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An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans through September 2001

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Since passage of the Balanced Budget Act of 1997 (BBA), enrollment in Medicare+Choice (M+C) plans in all counties increased from 5.2 million persons in September 1997 to a peak of 6.3 million persons in September 1999, then declined to 5.6 million persons by September 2001 (based on aggregate enrollment data posted on the Centers for Medicare and Medicaid Services [CMS] web site: http://www.hcfa.gov/stats/mmcc.htm). In addition, the number of risk contracts has dropped from a peak of 347 contracts in September 1998 to 179 contracts in October 2001, in part reflecting the exit of some plans that occurred during the 1999-2001 period (to be discussed later). Data[1] in this *Brief* describe: (1) enrollment in rural counties through September 2001, the most recent county-specific data available,[2] and (2) plan entry and exit through January 2002.

I. MEDICARE+CHOICE ENROLLMENT IN RURAL COUNTIES

While enrollment in M+C by Medicare beneficiaries has increased considerably in recent years, it remains quite low in rural areas.

Total Number and Percent of Enrollment

As of September 2001:

- 150,648 (1.6%) rural Medicare beneficiaries were enrolled in M+C plans (Figure 1). This is a considerable drop from October 2000 when 201,655 (2.1%) of rural Medicare beneficiaries were enrolled in M+C plans.
- In urban areas, 17.7% of Medicare beneficiaries were enrolled in M+C plans, a decrease of 2.1 percentage points from October 2000.

[1]Source: The RUPRI Medicare County Capitation File. RUPRI Center for Rural Health Policy Analysis.

[2]Note that throughout this Brief enrollment will be reported for the most part for the months of September or October, because enrollment counts at the beginning or the end of calendar years are less stable.

From September 1997 to September 2001:

- Total rural enrollment dropped from 173,359 beneficiaries (1.9%) to 150,648 (1.6%).
- Urban enrollment grew from 4,836,100 (16.5%) to 5,410,409 (17.7%).

Enrollment in all rural counties has fallen since 1999. Enrollment in rural counties not adjacent to an urban area was lower in October 2000 than it was in September 1997, while enrollment in rural counties adjacent to an urban area increased from September 1997 to October 2000. These trends reflect, in part, the exit of M+C plans that occurred in 1999 and 2000.

Enrollment by Region

Map 1 displays the enrollment in M+C plans across the U.S. and shows that in September 2001 M+C enrollment in rural counties was:

- highest in the Northwest region (5.1%);
- relatively high in the West (3.6%); and
- lowest in the Midwest (0.5%) and South (0.9%).

Enrollment by County

Table 1 shows the trend in M+C enrollment by county for the period 1997 through 2001, and it shows that in September 2001:

- 7.7% of all rural counties had M+C enrollees;
- 5.7% of all rural counties had 100 or more enrollees; and
- 1.7% of all rural counties had 1,000 or more enrollees.

These figures are in stark contrast to much broader M+C coverage in urban counties (see Table 1). Table 1 also shows that the percent of rural counties with M+C enrollees decreased in 2000 and 2001, as compared to the 1997-1999 period when the percent of rural counties with enrollment was increasing.

Of the 179 M+C plans in existence in 2001:

- 110 plans had rural enrollees;
- 72 plans had 100 or more rural enrollees; and
- only 40 plans had 1,000 or more rural enrollees.

Enrollment by State

In September 2001:

- 40 states had rural Medicare beneficiaries enrolled in M+C plans;
- rural M+C enrollment exceeded 1,000 beneficiaries in only 22 states;

- rural M+C enrollment was greatest in Pennsylvania (38,240 enrollees), Washington (15,185), and Oregon (13,269); and
- 10 states had no rural M+C enrollees (Alaska, Iowa, Mississippi, Montana, New Hampshire, North Dakota, Nebraska, South Carolina, Vermont, and Wyoming).

