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CO-OP Health Plans: Can They Help Fix Rural America's Health Insurance Markets?

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) provides authority and funding to support the creation of non-profit health insurance plans in the individual and small group markets. Under the Consumer Operated and Oriented Plan (CO-OP) program, the ACA authorized \$6 billion in grants and loans to support non-profit organizations in developing, marketing, and maintaining health insurance plans in the private marketplace.ⁱ Given the failings of the rural private health insurance market, some have envisioned the CO-OP program as an opportunity for expanding access to affordable coverage in rural areas. This brief:

- Provides an overview of the CO-OP program legislation;
- Identifies the challenges to obtaining private health insurance in rural areas; and
- Assesses the opportunities and challenges of using the CO-OP program to address the limitations of the rural private health insurance market.

BACKGROUND

The CO-OP Program

The ACA established the CO-OP program to foster the development of qualified nonprofit health insurance plans in the individual and small group health insurance markets.ⁱⁱ Participating entities must be organized under state law as nonprofit, member corporations, and must issue plans exclusively in the individual and small group markets of the state(s) in which they are licensed to operate. Current insurance providers are ineligible to offer CO-OP plans. CO-

OP plans must comply with all the regulations that other issuers of qualified health plans are required to meet in a particular state.

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To be treated as a qualified nonprofit health insurance issuer under the CO-OP program, the governance of the organization must be subject to a majority vote of members, and plans are obligated to maintain a strong consumer focus by ensuring accountability to plan participants. CO-OP plans must be governed in ways that protect against insurance industry involvement, including the establishment of a code of ethics that precludes individuals with ties to the industry from serving on CO-OP boards. Any profit made by the organization must be used to lower premiums, improve benefits, or sustain programs intended to enhance the quality of health care delivered to members.

Qualified CO-OP plans may be eligible for federal loans and grant monies to assist in meeting start-up costs and satisfy solvency requirements of the state(s) where the issuer seeks to be licensed. In awarding grants and loans, priority will be given to applicants that seek to offer qualified health plans on a statewide basis, use integrated care models, and exhibit substantial private sector support. The ACA stipulates that adequate funding must be made available to establish at least one CO-OP plan in each state. If there is no application for the establishment of a CO-OP plan in a particular state, grants may be awarded to encourage the expansion of a qualified issuer from another state.

In order to increase cost efficiencies for qualified nonprofit health insurance issuers participating in the CO-OP program, the ACA allows for the establishment of private purchasing councils through which plans may enter into collective purchasing arrangements to procure items and services at a lower cost, such as health information technology, claims administration, and actuarial services. However, private purchasing councils are not permitted to engage in contract negotiations or rate setting with health care facilities or providers.

Rural Health Insurance Markets

The economic characteristics of rural areas place residents at a disadvantage in accessing and purchasing private health insurance. Employer-based coverage is less common in rural areas, where residents are less likely to work for an employer that offers coverage (Lenardson et al. 2009). This rural-urban difference in employer offers stems from the fact that rural residents are more likely than urban dwellers to work for small firms (Coburn et al. 1998; Ziller et al. 2006; Lenardson et al. 2009), to work part-time or for lower wages (Lenardson et al. 2009; Ziller et al. 2004), or to be self-employed (Lenardson et al. 2009). Rural residents are also more likely to be unemployed or out of the workforce than are urban residents (Lenardson et al. 2009). As a result of these employment factors, rural residents are more likely to purchase coverage in the individual market (Pryor and Prottas 2008, Ziller et al. 2006), to enroll in public coverage, or to remain uninsured (Lenardson et al. 2009).

The greater reliance on individual and small group private insurance in rural areas interacts with more limited insurance market competition to make private health insurance expensive for many rural residents. The markets for individual and small group plans are highly concentrated: In 36 states, three or fewer insurers account for 65 percent of these markets combined (Corlette 2011). Due to this lack of competition, insurers in these subsections of the industry have little incentive to improve their efficiency, to bargain effectively with providers over payment, or to pass any savings on to consumers (Bertko 2011; Corlette 2011). As a result, members of individual and small group plans typically pay significantly higher premiums, deductibles, and other out-of-pocket medical expenses than members of larger group plans (Bertko 2011; Corlette 2011). The effects of limited competition may be exacerbated in rural areas with evidence suggesting that rural small

employers pay more for the same coverage than urban firms of the same size (Gabel et al. 2006).

DISCUSSION

Can CO-OP Plans Help Cure the Ills of Rural Health Insurance Markets?

Some rural stakeholders have expressed interest in exploring CO-OP plans as a possible approach to advancing rural health (Lotven 2011). The appeal of CO-OPs to rural constituencies is understandable; the underlying principles of the CO-OP model resonate with rural traditions of mutual aid and shared responsibility. Moreover, proponents of rural CO-OP plans can cite past instances when health care cooperatives were used to increase access to health care in rural regions of the country. During the Depression era, the Farm Security Administration helped small farmers in 39 states form insurance pools and negotiate fee schedules with providers (Grey 2009).

