CHOICES
a publication of AAEA Agricultural & Applied Economics Association
The Magazine of Food, Farm and Resource Issues

4th Quarter 2009 | 24(4)

RURAL HEALTH INSURANCE AND COMPETITIVE MARKETS: NOT ALWAYS COMPATIBLE?

Keith J. Mueller

Since at least 1992, when the term "managed competition" was used as a buzz phrase in the presidential campaign, federal policy has been aimed toward fostering competition among health insurance plans. But, is there a viable health insurance market in rural areas? The past 20 years of federal policy debates have not answered this question. During 2002-2003 legislative discussions about creating a drug benefit in the Medicare program, for example, the same data were used to show the omnipresence of competing plans in the Federal Employees Health Benefits Program (FEHBP) and the absence of meaningful competition among those plans in remote rural areas. Among the health care reforms proposed in 2009 was the use of health insurance exchanges as agencies through which individuals and small groups can choose to purchase health insurance from among several competing plans. In the past year, members of Congress and the media have spoken about the promise of competition among plans as a means of making health care affordable. As federal policy makers debate how to extend affordable health insurance benefits through a reconstructed market, a new discussion—informed by lessons from previous experiences—of the implications of such changes for rural areas is warranted.

A foundation for understanding the presence or absence of health insurance alternatives is to understand the potential for competing health plans to attract sufficient enrollment to justify their investment into an area. Potential enrollment is a function of the ability of the population to purchase insurance based on the state of the rural economy and the numbers of persons who might enroll in plans based on how rural persons acquire insurance. Return on investment for health plans is also a function of costs, including contract negotiations with local health care providers. Assumptions about programs designed to promote active competition among health plans can be tested through the lessons of the FEHBP and the Medicare program.

Economics of Rural Areas and Affordable Insurance

The economic downturn that began at the end of 2007 has been particularly troublesome in rural areas. Rates of poverty are higher in rural counties, including those that are persistent poverty counties as measured over at least 10 years of census data. In rural areas, 15% of people live in households with less than poverty-level income, compared with 12% of people in urban areas (DeNavas-Walt, Proctor, and Smith, 2008). Although unemployment has risen in rural areas at a pace comparable to that in urban areas, unemployment percentages in rural areas grew to 9.8% as early as February 2009, higher than the urban figure of 8.7%. Increases in unemployment are associated with increases in uninsured, indicating that rates of uninsured are reaching new peaks in all of the United States, but more so in rural areas. As of February 2009, unemployment had risen above 10% in the rural areas of at least 21 states (McBride and Kemper, 2009).

Rural economic circumstances contribute to the absence of an attractive market for health insurance plans and help explain recent increases in rural enrollment into public plans. In summary, insurers who need to aggregate populations for the purpose of creating insurance pools face challenges in rural areas because of higher percentages of unemployment, lower incomes among those who are employed, and sparsely populated areas, particularly when not adjacent to urban areas.

Insurance Status of Rural Residents

While urban and rural rates of uninsurance are similar, in 2004, the rate among rural residents in counties not adjacent to urban areas was higher, 21% among adults between 18 and 65 years old, compared to 19% for urban areas; the rate peaked at 23% among people in counties with population totals less than 2,500 (Lenardson, et al. 2009). Data for the year 2007 show that among households in which farming was the primary occupation of the head of the household, 20% of the nonelderly were uninsured (Jones, et al. 2009). Expansions in public health insurance coverage (Medicaid and the Children's Health Insurance Program) helped close the coverage gap between urban and rural areas from 1997 through 2005 (Ziller and Coburn, 2009).