Enrollment Growth by Payment Rate

The payment reforms in the BBA were designed in part to spur enrollment growth in the counties that previously had the lowest M+C capitation rates. Map 2 shows how the enrollment changes have tracked the changes in payment rates. As expected, therefore:

- the average annual growth rate in enrollment from 1997 to 2001 has been greater in counties at the high floor ($525), where enrollment has grown from 1,111,061 to 1,280,562; and
- in counties with rates below the high floor, enrollment has actually declined in the 1998-2001 period, by 36% in counties at the low floor ($475) and 20% in counties between the low and high floor ($476-$524).

Prescription Drug Benefits

Much attention has been paid recently to the lack of prescription drug coverage for Medicare recipients under the traditional Medicare program. One advantage of some M+C plans over time has been that they offer some prescription drug coverage. The Medicare Compare database (http://www.medicare.gov/mgcompare/home.asp) shows that M+C plans offer prescription drug benefits in 573 counties. However, Table 2 shows that there is huge disparity in the availability of these benefits – prescription drug coverage is much more likely to be offered in central urban counties (69%) than in rural adjacent (13%) or rural nonadjacent (8%) counties.

II. ENTRY INTO AND EXIT FROM THE MEDICARE+CHOICE PROGRAM

Entry Into Medicare+Choice

The most prolific entry into M+C is that of the Sterling Life Insurance Company. Sterling entered M+C in July 2000, targeting rural enrollees, and by February 2001 had 10,098 enrollees. As of August 2001 Sterling:

- was operating in 1,617 counties (1,288 were rural counties) and 1,370 of these counties were floor counties (425 “low floor” counties with rates of $425 and 1,945 “high floor” counties with rates of $525);
- had 13,864 enrollees, of which 4,070 (29.4%) were rural enrollees; and
- was servicing a total of 24 states.

Although Sterling showed a 37% growth in enrollment from February 2001 to August 2001, it is important to remember that Sterling does not operate as a traditional M+C health maintenance organization plan, and its benefits are more consistent with a Medigap plan. In addition, Sterling’s enrollment is still only a small fraction (0.7%) of the beneficiaries that exist in the areas in which they serve.

Exits From Medicare+Choice

A considerable number of M+C plans either dropped out of Medicare completely or reduced their service areas in 1999 through early 2001. The Health Care Financing Administration (HCFA) reported that:

- in 1999, about 100 plan exits occurred, affecting about 407,000 M+C enrollees, in about 100 plans, in 372 counties (HCFA, 1998);
- in 2000, another 99 plan exits occurred, affecting about 327,000 M+C enrollees in 329 counties (HCFA, 1999a; HCFA, 1999b); and
- in 2001, 65 more plan exits occurred, affecting about 934,000 M+C enrollees in 464 counties, representing about 15% of the 6.2 million people enrolled in M+C plans at that time (HCFA, 2000).

Exits from M+C continue into 2002. According to CMS, 54 plans exited in early 2002, affecting about 536,469 enrollees in 293 counties (CMS, 2001). Of the 293 counties affected by exiting plans, 120 are rural counties, and 165 are counties where there is no remaining M+C plan. The previously mentioned Sterling plan, operating in many rural counties, is exiting from 88 counties, accounting for 25% of the county exits; however, only a small portion of the enrollees affected by exits are Sterling enrollees (2,521 enrollees out of over 500,000 total). The plan with the greatest impact on enrollees is Aetna US Healthcare, which will affect 98,947 enrollees (CMS, 2001).

Rural Enrollees Affected by Medicare+Choice Exits

Exits from M+C plans have impacted approximately:

- 47,600 rural enrollees in 1999;
- an additional 79,000 rural enrollees in 2000;
- an additional 65,200 rural enrollees in 2001; and
- an additional 17,200 rural enrollees in 2002.

In the 1999-2001 period, exits disproportionately affected rural beneficiaries. While only about 3.7% of M+C enrollees lived in rural areas, a much larger proportion of rural persons were affected by exits in the 1999-2001 period: 14% in 1999, 12% in 2000, and 7% in 2001. Only in 2002 did the exits seem to fall proportionately on rural residents, when 3.5% of persons affected by exits were from rural areas. It is important to note that of the rural residents who have lost their plan, many have not had access to other M+C plans–over 13,000 enrollees in 50 counties in 1999; 27,000 enrollees in 65 counties in 2000; and about 44,000 enrollees in 2001.

