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FARMER HEALTH INSURANCE COOPERATIVES: AN INNOVATIVE SOLUTION FOR OTHER AMERICANS?

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The national debate on health care reform focuses on making the private insurance market more socially efficient by reducing the number of uninsured. At the time of this writing, it is uncertain what national health insurance reform may be enacted—be it implementing a public plan option provided by a National Health Insurance Exchange, expanding Medicare and Medicaid to cover larger segments of the population, or mandating health insurance. Thrown into this mix of options is the cooperative provision of health insurance. To inform this discussion, we review the previous problems Wisconsin dairy farmers had in accessing affordable health care—leading to the formation of the Farmers' Health Cooperative of Wisconsin (FHCW).

While many farmers operating in remote rural areas may have limited access to health care practitioners, a more fundamental problem is access to affordable health insurance. Although today's farmers do not fall into the conventional categories of disadvantaged groups, the occupational hazards of farming make them an at-risk group that drives health insurance premiums to levels that exceed their willingness and ability to pay. Because farmers traditionally enter the health insurance market as individual purchasers and not part of larger pools, their burden of health care costs is substantially higher. Even if they make informed choices, farmers may face higher premiums and lower coverage than other individuals with comparable health characteristics.

In Wisconsin and many other states, the rich tradition of agricultural cooperatives provides a significant potential for health care delivery. Instead of transacting as high-risk individuals for health insurance, farmers can increase their bargaining power by forming a health insurance cooperative to purchase affordable group health insurance. The impetus behind the formation of Farmers' Health Cooperative of Wisconsin (FHCW) is simply that collective bargaining increases purchasing power—farmers can get health care coverage for a better value than buying it on their own. By pooling farmer interests and using the existing regulatory environment to form cooperatives we describe how farmers were able to improve upon their existing market choices of health care coverage. But, can lessons be learned from this experience about the viability of the cooperative option for other underserved segments of the population?

The Farmers Insurance Problem

With incomes and assets well above the U.S. household average, farmers do not typically belong to an economically vulnerable group and health insurance coverage is higher among farm households compared to other U.S. households (Jones, et. al., 2009). Still, as with any small business enterprise, health care costs remain a serious challenge because as a group farmers do not have adequate coverage. For instance, even though 95 % of all surveyed farm households studied in seven Mid-western states had health insurance, 23% reported financial hardship—resulting from health care expenditures exceeding 10% of monthly income (Pryor, et. al., 2008). In Wisconsin, a study of dairy farmers found that one in five farmers were uninsured. The same study also reported out-of-pocket health care expenses as a predominant cause for exiting farming. Dairy farmers with insurance reported that farm-related injuries and other chronic conditions were often not covered by the insurance they held at the time (Wisconsin Family Farm Facts, 2002 and Todd, 2007). This is because many farmers with health insurance have only major medical and catastrophic

coverage.

Like most small business owners, farmers have three choices in purchasing health insurance: they can buy insurance in the small group market, in individual insurance markets, or through off-farm employment. Each alternative poses problems. The small group insurance market is highly regulated in the United States. For instance, in Wisconsin, rating restrictions prevent premiums variations greater than 30% from the midpoint for policies issued by the insurer to the typical person in the pool. Wisconsin regulations also require insurers to provide coverage for pre-existing conditions, although it can be priced differently (OCI, 2009).

Typically farmers are priced at the high end of the rate band due to their de facto risk characterization. In this environment younger farm employees typically choose not to enroll in insurance plans with the farmer and buy insurance elsewhere or not at all. This means farmer-employers lose bargaining power because they have a pool comprised only of family members and older employees. Thus they are presented with the difficult choice of risking health and forgoing insurance for some or all family members, or purchasing insurance with extremely high deductibles and limited coverage. Furthermore, family farms without employees have to compete in the more expensive individual insurance market.

A vast majority of farmers buy health insurance in the individual market, if they buy at all. The choices available in terms of prices or coverage are very limited. Unlike small group markets, health insurance options within individual market are subject to fewer regulations. Insurance contracts are underwritten per risk factor and are customized to each farmer's risk attributes. Farmers can also be denied coverage, have pre-existing conditions clauses, and face unreasonably high deductibles and/or co-pay requirements. Again, sick and older farmers are more likely to bear the brunt of high health care costs. The 2002 edition of Wisconsin Family Farm Facts reported that over half of Wisconsin dairy farmers 55 or older were underinsured.

The last option available and used by the vast majority of farmers who have health insurance is coverage through off-farm employment, often through a member of the farm family (Wisconsin Family Farm Facts, 2002 and Pryor, et. al., 2008). The difficulty for many farmers, however, is access to those off-farm jobs. For many rural communities, employment opportunities, particularly opportunities that provide adequate health insurance benefits, are hard to come by. Losing family members to off-farm employment for health insurance purposes also means depletion of skilled labor for farm operations. Even though the initial intent for seeking off-farm labor is to keep the family farm intact, the loss of labor can have the effect of weakening the commitment to keep the farm and increasing the likelihood of closing family farms.