Rural residents may be insured, but the policies to which they have access are fundamentally different than those available in urban areas. For group plans purchased by employers, the cost is higher for rural businesses. Plans sold to small businesses in rural areas are more likely than those in urban areas to include deductibles (69.2% vs. 42.9%) and to have higher employee-only adjusted premiums ($3,385 vs. $3,178) (Gabel, et al. 2006). Partly because of those costs, private coverage has declined in rural areas over the past decade. As a result, rural workers in remote areas are less likely than urban workers to be employed in places offering health insurance coverage (64% vs. 71%) (Lenardson, et al., 2009). Many rural residents and the businesses employing them purchase health insurance through a local broker. A survey of farmers and ranchers in six states in the upper Midwest found that those buying through a broker spent $5,204 more than the cost of insurance obtained through government programs and $4,359 more than those obtaining insurance through off-farm employment (Pryor, et al. 2007). The net impact of the characteristics of the rural health insurance market for all rural residents is that they spend more of their own money out-of-pocket for health care than do urban residents, 40% vs. 33% (Ziller, Coburn, and Yousefian, 2006).

Insurance plans have historically coped with the special challenges of serving rural areas by designing policies with higher premiums and other out-of-pocket expenses including deductibles and co-payments. Sparsely populated and remote from any urban core areas, and places where employment is primarily through small businesses, can be challenging to health insurance firms. The insurer's financial risks related to the prevalence of chronic conditions and small numbers of persons help drive up the out-of-pocket expenses. In addition, working through local brokers can add to the administrative expense of selling and servicing insurance plans.

The Rural Health Care Delivery System

In many rural areas, the concentration of clinical services into only a few hands contributes to higher-cost health insurance. Rural areas often have only one inpatient acute care hospital, likely to be small. Over 1,300 rural hospitals are certified Critical Access Hospitals, with fewer than 26 acute care beds). There may also be a single physician practice with fewer than six practicing primary care providers. Further, in much of rural America there are not enough providers to keep pace with any growth in demand. Focusing only on primary care, as of 2005 there were 55 physicians per 100,000 residents in rural areas and 72 per 100,000 residents in urban areas. In isolated small rural areas the number drops to 36 (Fordyce, et al. 2007).

While some rural areas have delivery *systems* such as Giesinger Health System in Pennsylvania, Marshfield Clinic and Gundersen Clinic in Wisconsin, and Kaiser Health in the Northwest, much more often, sole rural providers are not linked in any formal way with other rural providers or with urban-based systems. This rural characteristic requires that insurance plans that seek to build networks of providers must work one-by-one with rural providers for whom their plan may represent a small percentage of the total practice. Insurance plans would incur a high administrative overhead for a potentially small market in sparsely populated rural areas.

Lessons Learned from the Federal Employees Health Benefits Program

Policy makers seeking to expand availability of affordable health insurance through market-based reforms can learn from the Federal Employees Health Benefits Program's (FEHBP) experience. The FEHBP offers federal employees a choice of competing health insurance plan options during each open enrollment period. Several national health plans participate in the FEHBP, often with several options within the plan. This wide availability and choice means that federal employees located anywhere in the United States can enroll in any one of a number of different plan options. In 2003, seven national plans offered 12 options, and six more

national plans offered to specific groups—for example, the Secret Service—were available to other federal employees for a fee. All FEHBP plan options are either health maintenance organizations (HMOs) or preferred provider organizations (PPOs). Therefore, all the plans have developed contractual arrangements with health care providers in networks that are then made available to enrollees. Enrollees who receive care outside of those networks have higher out-of-pocket costs.

The FEHBP impact on the health insurance options available to federal employees in rural areas can be measured in two ways. First, enrollment into plans is a signal as to which plans rural residents see as viable options. Enrollment data from 2001 show that six nationwide plans accounted for 87% of rural enrollment, while the same six plans accounted for only 67% of urban enrollment. One plan, Blue Cross/Blue Shield (BC/BS), accounted for 58% of rural enrollment. These six plans have a historical presence throughout America, with state-specific affiliates working through community-based brokers to enroll individuals and small groups as well as develop contracts with local providers. Among federal retirees in rural areas, 90% enrolled in nationwide plans. The number of plan options with enrollment differed considerably between urban and rural areas; 86% of urban counties had 10 or more active options with enrollment, compared to 30% of rural counties. Rural counties have a lower number of plans with active enrollment in part because a limited number of persons eligible for FEHBP enrollment reside in those counties; as of 2001, 35 counties had fewer than 10 enrollees. However, even in counties with much higher numbers of enrollees, enrollment is still concentrated in only a few plans (McBride, et al. 2003b).