New Plans in Rural Areas

Since passage of the BBA, 44 new M+C plans have been created that enrolled at least some rural residents between January 1998 and October 2000. Twenty-three of these plans had enrollees in October 2000, and these plans had a total of 18,780 enrollees. Six plans had more than 1,000 enrollees. These figures do not include the M+C plan created by the Sterling Life Insurance Company in July 2000, which had few enrollees as of October 2000. This plan is targeted at rural residents and had over 13,000 enrollees by

October 2001, as indicated above. However, other plans had significant rural enrollment: Central Oregon Independent Health Services Plan, Bend, Oregon; Gunderson Lutheran Health Plan, LaCrosse, Wisconsin; America's Health Choice Medical Plan, Vero Beach, Florida; Medspan Health Options Plan, Hartford, Connecticut; and Cariten Health Plan, Knoxville, Tennessee.

III. FUTURE

The future of M+C in rural areas depends on several factors. On one hand, the exodus from M+C continued in 2001, as described above, and rural enrollment in M+C plans has actually fallen from 173,359 in December 1997 to 150,648 in September 2001. On the other hand, the U.S. Congress recently raised the payment floors considerably, to $475 in almost all rural areas of the country and $525 in urban areas. These large increases in the payment floor were designed in part to diminish the number of exits from M+C. Although this should provide some potential for growth in M+C in rural areas, previous payment rate increases have not inspired significant growth in rural M+C enrollment (as described here), and research has indicated that other factors influence enrollment in M+C plans more significantly (Penrod, McBride, & Mueller, 2001).

The future of M+C in rural areas, therefore, depends in part on legislative changes to the M+C program and in particular to the capitation rates paid to M+C plans. It also depends on interest in M+C by managed care organizations to start up a plan, which is a function of previous experience with managed care in the area, the potential size of the market, and other business considerations (Penrod, McBride, & Mueller, 2001).

A significant new factor on the horizon in rural areas is the presence of the Sterling M+C plan, which started enrolling M+C recipients in 2000. By October 2001, Sterling's service area covered 24 states and over 1,600 counties, of which over 80% were rural counties. Furthermore, Sterling had enrolled almost 14,000 enrollees, and over 4,000 were rural residents, about 30% of its enrollment. Since the vast majority of the counties in which Sterling operates are counties in which the "low floor" of $475 is now in place, the viability of the Sterling model is now significantly more enhanced by recent legislative changes.

REFERENCES

Centers for Medicare & Medicaid Services. (2001). *Medicare+Choice nonrenewals: Updated September 2001, calendar year 2002 nonrenewal report, by state, county, plan.* Retrieved June 2002 from http://cms.hhs.gov/healthplans/nonrenewal/reports2002.asp

Health Care Financing Administration. (2000). *Medicare+Choice (M+C) enrollees affected by non-renewals and service area reductions for 2001. Data as of July 21, 2000.* Retrieved June 2002 from http://www.hcfa.gov/medicare/nrwebdat.htm

Health Care Financing Administration. (1999a). *Statement of HCFA deputy administrator Michael Hash, Medicare+Choice plan renewals, press release, July 15, 1999.* Retrieved June

2002 from http://cms.hhs.gov/media/press/release.asp?Counter=136

Health Care Financing Administration. (1999b). *Medicare+Choice: Changes for the year 2000, an analysis of the Medicare+Choice program and how beneficiaries will be affected by changes.* Retrieved June 2002 from http://www.hcfa.gov/medicare/mc00rept.htm

Health Care Financing Administration. (1998). *Managed care organization service termination and service area reductions, press release, October 8, 1998.* Retrieved October 8, 1998, from http://www.hcfa.gov/medicare/nonrenew.htm

Penrod, J., McBride, T. D., & Mueller, K. (2001). Geographic variation in determinants of Medicare managed care enrollment. *Health Services Research, 36,* 733-750.