More recently, health cooperatives offering integrated care and coverage have extended their operations from urban to rural areas within and across state lines; Group Health of Puget Sound has members in Washington and Idaho (Rakow 2011), while Minneapolis-based HealthPartners serves both urban and rural communities in Minnesota and Wisconsin (Walsh 2011). HealthPartners, in particular, has demonstrated a concern for rural health needs: In 2002, the cooperative collaborated with a health care purchasing alliance in northwestern Minnesota to help rural communities in the area pool their insurance risk and to design a benefits package tailored to the circumstances of rural residents (*Managed Care Outlook* 2002).

In theory, if new CO-OP plans were able to constitute themselves so as to serve rural areas, they could help to alleviate problems endemic to rural health insurance coverage and health care delivery. To begin with, CO-OP plans might introduce greater competition in highly concentrated rural health insurance markets by offering better value. For example, some argue that because these plans would pay no brokers' fees and would face comparatively low overhead, they could enjoy premium pricing advantages of 8 to 10 percent over insurers offering similar coverage (O'Connor 2009; Vesely 2009). The CO-OP plans' consumer orientation and non-profit

status should help to ensure that any cost savings would be passed on to members.

In addition to insurance cost savings, CO-OP plans could also contribute to improving health care delivery in rural communities if, as envisioned by the law, they give members access to integrated delivery systems to promote greater coordination and continuity of care and better health outcomes (Collins 2011). There is also some possibility that depending on their mechanisms for member representation, CO-OP plans might offer rural residents greater potential for local control of their health care infrastructure than other types of health plans. In sum, a viable rural CO-OP could afford rural consumers expanded coverage options, improved affordability, enhanced quality of care, and a substantive role in plan governance.

Barriers to Implementing CO-OP Plans that Serve Rural Populations

Although the CO-OP model could, under ideal circumstances, yield benefits for rural communities, the creation of CO-OP plans is likely to be difficult, particularly in the rural context. The development of CO-OP plans will require significant financial and administrative capacity, and the plans must achieve considerable scale of enrollment and operations to become stable, sustainable enterprises. Most importantly, a CO-OP plan must raise capital and surplus reserves sufficient to guarantee premium rates, cover future claims, meet working capital needs, and ensure ongoing solvency in the face of both expected and unusual stress scenarios (O'Connor 2009; Praeger 2011). According to some estimates, new CO-OP plans would need \$100 to \$150 million in capital and surplus (Hazen 2011). Such sums are not likely to be within easy reach of a start-up, non-profit health insurance cooperative in a rural setting.

CO-OP plans must also achieve membership levels that will allow the organization to maintain financial and operational stability (Bertko 2011; Hazen 2011). It has been suggested that for these purposes, at least 25,000 members are needed (Bertko 2011). The low population densities in rural areas means that rural CO-OP plans would likely need to operate regionally within a state or across states to meet this minimum membership threshold. Interestingly, the ACA precludes CO-OP plans from using federal grant funding for market research and advertising, without which recruitment and enrollment could be hindered (*Patient Protection and Affordable Care Act* 2010). The

Federal Advisory Board on the CO-OP program has recommended that “marketing” be defined in such a way that outreach and member education would be allowable grant costs (U.S. Department of Health and Human Services 2011).

The scarcity of human resources and infrastructure in rural areas may represent another formidable barrier to establishing rural-based CO-OP plans. Like all other health plans, these plans will be responsible for multiple plan administration functions, and they will need to contract with other organizations that offer services such as enrollment; claims administration and adjudication; actuarial consultation; information technology support; billing and accounting; and legal guidance (Bertko 2011). Although these services may be readily available in the market, start-up rural CO-OP plans could have difficulty locating appropriate providers of these services and negotiating contracts with providers if the plans do not have staff and board members with relevant expertise and experience in health plan management. In addition, the competitiveness of the CO-OP plan could be affected depending on the prices it pays for these administrative functions.

Finally, provider shortages and the adequacy of the rural provider network could pose problems for start-up CO-OP plans that serve rural areas. Specifically, CO-OP plans might find it challenging in some areas to meet provider access standards set by the Health Insurance Exchanges, either because the requisite health care providers to ensure appropriate beneficiary access are scarce, or because CO-OPs lack the membership levels needed to persuade providers to participate in the plan.

Given the challenges inherent in establishing a CO-OP plan, particularly those related to scope, it is unlikely that plans serving exclusively rural areas of a state will be viable. Although there are some areas of the country where a micropolitan area could serve as the hub to a regional rural plan, these are likely to be unique circumstances. Instead, the establishment of most CO-OPs would probably start in urban areas where there is greater population and provider density and infrastructure to support these start-up organizations. Whether these urban-based CO-OP plans would have incentives to market in rural areas, or whether they would behave like other private insurers, is unclear.

