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Can Payment Policies Attract M+C Plans to Rural Areas?

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INTRODUCTION

The Balanced Budget Act of 1997 (BBA) (Public Law 105-33), the Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, & SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) increased Medicare payment rates to encourage managed care plans to offer products in areas that previously had low rates. Despite the higher payments, availability of managed care for rural Medicare beneficiaries remains modest at best: 201,655 rural beneficiaries were enrolled as of October 2000. This policy brief presents information to help policymakers understand some of the factors that discourage insurance plans from offering Medicare managed care plans in non-metropolitan counties.

BBA, BBRA, and (BIPA) EFFECTS ON RURAL MEDICARE MANAGED CARE ENROLLMENT

Before passage of the BBA, few nonmetropolitan counties had Medicare+Choice (M+C) plans available. Only 3% of rural counties not adjacent to a metropolitan county and 20% of rural counties adjacent to metropolitan counties had M+C plans available in 1996 compared to 95% and 45% in central metropolitan and other metropolitan counties respectively.

Balanced budget legislation in 1997 (BBA), 1999 (BBRA), and 2000 (BIPA) created financial incentives to offer M+C plans in rural counties:

- floor payments of $367 (BBA);
- 5% first year, 3% second year bonuses to enter previously unserved markets (BBRA);
- floors of $525 in large urban, and $475 in all other counties (BIPA); and
- extension of bonus payments to include counties from which M+C plans recently withdrew (BIPA).[1,2]

Table 1, columns 2 and 4, show the availability of M+C plans in nonmetropolitan counties from 1997 to 2000. In 1997, 22.5% of rural counties adjacent to a metropolitan county had an M+C plan available, but availability decreased 20.5% by 2000. Approximately 4% of rural counties not adjacent to metropolitan counties had plans

available in 1997 compared to 4.2% in 2000. These data suggest the BBA and the BBRA have not had the desired policy effect of dramatically increasing the availability of M+C plans in rural counties, and changes in BIPA may also have only a limited effect. What accounts for the minimal response to M+C?

FACTORS AFFECTING THE AVAILABILITY OF M+C PLANS

Although the rate of payment from Medicare to M+C plans is a factor affecting the availability of M+C plans, other county and market characteristics are important factors affecting Medicare managed care enrollment. Counties with a higher probability of any Medicare HMO enrollment were those with higher AAPCC rates, more commercial managed care enrollment, a larger Medicare population, and a larger population of "young-old" people in the county.[3]

These empirical results are used to simulate the effect of the BBA and BBRA on M+C plan availability in nonmetropolitan counties. As shown in the simulation results on Table 1, columns 3 and 5, the model suggests that changes in payment rates implemented with the BBA (and altered slightly later in the BBRA) would have been expected to have little impact on the availability of M+C plans in nonmetropolitan counties. The simulations indicate that despite the payment rate changes, availability of plans would not change appreciably between 1997 and 2000, increasing from 19 to 20 percent of nonmetropolitan counties adjacent to a metropolitan county. In nonmetropolitan counties not adjacent to a metropolitan county the effect would be a small increase from 3 to 4 percent from 1997 to 2000. Simulations for 2001, which incorporate the rates as changed by BIPA, show very little additional availability will result; only a 4 percentage point increase for rural adjacent areas, and a 1 percentage point increase for non-adjacent rural areas.

Table 1. Actual and simulated availability of M+C plans in nonmetropolitan counties, 1997-2000 [a]

Year	Nonmetro Adjacent [b]		Nonmetro Nonadjacent [b]	
	Actual	Simulated	Actual	Simulated
1997	22.5	19	3.9	3
1998	27.8	20	5.4	4
1999	24	19	5.5	4
2000	20.5	20	4.2	4

SOURCE: RUPRI Center for Rural Health Policy Analysis: Analysis of Medicare+Choice enrollment.

NOTES:

[a] A county has an M+C plan available if there is at least one enrollee and that county is in the service area of the plan.

[b] Percent of counties with M+C plans available

A comparison of these simulations (columns labeled "Simulated") with the actual experience for the M+C program (columns labeled "Actual") indicates that this model is a reasonably accurate prediction of the impact of the payment rate changes. Thus, the model can be used to answer the question: *Why do payment increases have such modest effects on the supply of M+C plans in rural areas?*

The simulation analysis shows that Medicare managed care enrollment is determined not only by payment from Medicare, but by other factors. In particular, the amount of non-Medicare HMO enrollment has a larger effect on Medicare HMO enrollment than payment rates. Our model shows that a $100 increase in the monthly payment rate would lead, all else equal, to an increase in enrollment of only 2.2 percentage points. However, an increase in commercial HMO enrollment of 10 percentage points would increase enrollment by 4.8 percentage points.

Another way to demonstrate this point is to compute how high the payment rate would have to be, given the characteristics of nonmetropolitan counties (such as the level of commercial managed care enrollment, the number of Medicare eligibles), to attract Medicare managed care plans. Given existing measures of all other variables, only

about 20% of nonmetropolitan counties adjacent to a metropolitan county can be expected to have M+C plans available if the M+C rate is about $406. For nonmetropolitan counties not adjacent to a metropolitan county, the M+C payment rate would have to be about $532 to attract plans to 10% of counties. The floor payment in 2000 was in fact $401.61 and about 6.2% of counties had plans available. Thus, the simulation provides an accurate prediction of plan availability.