Table 1. Percent of Counties with Medicare+Choice Enrollment: 1997 through 2001

	Rural Counties			
	Rural Total	**Rural Nonadjacent**	**Rural Adjacent**	**Urban Total**
Percent of counties with any M+C enrollment:				
September 2001	7.7%	6.3%	22.3%	52.7%
October 2000	16.3%	6.7%	28.7%	67.5%
September 1999	18.3%	7.7%	32.0%	70.3%
September 1998	17.7%	7.1%	31.2%	69.9%
September 1997	14.2%	5.4%	25.4%	63.6%
Percent of counties with 100 or more M+C enrollees:				
September 2001	5.7%	3.4%	20.0%	50.9%
October 2000	9.1%	2.5%	17.6%	60.0%
September 1999	10.7%	3.6%	19.7%	62.6%
September 1998	10.5%	3.3%	19.7%	62.2%
September 1997	8.6%	2.7%	16.1%	55.0%
Percent of counties with 1,000 or more M+C enrollees:				
September 2001	1.7%	1.3%	8.8%	40.1%
October 2000	2.3%	0.5%	4.6%	45.6%
September 1999	2.9%	0.8%	5.6%	47.5%
September 1998	3.0%	0.9%	5.6%	45.8%
September 1997	2.8%	0.8%	5.4%	38.4%
Number of counties	2,289	1,286	1,003	836

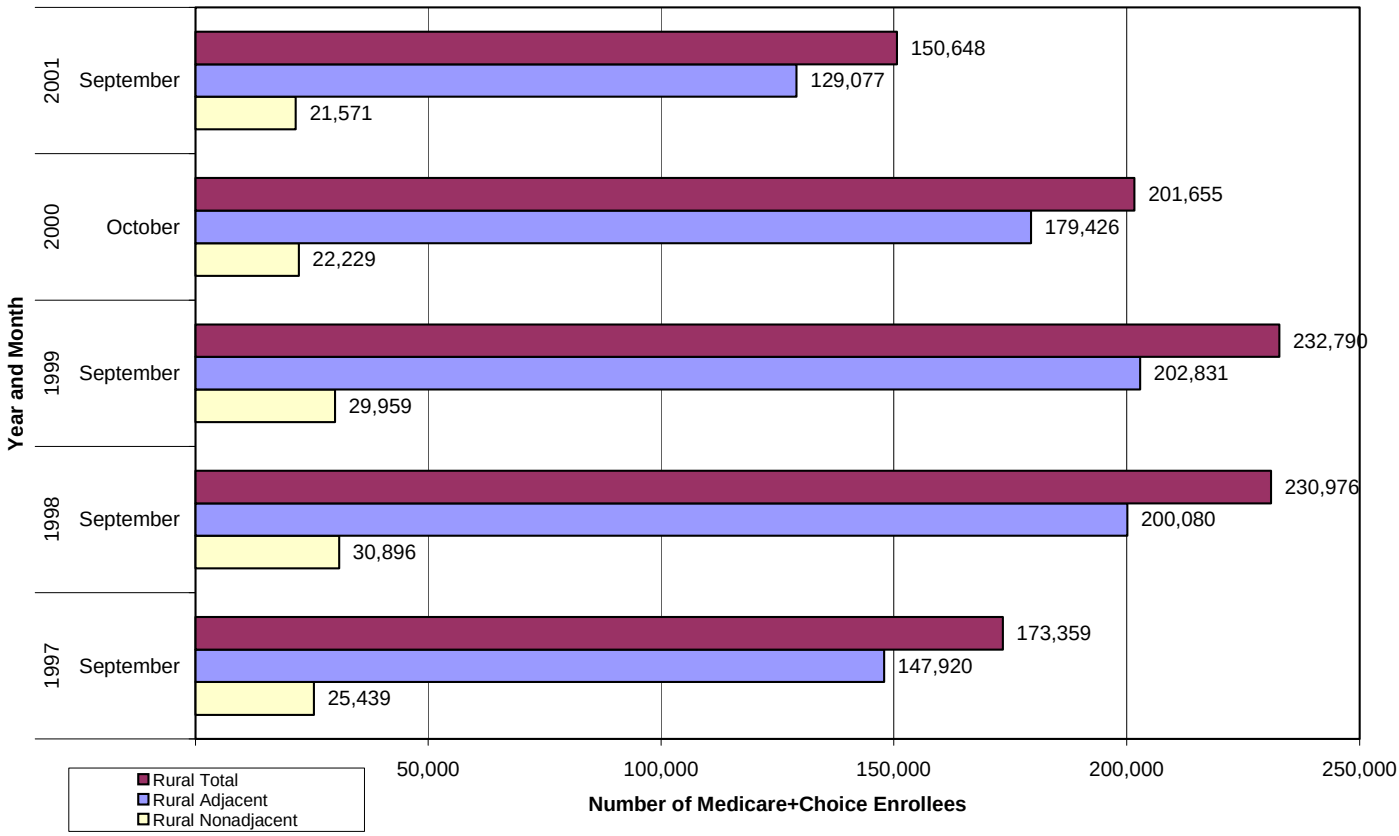
Source: The RUPRI Medicare County Capitation File. RUPRI Center for Rural Health Policy Analysis

