas compared to 69% of urban workers.<sup>3</sup> Fewer than half of remote rural workers are covered by

employment-related insurance, compared to 60% of workers in urban areas.<sup>4</sup> While the level of Medicare and Medicaid coverage tends to be higher in remote areas, the absolute level of the uninsured remains high.<sup>5</sup> When rural residents become uninsured, moreover, they tend to be uninsured for much longer. According to one study, the average length of a spell of uninsurance was 8 months for urban residents, 16 months for rural residents, 22 months for “frontier” residents.<sup>6</sup> Remote rural residents tend to be older and poorer than the American population generally, and less likely to be offered insurance by their employer.<sup>7</sup>

Rural residents are much more likely than urban residents to work for very small businesses or to be self-employed. They tend to work at lower-income jobs, which do not come with insurance. Insurance in the non-group and very small group markets, particularly high quality insurance, is inevitably expensive. Insured residents, therefore, have poorer quality insurance. A recent study found that residents of rural areas had fewer covered benefits than insured persons in urban areas and were more likely to have a deductible, and pay more in cost-sharing.<sup>8</sup> Rural Americans are much less likely than urban Americans to be covered for preventive care or dental care, and are fifty percent more likely than the urban insured to not have drug coverage.<sup>9</sup> Their out-of-pocket expenses are 10 percent higher than those of urban-insured residents.<sup>10</sup>

Farm owners are more likely than other rural residents to be insured. Most are insured, however, through high-cost, low-value non-group policies. While nationally only 6 percent of the population is insured in the non-group market, about half of farmers are.<sup>11</sup> Non-group policies are often unavailable to persons with medical problems and usually exclude coverage of preexisting conditions.

The high levels of uninsurance and underinsurance in rural areas has a direct and immediate impact on health care providers in those markets. One recent study found that 17% of 246 rural counties were at risk of losing access to local hospital services because their hospitals had an average 3-year negative margin. Rural hospitals provide a higher level of charity and uncompensated care than other hospitals.<sup>12</sup>

### **Insurance Markets in Rural America**

Recent studies have demonstrated that health insurance markets are heavily concentrated throughout the United States. This is particularly true in rural states and in local areas within those states. One insurance company dominates 88% of the small group insurance market in North Dakota, with two others holding an additional 6%.<sup>13</sup> One insurer controls 75% of the market in Montana, with another insurer holding an additional 10%. One insurer holds 71% of the market in Iowa, while another covers an additional 95. Local markets, where insurance is actually sold, are even more concentrated. Two insurers control 90% of the market in Ames, Iowa, and 94% of the market in Sioux City. One insurer controls 95% of the market in Great Falls and 90% of the market in Missoula. Not surprisingly, given the lack of competition in these markets, health insurance premiums are rising dramatically, 89% between 2000 and 2007 in Montana; 74% in North Dakota; and 73% in Iowa.

Many of these dominant insurers are Blue plans, while some are large national insurers. Some Blue plans are nonprofit, but as Senator Grassley’s path-breaking work in examining nonprofits

has repeatedly reminded us, nonprofit is not synonymous with a public-service orientation. In fact nonprofit insurers are indistinguishable from for-profit, charging high premiums, refusing to insure high-risk applicants or subjecting them to pre-existing conditions clauses, dropping high cost insureds, paying high executive salaries, and accumulating large surpluses rather than lowering premiums. Even though insurers are reaping enormous revenues, it is difficult for competitors to enter markets and compete, not only because of regulatory barriers to entry, but also because of the difficulty of building provider networks in the face of most-favored nations clauses and other barriers to competition.<sup>14</sup>

### **Can Cooperatives Compete in Rural America?**

The cooperative is a familiar concept in rural America. Rural electric cooperatives began in the 1930s as a public-private partnership initiated by the Rural Electrification Act of 1935, serve large parts of rural America. Rural electrical cooperatives were begun with federal assistance and are still subsidized by Rural Utility Service loans. It must be understood, however, that rural electrical cooperatives were begun because commercial electric companies refused to serve rural areas, which they found unprofitable. Rural cooperatives never had to face competition with large for-profit utilities. Rural cooperatives were also sold power at preferential rates by federal power marketing agencies, such as the Bonneville Power Administration, which operated 133 federally constructed dams throughout the United States.