Second, the inclusion of local primary care providers in FEHBP plan networks is an indicator of viability of the FEHBP model for establishing competition among insurers for rural enrollment. Although nationwide plans are available to any eligible person, many plans will not have contracts with local providers. If local providers are not included in the plan network, enrollees who want to take full advantage of low out-of-pocket payments would have to travel great distances to the nearest primary care provider who is in the network. For example, a 2003 study reported that in some communities the nearest primary care provider under contract with a plan would be more than 100 miles away. Only one nationwide plan, BC/BS, consistently contracted with local primary care providers in small rural communities (McBride, et al., 2003b).

Given the previous discussion of the characteristics of rural populations, including economic conditions, dispersed populations, and limited number of providers, the FEHBP findings are not surprising. In rural areas, a competitive marketplace among health insurance plans should not be expected.

Lessons Learned from Medicare+Choice

The federal policy discussions in 1992-1993 of managed competition as a platform for systemic health reform were followed in 1995-1997 by a discussion of encouraging competition in the Medicare program as a means of reducing expenditures through efficiencies implemented by private plans. The final report of the Medicare Reform Commission, cochaired by Representative Newt Gingrich (R,GA) and Senator John Breaux (D,LA), supported expanding the use of managed care in the program. Subsequently, in 1997, Congress created the Medicare+Choice (M+C) program and increased monthly per beneficiary payments, including a minimum payment in rural areas, to entice managed care plans to enroll more beneficiaries. In 2003, the M+C program was replaced with the Medicare Advantage (MA) program, and the types of health plans that could contract with Medicare to provide all services to beneficiaries were expanded to include private fee-for-service (PFFS) plans and regional PPOs.

As with the FEHBP, greater plan competition in urban areas was also a characteristic of the M+C and MA programs. The M+C program was established with aspirations that Medicare managed care plans would offer viable alternatives in rural areas, supported in large part by a minimum payment floor from the Medicare program for each enrollee (per member per month or pmpm). In contrast to the FEHPB, expectations for competing plans were much more modest since no pre-existing national plans were marketed in all areas of the country. Instead M+C was based on a foundation created by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which allowed managed care plans to enroll Medicare beneficiaries county-by-county per the plan's chosen market areas. The result of this strategy was that as of August 2001 only 9% of rural counties had M+C plans operating within them, and only 2% had multiple M+C plans (McBride, et al. 2003a).

A report of availability of managed care plans in rural areas using data describing commercial plans in 1999 showed that access to competing plans was more limited than in urban areas. Among rural counties, 21% were served by one plan or no plan, compared to 3% similarly served in urban areas (McBride, et al. 2003a). As the population base of prospective enrollees widens from Medicare beneficiaries or federal employees to

the general population, the likelihood that there would be competing plans would potentially increase. For example, health plans will actively pursue national contracts with large national employers. Those plans would need to be available everywhere there are employees or retirees, even if the plans contract with local providers to pay full charges and they have only a limited number of persons to enroll.

Lessons from Medicare Advantage

As noted, the MA program supplanted the M+C program in 2004 after enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Payment to MA plans was increased to a minimum level in each of three geographic classifications—rural, small urban, and urban. The MA program also allowed for PFFS plans to be treated the same as HMOs and PPOs for payment but did not require them to form provider networks. As might be expected, PFFS plans became the prime vehicle for rural beneficiaries to enroll in MA plans, although the rural enrollment pattern shifted in 2009 from PFFS plans to network plans. However, that shift took place in the context of only 14.5% of rural beneficiaries being enrolled in MA plans as of September 2009, based on data from the RUPRI Center for Rural Health Policy Analysis web site: http://www.unmc.edu/ruprihealth. Rural enrollment has shifted from 51% in HMOs or Point of Service plans and 18% in PFFS plans in December 2005 to 55% in PFFS plans in June 2007, and to 13% in PFFS plans in July 2009, with PPO and other MA plans growing from 1% in 2005 to 17% in July 2009 (Kemper, McBride, and Mueller, 2009). The shift to PPO plans is due in part to a requirement from the Medicare Improvements for Patients and Providers Act of 2008 that PFFS plans develop provider networks by 2011. The national data disguise the fact that the percentage of rural beneficiaries enrolling in MA plans varies considerably by state. As of September 2009, in nine states rural enrollment exceeded 20%, and in 19 states it was less than 10%, based on data from the RUPRI Center for Rural Health Policy Analysis web site, http://www.unmc.edu/ruprihealth.