The results shown in Table 2 illustrate dramatically how the other conditions in rural areas are not conducive to the development of M+C plans. For instance, in counties with commercial HMO enrollment of 10%, the payment rate would have to reach $722 before M+C availability would be expected to reach 10% of rural counties. In contrast, in counties with 40% commercial HMO enrollment, an M+C payment rate of only $189 would stimulate M+C availability in 10% of rural counties, and M+C payment rates of $467 would stimulate availability in 40% of nonmetropolitan counties with 40% of their population in commercial HMOs.

Rural areas with limited non-Medicare managed care enrollment may not be attractive to plans when they consider expansion into non-metropolitan areas. Similarly, Medicare managed care enrollment will be much lower, all else equal, in rural areas with a very low population of Medicare eligibles and Medicare payment policy is not going to affect the population in rural areas.

These results suggest why the M+C program has not reached the vast majority of rural residents in the years following the passage of the legislation. In particular, there has been little enrollment in commercial managed care plans in these counties. Other characteristics of rural areas are also not favorable to the development of Medicare managed care. As shown in Table 2, counties with very low population, low incomes, high poverty rates, and an older population base are not attractive areas for M+C plans.

POLICY IMPLICATIONS

There are some rural counties where the payment rate needed to attract managed care plans will be much higher than what legislators would be willing to pay to encourage firms to expand to previously low payment areas with unfavorable county characteristics. In light of the market characteristics of rural counties, what policy levers other than payment rates are available to policymakers interested in giving rural beneficiaries access to the same benefits as urban beneficiaries?

- Combine counties into service areas for purposes of M+C payment such that the service area has more favorable market characteristics from the point of view of managed care plans.
- Follow the suggestion of the Medicare Payment Advisory Commission to use risk-adjusted fee-for-service (FFS) payment and abandon geographically-based M+C payment rates.
- Accept that traditional FFS Medicare will be the only option for many rural beneficiaries and turn the focus towards equity in FFS payment policies and expansion of Medicare benefits offered through the FFS program.

Endnotes

1 Rural Policy Research Institute. (1997). Rural implications of the Balanced Budget Act of 1997. (Paper No. P97-10). Columbia, Missouri: Keith Mueller. http://www.rupri.org/

2 Rural Policy Research Institute. (1999). Rural implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999. (Paper No. P99-11). Columbia, Missouri: Keith Mueller. http://www.rupri.org/

3 Penrod, J.D., McBride, T. D., & Mueller, K. J. (2001). Geographic variation in determinants of Medicare managed care enrollment. Health Services Research.

Table 2. Payment rate needed to stimulate Medicare+Choice plan availability in nonmetropolitan counties (in 2000 dollars)[a]

	Proportion of counties likely to have M+C plans available								
	10%	20%	30%	40%	50%	60%	70%	80%	90%
Using means for rural counties	$425	$544	$630	$704	$772	$841	$914	$1,000	$1,119
All characteristics set at rural mean except for:									
Rural Adjacent	$287	$406	$492	$566	$634	$703	$776	$862	$981
Rural Nonadjacent	$532	$652	$738	$811	$880	$948	$1,022	$1,108	$1,227
Percent in HMOs=10%	$722	$841	$927	$1,001	$1,069	$1,138	$1,211	$1,297	$1,416
Percent in HMOs=40%	$189	$308	$394	$467	$536	$605	$678	$764	$883
Percent in HMOs=10% Percent Other Managed Care=25%	$845	$964	$1,050	$1,123	$1,192	$1,260	$1,334	$1,420	$1,539
Percent in HMOs=30%, Percent Other Managed Care=50%	$292	$411	$497	$571	$639	$708	$781	$867	$986
Medicare eligibles=1,000	$488	$607	$693	$766	$835	$903	$977	$1,063	$1,182
Medicare eligibles=7,500	$452	$571	$657	$730	$799	$867	$941	$1,027	$1,146
Income per capita=10,500	$476	$595	$681	$754	$823	$892	$965	$1,051	$1,170
Income per capita=25,500	$372	$492	$578	$651	$720	$788	$862	$948	$1,067
Poverty rate=5%	$376	$496	$581	$655	$723	$792	$866	$951	$1,071
Poverty rate=25%	$497	$616	$702	$775	$844	$912	$986	$1,072	$1,191
Age 65-74=50%	$543	$662	$748	$822	$890	$959	$1,032	$1,118	$1,237
Age 65-74=65%	$336	$455	$541	$614	$683	$751	$825	$911	$1,030

SOURCE: RUPRI Center for Rural Health Policy Analysis: Analysis of Medicare+Choice enrollment.

NOTE: [a] Adjusted to 2000 dollars using growth in Medicare spending over the 1997-2000 period – the growth rate used to adjust Medicare+Choice payment rates.