Starting an electric cooperative with federal assistance and subsidized power and without serious private sector competition has nothing to do with trying to start up a health insurance cooperative in a rural area from scratch, competing with one or two large and powerful insurers that completely dominate the local market.

Carl McDonald of Oppenheimer recently published a research note examining the cooperative proposal, concluding that they would effectively be dead on arrival and pose no threat to private insurers.<sup>15</sup> Questions he raised include:

- What experience do those who would run local cooperatives have with predicting medical cost trends, underwriting, and pricing premiums?
- How would coops establish benefit plans? If they are licensed on a state-by-state basis, they will need to comply with all state benefit and provider mandates in the small group and non-group market, and may be stuck with marketing very expensive policies.
- How will they obtain competitive rates from providers? In many rural areas, there is only one dominant hospital and very few physicians in most specialty areas. At least initially cooperatives will be small and have no market power. Why would any provider give a coop the same rate it gives the dominant insurer, or even deal with it at all? Some dominant insurers have “most favored nations” clauses requiring providers to offer them the best rate offered any competitor. Where these apply, it is not imaginable that providers would lower their rates for cooperatives. But how will cooperatives ever attract enough members to gain market power if they can’t build provider networks? How will they build up reserves?
- How would cooperatives build the infrastructure to control costs through case, medical or disease management?

- Indeed, how would they be able to afford the infrastructure needed just to start providing insurance? Insurance is a very complicated business, much more so than a milk cooperative. Coops would need to build the infrastructure to do underwriting, premium pricing, claims payment, customer relations, and actuarial estimating. None of this expertise comes cheap.

Another probably insurmountable problem is that of risk selection. If cooperatives tried to serve all of the uninsured in their community, they would inevitably become the victims of adverse selection and the dumping ground for private insurer risk selection. They would simply become a high risk pool, unaffordable to all but the sickest members of their community. Alternatively, if they underwrote vigorously to try to maintain a viable risk pool, they would exclude those most in need of insurance, and offer nothing to solving the problem of the uninsured.

We are not writing on a clean slate here. We have tried health insurance cooperatives before in rural America, and they failed. During the 1930s and 1940s, the heyday of the cooperative movement in the United States, the Farm Security Administration encouraged the development of health cooperatives. At one point, 600,000 mainly low-income rural Americans belonged to health cooperatives. The cooperatives were small and undercapitalized. Physicians opposed the cooperative movement and boycotted cooperatives. When the FSA removed support in 1947, the movement collapsed

## **Conclusion**

Rural America desperately needs access to good affordable health insurance. Rural America desperately needs health insurance competition. Local cooperatives cannot and will not contribute anything to rural America. In particular, they will not drive cost control, improve quality, reform the delivery system, provide accountable and transparent insurance, or guarantee rural Americans the access to quality health care that they want and need. Rural America needs national public plan choice.

## References

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<sup>1</sup> <http://law.wlu.edu/faculty/page.asp?pageid=907>

<sup>2</sup> John Bailey, Health Care in Rural America, Center for Rural Affairs (2004), [http://www.cfra.org/pdf/Health\\_Care\\_in\\_Rural\\_America.pdf](http://www.cfra.org/pdf/Health_Care_in_Rural_America.pdf)

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Thomas D. Rowley, The Rural Uninsured: Highlights from Recent Research, <http://ruralhealth.hrsa.gov/policy/Uninsured.htm>

<sup>6</sup> Ibid.

<sup>7</sup> Bailey, op. cit.

<sup>8</sup> David Hartley, Lois Quam, and Nicole Lurie, Urban and Rural Differences in Health Insurance and Access to Care, *Journal of Rural Health* 10(2): 98-108 (2008).

<sup>9</sup> Bailey, op. cit.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Rowley, op. cit.

<sup>13</sup> All data in this paragraph are from HCAN, Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses (May 2009), available at [http://hcfan.3cdn.net/dadd15782e627e5b75\\_g9m6isltl.pdf](http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltl.pdf)

<sup>14</sup> See Testimony of David Balto, Senate Judiciary Committee, March 10, 2009, available at [http://www.americanprogressaction.org/issues/2009/03/pdf/balto\\_varney\\_testimony.pdf](http://www.americanprogressaction.org/issues/2009/03/pdf/balto_varney_testimony.pdf)

<sup>15</sup> <http://blog.corporateresearchgroup.com/2009/06/15/co-op-health-plan-idea-raises-lots-of-questions/>