Rural Policy Brief

Volume Eight, Number Five (PB2003-5) March 2003 RUPRI Center for Rural Health Policy Analysis

An Analysis of Availability of Medicare+Choice, Commercial HMO, and FEHBP Plans in Rural Areas: *Implications for Medicare Reform*

Authors:
Timothy McBride, Ph.D.
Courtney Andrews
Keith Mueller, Ph.D.
Michael Shambaugh-Miller, A.B.D.

The Rural Policy Brief series is published by the Rural Policy Research Institute (RUPRI) for the RUPRI Center for Rural Health Policy Analysis. RUPRI provides objective analyses and facilitates dialogue concerning public policy impacts on rural people and places.

The RUPRI Center for Rural Health Policy Analysis is one of six Rural Health Research Centers funded (Grant #5U1C RH00025) by the Federal Office of Rural Health Policy. The mission of the Center is to provide timely analysis to federal and state health policymakers, based on the best available research.

For more information about the Center and its publications, please contact: RUPRI Center for Rural Health Policy Analysis, 984350 Nebraska Medical Center, Omaha, NE 68198-4350. (402) 559-5260. http://www.rupri.org/healthpolicy

Introduction

This *Policy Brief* examines the viability of introducing private competition into the Medicare program by studying the availability of Medicare+Choice[1] (M+C), commercial HMO, and Federal Employees Health Benefits Program (FEHBP) plans in rural (nonmetropolitan) counties.[2] The *Brief* also presents evidence regarding the variables that influence plan availability and impact plan choice across counties in the U.S.

During a time of growing popularity of the argument that consumer choice among health plans would improve offerings and lower cost, these findings indicate that differences in markets would need to be considered in any policy grounded in such assumptions.

Full Policy Implications on Page 8 (back cover)

The findings in this *Brief* will be useful to policymakers considering using a competitive model to design a Medicare prescription drug benefit or to redesign the entire Medicare program. As changes in the Medicare program are considered, the information in this *Brief* will provide background regarding rural participation in earlier Medicare program changes and in other programs said to be models for change.

Plan Availability in Rural Areas

There are different expectations for the number of competing plans across the three programs analyzed in this *Brief*, associated with the maturity of each program and what has been learned about market responses to the possibilities created. For example, the FEHBP is a well-established program that invites participation by any type of insurance plan, either as a national plan or as a plan within a subnational area. Therefore, a number of competing plans should be available everywhere, which means that all areas should have a choice of at least two or more plans. In contrast, commercial HMOs have been active since the 1970s but are more narrowly defined as insurance plans using the HMO (not preferred provider organizations) model. The expectation, then, is for active but modest competition (at least two competing plans) in most rural areas. Finally, the M+C program is a newer program developed in 1997 (with some preceding activity under the title Medicare "risk" program), and it has had a turbulent history of plans being started and plans withdrawing from the program. Thus, the expectation for competing M+C plans is more limited, making the presence or absence of any plan, and competition of two or more plans, the meaningful categories to measure variance across counties. Due to difficulties matching political jurisdictions with county level data, Alaska and Hawaii are excluded from the analyses reported in this *Brief*.