Reducing Barriers to Rural Implementation

Both state policies and private initiatives could enhance the likelihood that CO-OP plans that are developed will serve rural areas.

States wishing to foster the development of CO-OP plans could consider several policy strategies. To assist CO-OP plans in achieving necessary scale, states could permit the organizations to sell their plans to large employers outside of health insurance exchanges.ⁱⁱⁱ They could also give CO-OPs preferred status as providers of managed care plans for Medicaid beneficiaries and for state employees. To help CO-OPs deal successfully with any federally imposed limitations on their ability to negotiate provider payments, states could require health care providers to give CO-OPs the lowest rates that they grant to other insurers (Collins 2011). There is evidence demonstrating the effectiveness of at least the first two of these strategies. For example, Group Health Cooperative and HealthPartners each increased their membership numbers and enhanced their financial stability by offering plans through public programs and by serving employers of all sizes (Rakow 2011; Walsh 2011).

Health care provider systems that are based in or serve rural areas could also play a significant role in fostering the formation of CO-OP plans. Existing, not-for-profit, integrated health care delivery systems may be in the best position to overcome the challenges involved in forming CO-OPs and in offering CO-OP plans to rural residents. Integrated delivery systems may already have access to capital that would assist them in meeting a CO-OP's capitalization requirements. In addition, such systems would have readily available means to build CO-OP membership, as they could offer their new CO-OP plans to their current employees and patients. Moreover, integrated delivery systems could build on their existing administrative infrastructure to meet CO-OP plan needs.

Although most integrated health care delivery systems are based in urban areas, there are a growing number of such systems that include large numbers of rural providers. In addition, there are integrated systems that are predominately comprised of rural providers. As a general rule, however, rural communities are most likely to gain access to CO-OP plans sponsored by integrated systems if such organizations are prepared to launch statewide or regional plans. As

indicated above, prototypes for plans designed along these lines include Group Health Cooperative of Puget Sound and HealthPartners, both of which operate in interstate regions and thereby make their insurance products and health care services available to rural residents (McCarthy et al. 2009).

Balancing CO-OP Viability and Rural Interests

In developing a policy stance with respect to CO-OPs, policy makers and rural health advocates must consider that some of approaches needed to make CO-OPs viable might not be wholly compatible with all the goals of rural providers and communities.

As suggested previously, urban-based integrated delivery systems may be in the best position to develop sustainable CO-OP plans. In some cases, these systems already include rural providers and serve rural communities. In others, rural residents would likely have access to CO-OPs only if urban-based systems and plans reach out to rural areas. Under such circumstances, rural residents would be a minority among CO-OP members, potentially undermining one of the attractive features of the CO-OP plan, namely greater "local control" over health plan policy and operations.

In addition to these potential governance issues, there is a concern that urban-based CO-OP plans might employ a tiered provider strategy that could result in the exclusion of some rural health care providers from the plan's provider network. Under these circumstances rural CO-OP members might be steered away from their usual sources of care. In addition to potentially creating access concerns for patients, this could also affect the viability of local, rural providers. To address the issue of access, the program's Advisory Board has recommended that preference be given to plans that have strong local networks, and that CO-OP applicants be required to provide evidence of the reach of their provider network and to identify areas where preferred relationships with providers could affect members' access (U.S. Department of Health and Human Services 2011).

While the dilemmas involved in CO-OP implementation might be difficult to resolve in ways that would be ideal for rural communities, urban-based CO-OP plans could still represent an improvement over the options currently available to rural citizens and communities, particularly if CO-OPs

embraced service to rural populations as an explicit part of their mission. In keeping with the example set by HealthPartners, a CO-OP plan with regional scope and a commitment to rural health promotion could spearhead quality improvement initiatives that would benefit its rural members (Walsh 2011), and it could collaborate effectively with rural advocacy organizations to address the special coverage and health system development needs of rural communities (*Managed Care Outlook* 2002). As the ACA already gives preference to funding CO-OP plans that operate statewide, special consideration could also be given to entities that include a specific proposal in their governance and operations materials for meeting the needs of underserved populations and areas of the state, including rural areas.

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ⁱ As of this writing, \$2.2 billion has been cut from the program as part of the 2011 budget compromise.

ⁱⁱ This section is based on the authors' reading of *An Act Entitled The Patient Protection and Affordable Care Act*. Washington, D.C.: U.S. G.P.O., 2010. Print.

ⁱⁱⁱ While the ACA specifically indicates that CO-OP plans must sell in the individual and small group markets through Health Insurance Exchanges (HIEs), there is no language prohibiting them from selling outside the exchanges as well, although "substantially all" of their business should be in the individual and small group markets. Similarly, there is nothing in the legislation that indicates they could not become Medicaid managed care plans; however, clarification of these potential roles through the rule-making process would be advised. The CO-OP Advisory Board (April 15, 2011 report) has recommended that the phrasing "substantially all" in ACA be interpreted with flexibility in this area, particularly during the start-up phase.

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ABOUT SHARE

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