The MA program has been less troubled than commercial insurers by the challenges of insuring rural Americans. The option for PFFS plans to receive capitated payment from the Medicare program but not be required to establish networks overcame one of the market constraints that in rural areas there may be a concentration of provider access that makes contract negotiation challenging and costly. Payment from Medicare has exceeded historical costs of treating Medicare beneficiaries, making all areas of the United States attractive from the perspective of generating a return on investment. Some of these adjustments to the operational rural market are likely to diminish as the U.S. Congress looks for savings in the Medicare program, such as reducing floor payments. Meanwhile, modest rural enrollment in MA plans is one more indicator of the challenge of relying on market mechanisms to improve access to affordable coverage in rural areas.

Implications for Affordable Rural Health Insurance

Can the rural health insurance market support competing health plans? In much of rural America the short answer is no. Especially in sparsely populated areas of rural America, multiple competing plans would not generate sufficient enrollment of paying clients to sustain the plans. Both the characteristics of the rural population and experiences from programs designed to encourage competing health plans demonstrate the special circumstances that create roadblocks to market competition. Creating affordable options for rural residents requires (1) that there be nonlocal methods for creating larger pools of potential enrollees, and/or (2) that regulation of health plans be combined with a subsidy program, making the limited number of viable plans affordable for rural residents.

One approach to establishing competitive rural markets is to create larger pools by broadening the market area far beyond the county boundaries that cluster into sparsely populated regions, such as frontier counties in western states. The MMA took this approach in establishing a moratorium on county-specific plans and creating single and multi-state regions. PPOs developed during the first three years of MMA implementation were required to offer the same plan, including benefits and premiums, everywhere in a given region. Very little enrollment into regional plans took place, perhaps because plans continued to emphasize increased enrollment in local areas where they already existed rather than expanding into new areas. Within the FEHBP, national plans have captured most of the rural enrollment.

The MMA and FEHBP experiences show the need for a policy that encourages competition among national plans for the rural market. Doing so will require at least these actions.

- First, national plans will need to abide by separate state insurance regulations, as the national plans in the FEHBP do now.
- Second, legislation should establish a rules-of-engagement policy to foster negotiations between insurance plans and local providers. The MMA included such a policy by setting Medicare payments as the floor in any negotiations and allowing the Secretary of Health and Human Services to pay essential hospitals if an MA plan certifies it was unable to reach an agreement. The plan must still pay the Medicare equivalent payment (Mueller, 2004).
- Third, rural residents must receive information about what is available to them from the national plans. A combination of insurance brokers, government agencies such as local health departments and area agencies on aging, and civic organizations can provide access to information through consultations with rural residents. A significant percentage of rural residents would find access to information through the Internet adequate to make their choices, but others would need guidance.

A second approach to meeting the challenges of the rural market is to regulate insurance plan offerings to ensure they are affordable to rural residents and to subsidize insurance companies to offset the costs of developing and maintaining insurance plans in sparsely populated, low-income rural areas. Two lessons from Medicare policy are relevant. First, a floor payment creates opportunities for health plans to enter counties with lower enrollment numbers and hence higher per person administrative costs because the payment per enrollee exceeds historic levels. Second, enrollment campaigns for Medicare Part D have enlisted help from multiple "partners," including local civic organizations such as Knights of Columbus clubs and local churches. The regulations would need to include policies introduced in health reform legislation in 2009, for example, prohibiting use of pre-existing conditions in denying coverage in plan design, guaranteeing issue, guaranteeing renewability, and restricting rating practices. In exchange, insurance plans would need to be assured of as large a market pool as possible, most likely by mandating individual purchase of insurance, either as an individual or through a group.