Medicare+Choice

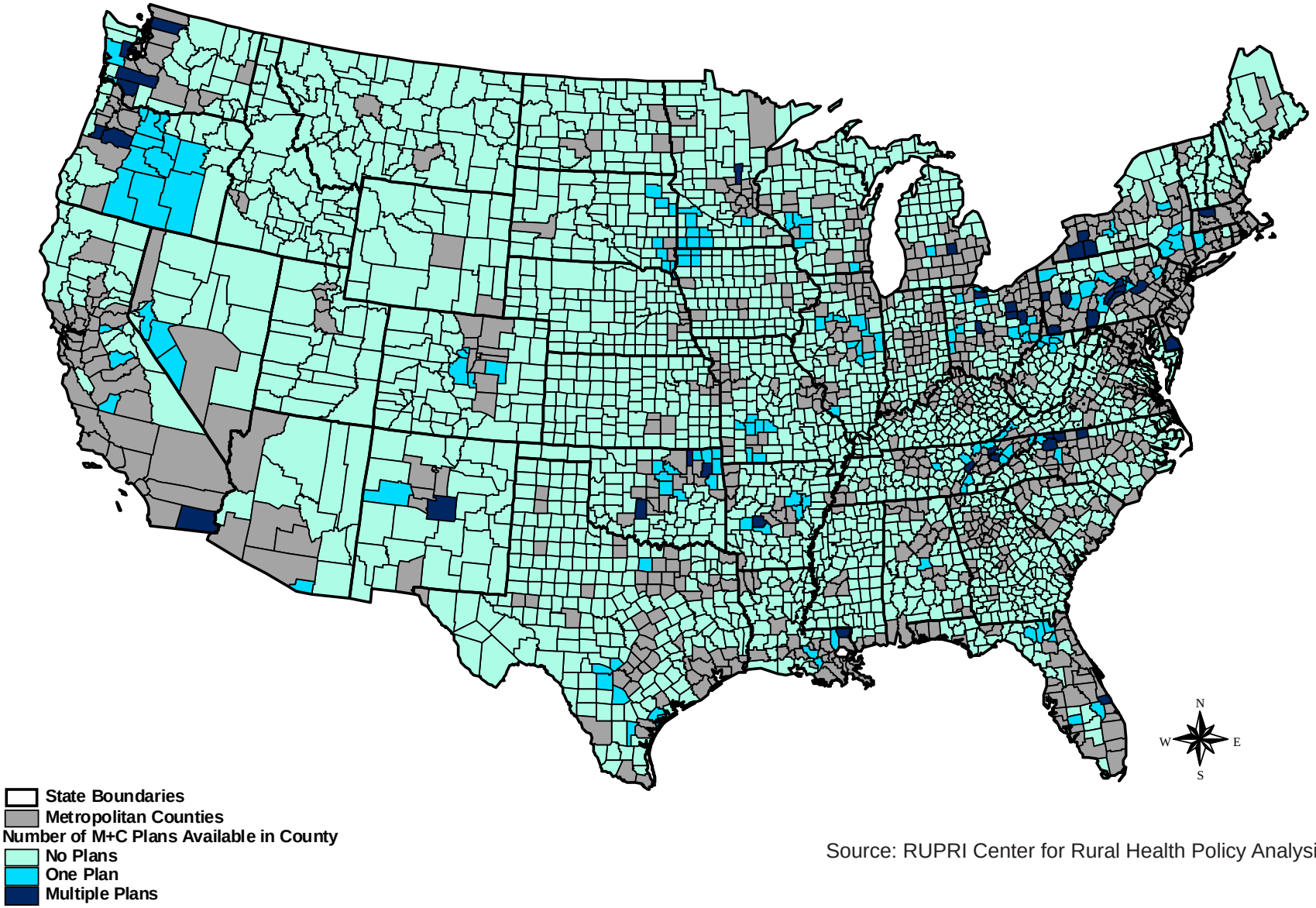
As shown in Table 1, almost 80% of all counties had no M+C plans available to them in August 2001, while only 10% had one plan available, and 10% had multiple plans. Among rural counties, that pattern of limited penetration is even more stark, as also shown in Map 1: 91% had no M+C plans, and only 2% had more than one plan.

Table 1. Medicare+Choice Availability by County, August 2001

	Rural Counties	Metropolitan Counties	All Counties
No plans	91%	50%	80%
1 plan	7%	18%	10%
Multiple plans	2%	32%	10%

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

Map 1
Number of M+C Plans Available in Rural Areas
2001



Source: RUPRI Center for Rural Health Policy Analysis.

Commercial HMOs

In contrast to the story for M+C plans, multiple commercial HMO plans were available in 84% of all counties in January 1999 (Table 2). In addition, one plan was available in 11% of all counties, and no plans were available in 5% of all counties. Rural counties were less likely to have 10 or more plans (2% as compared to 14% for all counties and 47% of metropolitan counties) and were more likely to have zero or one plans (21% as compared to 16% for all counties). The areas with the most limited availability of plans included portions of Census Division Four, particularly North Dakota, South Dakota, Nebraska, and Kansas; and Census Division Eight, in Montana, Wyoming, and Nevada. All other areas had considerable availability of commercial HMOs (Map 2).