The 2002 study of Wisconsin dairy farmers showed that even when farmers had access to health insurance, 58% reported carrying only major medical policies with \$500 deductibles (Wisconsin Family Farm Facts, 2002). Only one out of every four fully insured farmers reported having any preventive care. This means farmers either neglected getting routine care—increasing the likelihood of future major medical expenses—or paid for preventive care out of pocket. Furthermore, because many farm-related injuries are not covered by insurance, farmers have to absorb both the cost of medical bills due to the injury as well as lost income. Most farm workers do not qualify for worker compensation.

The Cooperative Organizational Form

A health insurance cooperative differs from other organizational forms in that owners of the firm are the insurance consumers. This means two separate economic interests, business decisions—aimed at profit making, solvency, monitoring management among others--and consumption decisions--such as standardization of plans, coverage options and services desired--are condensed in a single stakeholder group. The consolidation of interests can create benefits for insurance consumers.

Collectively bargaining as owners, consumers can voice their preferences on type of coverage, choice of standardized insurance plans, and stabilizing premiums. Because of the size of the bargaining unit, even in the presence of risk rating, consumers-owners may face better premiums as compared to the individual market, for a given risk category. In this sense consumer-ownership removes the social cost of under consumption and extends the market to include high-risk people who otherwise get priced out of the market. Increased size of bargaining unit and cohesive preferences for insurance can widen choice in coverage and plans available to the patron owners. This can be a significant market benefit. Evidence suggests that administrative cost burdens severely restrict consumer choice in health plans in the individual and small

group (Wicks, 2002).

Cooperatives require a critical mass of consumers for insurers to be willing to insure them. Sociologists and psychologists have long argued that group identity can significantly alter economic decisions; ownership and common bond can make a consumer feel like an insider and create enough incentives to prevent the pool from unraveling. Being an insider can also deter ex-post moral hazard by providing incentives to prevent risky or costly behavior. As owners, the board can collectively monitor and combat over utilization by changing the benefit plan designs. Cohesion of interests can serve as an effective tool to reduce risky behavior. For example, I am less likely to operate a chain saw under the influence of alcohol if my neighbor farmer who is also a member of the cooperative is watching me.

While size of the bargaining unit and ownership have the potential to improve upon market outcomes, close proximity of consumer-owners to the board and management may hinder best business practices. For example, a well-meaning consumer board may try to accommodate too many disparate consumer interests, jeopardizing pool stability and leading to pool disintegration.

There are many examples of Health Insurance Purchasing Cooperatives (HIPCs) that have failed because of small pool sizes, inability to contain administrative costs and difficulty in attracting insurers. A single bad year with many claims can expose the cooperative to the “death spiral” where healthy people start leaving (Hall, Wicks and Lawler, 2001). Other examples of failed cooperatives include the Family Health Plan Cooperative in Wisconsin, which wrote health maintenance plans for more than 70,000 enrollees but exercised bad management practices, resulting in the cooperative failing (OCI, 1997).

Farmers’ Health Cooperative of Wisconsin

Because of the rich tradition of agricultural cooperatives in Wisconsin, particularly within the dairy sector, farmers came together with the Cooperative Network to advocate legislation that would permit farmers to form cooperatives for health care purposes. The result was the Farmers’ Health Cooperative of Wisconsin (FHCW). It provides an informative case study in the context of the current health care reform debates.

The legislation focused on increasing farmers bargaining power, given their unique insurance needs and their risk characteristics, so that collectively they could negotiate better insurance contracts than on their own. In 2003, Coop Care, the state legislation under Wisconsin statutes section 185.99, authorized the formation of HIPCs and allows them to buy insurance, under rules that apply to the large-group insurance market, from licensed insurers for their member employers and farmer households. Cooperatives that form under Coop Care do not have the authorization to act as insurers. The state of Wisconsin has a separate statute for cooperatives to act as insurers that subject them to state insurance regulations.

Since farmers are considered a high-risk group, the credibility of the cooperative hinged on the Federal appropriation of \$ 4.45 million, through the United States Department of Agriculture, for startup administrative costs and an initial stop-loss fund. In 2007 the FHCW bargained and formulated an insurance scheme tailored to meet farmers’ needs at more reasonable prices through ATENA (ANTHEM, starting January 2010) Insurance.

All Wisconsin farmers between the ages of 18-64 with 66% of their income derived from farming activities are eligible to become members of FHCW including individual farmers, farm households, farm employees, and larger farmer/agribusinesses. At present, FHCW provides insurance for 1,146 households with approximately 2,600 individuals covered. The cooperative offers six different plans with initial underwriting that establishes differential rates across members. This allows some flexibility in crafting policies that are specific to each person’s risk characteristics and needs.