Table 2. Counties Containing a Medicare+Choice Plan that Offers Prescription Drug Coverage, December 2001

County Type	Prescription Coverage Offered	Total Number of Counties of This Type	Percent of Counties Offering Prescription Coverage
Central urban	122	177	69%
Other urban	210	660	32%
Rural adjacent	132	1003	13%
Rural nonadjacent	108	1289	8%

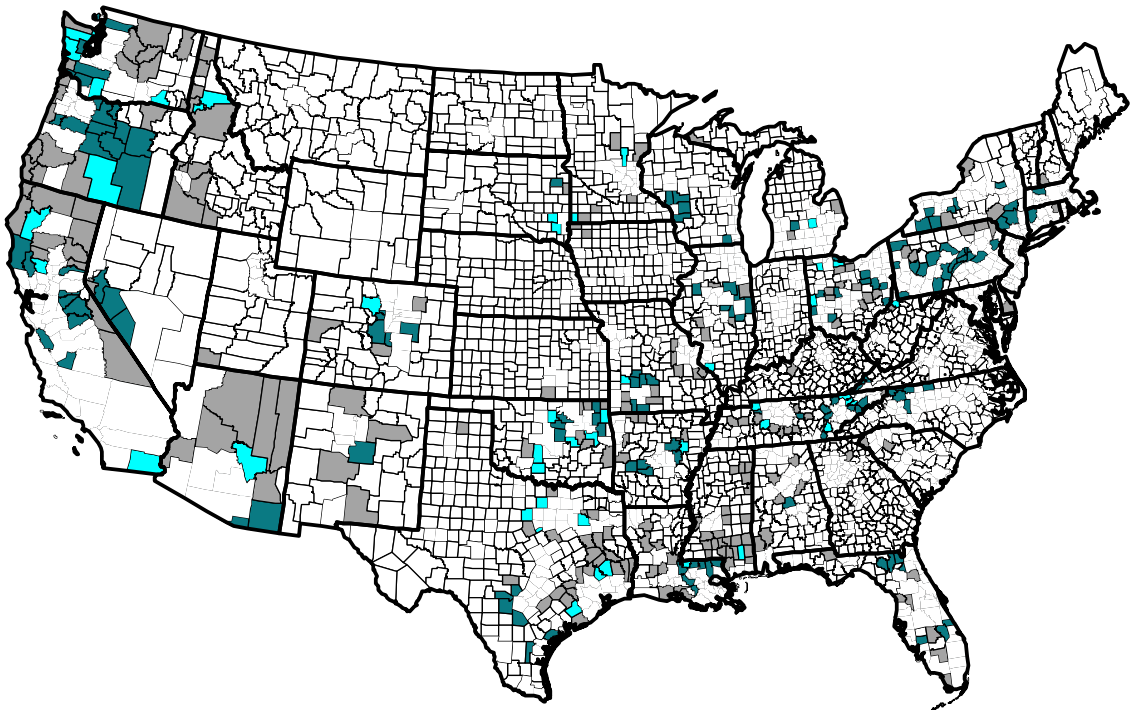
Source: The RUPRI Medicare County Capitation File. RUPRI Center for Rural Health Policy Analysis