Table 2. Commercial HMO Availability by County, January 1999

	Rural Counties	Metropolitan Counties	All Counties
No plans	7%	0%	5%
1 plan	14%	3%	11%
2-9 plans	77%	51%	70%
10 or more plans	2%	47%	14%

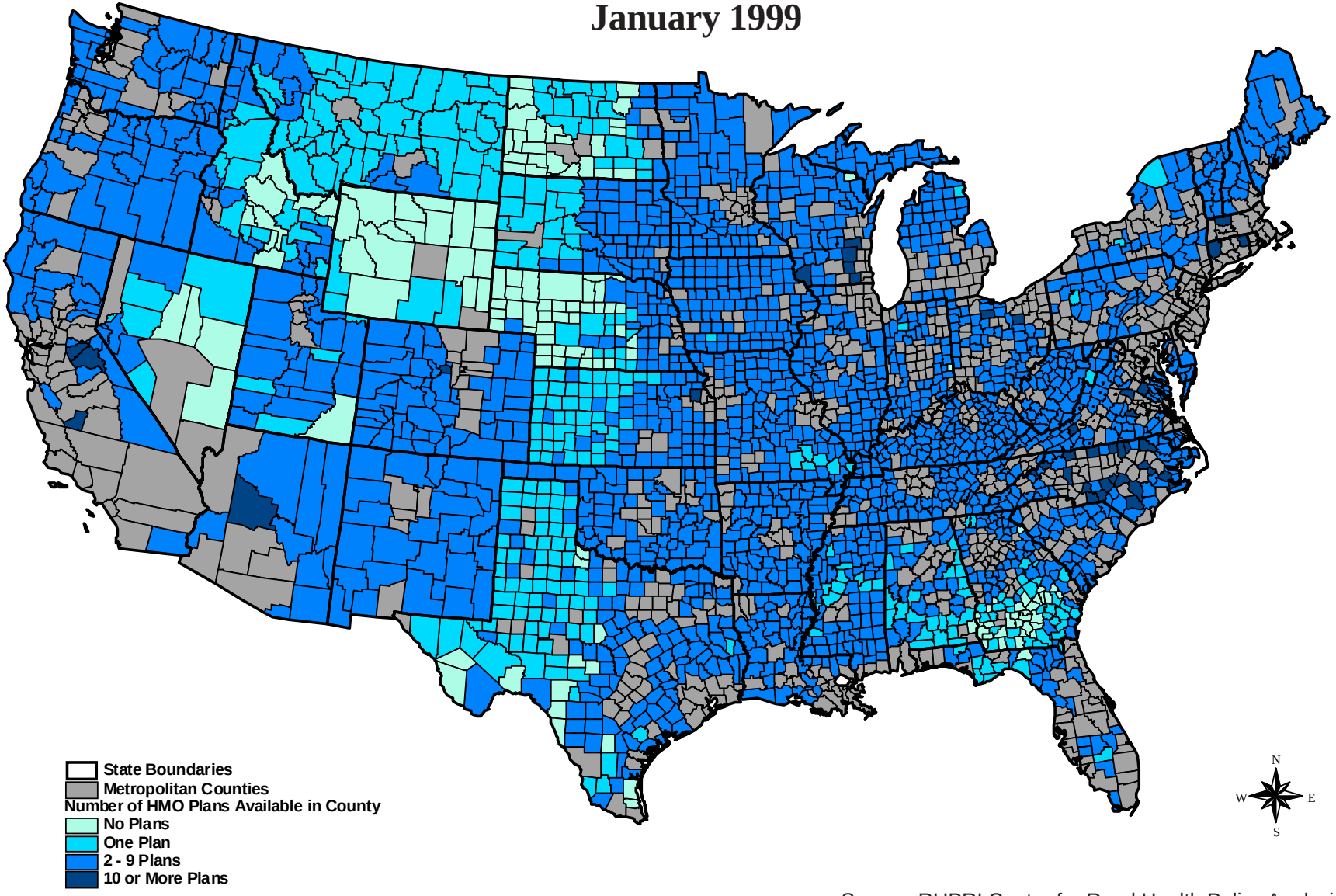
Source: County Surveyor National Database, InterStudy.

Federal Employees Health Benefits Program

There are twelve plans in the FEHBP program that are available to federal employees throughout the nation. All twelve are fee-for-service (FFS) plans (no health maintenance organizations or point-of-service plans), some with preferred provider options *where there are provider panels affiliated with the plan*. There are also six FFS plans available nationwide for specific groups such as rural carriers, special agents, and foreign service employees. All plans are available for actively employed and retired federal employees. Thus, one can argue that there are at least twelve plans available everywhere for everyone, and six more for certain groups.