The cooperative insurance plans have the following features: guaranteed issue—all farmers meeting eligibility criteria can purchase insurance through the cooperative, coverage for work related injuries—the plan also covers work related injury not covered by worker compensation benefit and provides up to \$2000, per member and per accident, to cover out-of-pocket medical costs resulting from accidents; preventive care coverage up to \$ 500; prescription drug coverage; maternity coverage; and mental health coverage.

The FHCW is still in its formative stage, and, hence, it is too soon to predict whether it will succeed.

Anecdotal evidence, however, suggests that farmers belonging to the cooperative are pleased with the health insurance scheme.

Preliminary Evidence of Improved Market Outcomes

Because of guaranteed issue, even those farmers with pre-existing conditions, meeting the eligibility requirement, can purchase insurance. This is a marked improvement from the individual market where insurers can deny coverage. The cooperative has extended the insurance market to include approximately 200, or 8% of current members, previously uninsured farmers. Clearly, guaranteed issue can be a double-edged sword; it can attract higher risk consumers to the more generous coverage thus making the pool vulnerable to unraveling. FHCW has increased its membership by 146 since opening its doors to 1000 member households.

The best improvements, according to anecdotal evidence, are in the form of improved insurance coverage and choice in plans and providers. Many farmers claim that for the first time they have access to 24-hour nurse line, preventive care, a choice among plans, and freedom to choose from different health care providers. FHCW provides the state-mandated package with maternity care and mental health. In the individual market, maternity coverage is generally purchased as a rider, which can add \$1000 annually to premiums. Furthermore, the Federal Mental Parity Law does not apply to individual markets so mental health coverage, if offered at all, is extremely limited.

Since Wisconsin dairy farmers are already entrenched in the culture of cooperative business structures they are less likely to leave the health insurance cooperative for marginal improvements outside the cooperative. The benefits of ownership stake, improved product choice, product quality and requiring a three-year commitment must outweigh healthy farmers' outside options—with perhaps less generous coverage—to prevent the pool from unraveling.

This said, given the risk characteristics of the pool, guaranteed issue, and historical evidence of HIPC failure, it is likely that some government intervention will be needed to keep the cooperative viable. The \$4.45 million stop loss fund buffers the cooperative against an extremely bad claims year.

Future Potential for Health Insurance Cooperatives

The FHCW provides insights into the expandability of cooperatives to cover farmer groups in other states, or small businesses and the self-employed. Advantages of the cooperative model include the following:

1. Collective bargaining can improve choice in plans and standardizes coverage giving consumers a better value at competitive rates.
2. Strong common insider identity can act as a commitment device to prevent pool disintegration.
3. Insider identity and ownership stake can provide better incentives to reduce ex-post moral hazard—stabilizing premium increases for the consumer-owners.
4. To the extent there is imperfect competition in the market for health insurance, consumer ownership might lead to a pro-competitive effect of enhanced coverage and quality.
5. Inside information and participatory governance can create incentives for monitoring management and leveraging bargaining power.

Since the inception of Coop Care many other bargaining cooperatives have formed in Wisconsin. For example, Healthy Lifestyles Cooperative currently includes 120 small employers and 3,600 individuals and Physicians Health Cooperative includes members of the Wisconsin Medical Society.

Still, the cooperative business model does not solve adverse selection problems. Guaranteed issue to include all risk types, a desired social optimum, tends to attract a higher ratio of unhealthy people. If the healthy people do not value ownership and insider identity sufficiently to forego outside options, like all other private insurers in the small group and individual market, providers need to write insurance contracts that are less attractive to the high claimants. In such an instance cooperatives will not be able to keep health care costs low. Cooperatives are not good institutional solutions for a group comprised entirely of high-risk users such as the elderly or dialysis patients. Cooperatives rely on critical pool size and a high ratio of healthy

people in their group to effectively provide insurance.

Cooperatives may not be the best market intervention for the very poor if the negotiated premiums are too high and exceeds their willingness and/or ability to pay. In this case the government would need to intervene and subsidize the cooperative negotiated premium. Thus, cooperatives can be a potential solution to the health care crisis but cannot be the entire solution; they are not a “magic bullet”. Government subsidies are still required to achieve the socially desirable outcome of insuring the poor or the sick. Governments have a critical role to play if HIPC are to be part of any reform package—as an arms length reinsurer for unforeseen high claims years or a subsidizer of high risk claimants.

Figure 1: Health Insurance Cooperatives

<u>Can</u>	<u>Cannot</u>
Increase the size of the bargaining unit.	Solve adverse selection problems.
Standardize health insurance plans.	Guarantee pool stability if there are too many high claimants—need government as an arms length reinsurer.
Insider identity as owners can increase pool stability.	Bargain better premiums for the really poor or the really sick.
Mitigate ex-post moral hazard and reduce over-utilization.	

For More Information

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