In conclusion, competition and the rural health insurance market need not be incompatible. Rather, a market in all of rural America would need to be one of managed competition, with a role for government in setting regulatory policy and guaranteeing affordability for the purchaser and profitability for the health plan.

For More Information

DeNavas-Walt, C., Proctor, B. D., and Smith, J. C. (2008, August). *Income, poverty, and health insurance coverage in the United States: 2007* (P60-235). Washington, D.C.: U.S. Census Bureau.

Fordyce, M. A., Chen, F. M., Doescher, M. P., and Hart, L. G. (2007). *2005 physician supply and distribution in rural areas of the United States* (Final Report #116). Seattle, Wash.: WWAMI Rural Health Research Center, University of Washington.

Gabel, J., McDevitt, R., Gandolfo, L., Pickreign, J., Hawkins, S., and Fahlman, C. (2006). Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down. *Health Affairs, 25*(3), 831-843.

Jones, C. A., Parker, T. S., Ahearn, M., Mishra, A. K., and Variyam, J. N. (2009, August). *Health status and health care access of farm and rural populations* (ERS Report Summary). Washington, D.C.: U.S. Department of Agriculture, Economic Research Service.

Lenardson, J., Ziller, E., Coburn, A., and Anderson, N. (2009, July) Health insurance profile indicates need for reform in rural areas (Research & Policy Brief). Portland Maine: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

Kemper, L., McBride, T. D., and Mueller, K. (2009, August). *July 2009: Rural enrollment in Medicare Advantage continues to grow* (Brief No. 2009-8). Omaha, Neb.: University of Nebraska Medical Center, RUPRI Center for Rural Health Policy Analysis.

McBride, T., Andrews, C., Mueller, K., and Shambaugh-Miller, M. (2003a, March). *An analysis of availability of Medicare+Choice, commercial HMO, and FEHBP plans in rural areas: Implications for Medicare reform* (Rural Policy Brief PB2003-5). Omaha, Neb.: University of Nebraska Medical Center, RUPRI Center for Rural

Health Policy Analysis.

McBride, T., and Kemper, L. (2009, June). *Impact of the recession on rural America: Rising unemployment leading to more uninsured in 2009* (Rural Policy Brief 2009-6). Omaha, Neb.: University of Nebraska Medical Center, RUPRI Center for Rural Health Policy Analysis.

McBride, T., Mueller, K., Andrews, C., Xu, L., and Fraser, R. (2003b, July). *Enrollment in FEHBP plans in rural America: What are the implications for Medicare reform?* (Rural Policy Brief PB2003-8). Omaha, Neb.: University of Nebraska Medical Center, RUPRI Center for Rural Health Policy Analysis.

Mueller, K. J. (2004, January). *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173): A summary of provisions important to rural health care delivery* (Policy Paper P2004-1). Omaha, Neb.: University of Nebraska Medical Center, RUPRI Center for Rural Health Policy Analysis.

Pryor, C., Prottas, J., Lottero, B., Rukavina, M., and Knudson, A. (2007, December). *How farmers and ranchers get health insurance and what they spend for health care* (Issue Brief No. 2). Boston, Mass.: The Access Project.

Ziller, E., and Coburn, A. (2009, February). *Rural coverage gaps decline following public health insurance expansions* (Research & Policy Brief). Portland Maine: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center.

Ziller, E. C., Coburn, A. F., and Yousefian, A. E. (2006, November/December). Out-of-pocket health spending and the rural undersinsured. *Health Affairs, 25*(6), 1688-1699.

Keith J. Mueller (kmueller@unmc.edu) is Professor, Department of Health Services Research and Administration, and director, Rural Policy Research Institute Center for Rural Health Policy Analysis, University of Nebraska Medical Center, Omaha, Neb.

The author thanks the anonymous reviewers for their comments and suggestions and Sue Nardie for editing the manuscript.