Figure 1. Medicare+Choice Enrollment in Rural Counties: 1997-2001



Source: The RUPRI Medicare County Capitation File, RUPRI Center for Rural Health Policy Analysis

Map 1. Percent of Rural Medicare Beneficiaries Enrolled in Medicare+Choice, September 2001



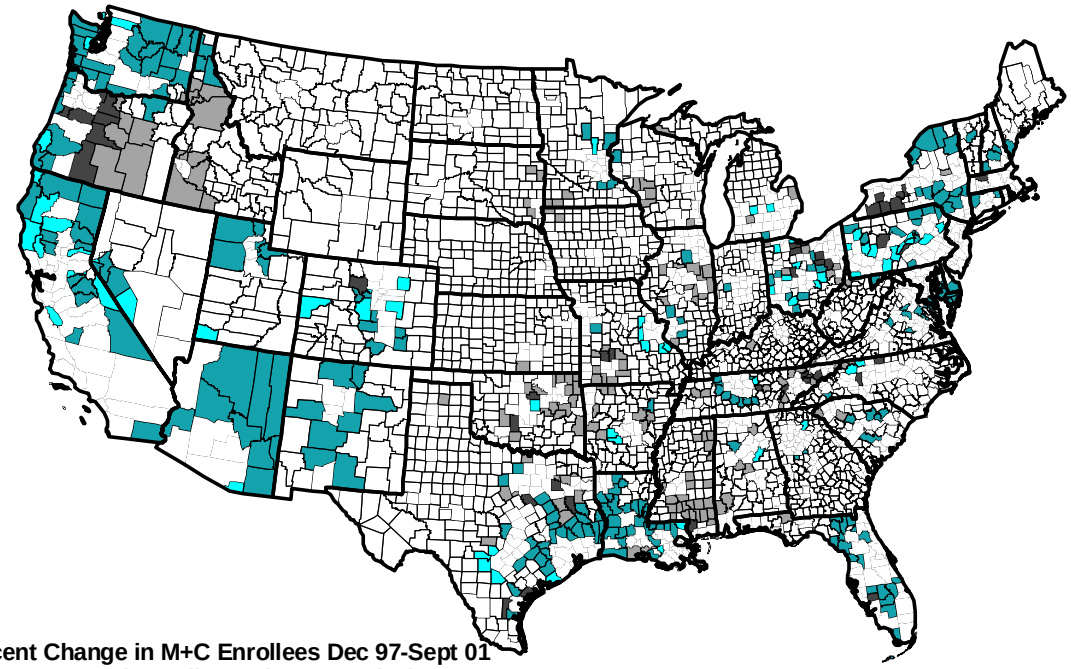
Percent of Medicare Beneficiaries Enrolled in Medicare+Choice, September 2001

- zero (2172 counties)
- <5% (325)
- 5-10% (68)
- 10% or Greater (562)

Urban counties not displayed (white, no boundary).

Source: The RUPRI Medicare County Capitation File, RUPRI Center for Rural Health Policy Analysis.

Map 2. Percent Change in Rural Medicare+Choice Enrollment, December 1997 to September 2001



Percent Change in M+C Enrollees Dec 97-Sept 01

- Decreased Enrollment (503 counties)
- <100% Increase (271)
- 100% or Greater Increase (127)
- No enrollment in Dec 1997, enrollment in Sep 01 (223)
- No enrollment in Dec 1997 and September 2001 (2000)

Urban counties not displayed (white, no boundary).

Source: The RUPRI Medicare County Capitation File, RUPRI Center for Rural Health Policy Analysis.