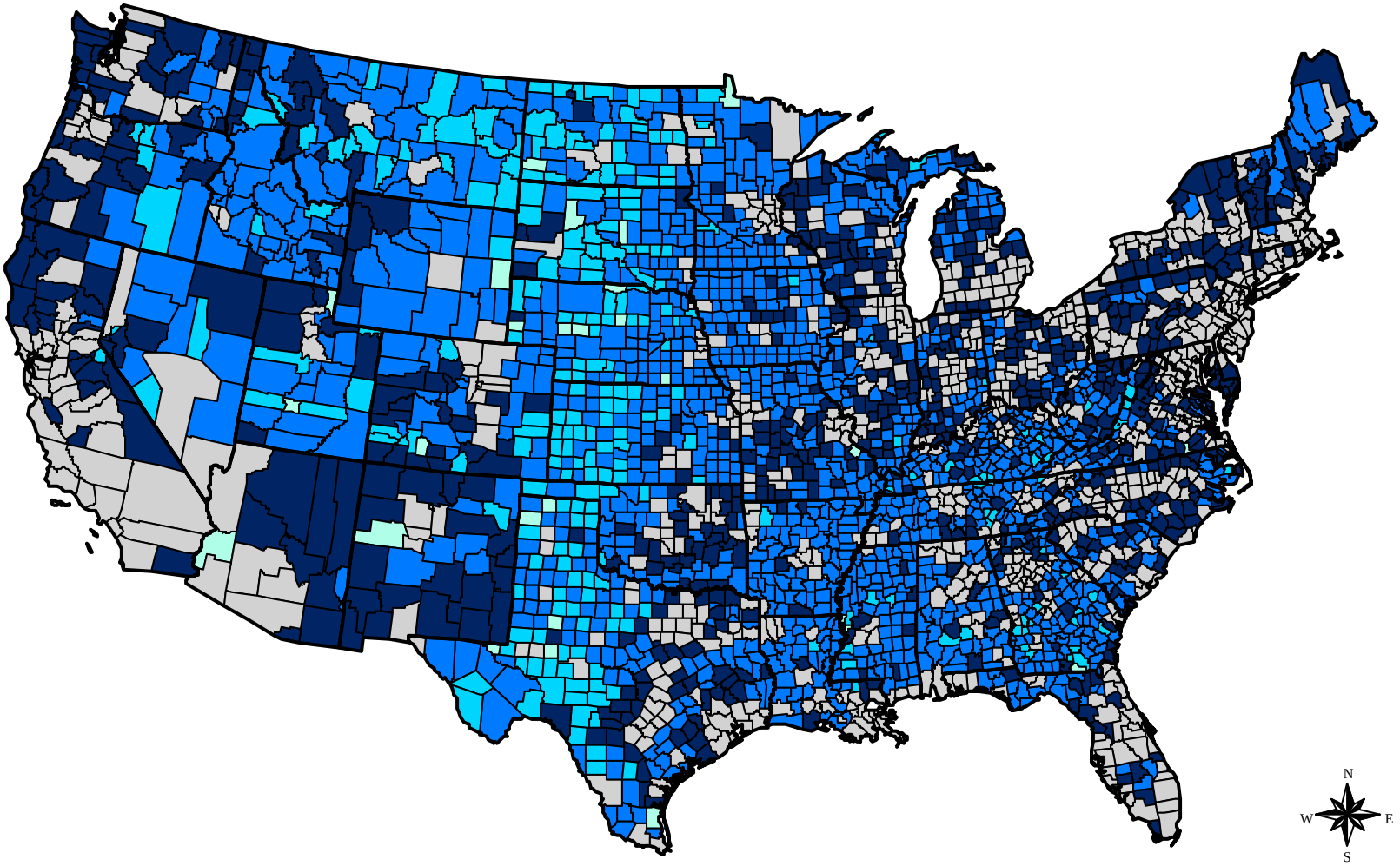
There is a difference between a plan being available because it is on the web site (Office of Personnel Management, opm.gov) as nationwide, and having the plan be active in a particular area (marketed with resulting enrollment). The data in this *Brief* reflect plan activity in each county, as indicated by enrollment in that plan. Thus, when the data show 3-5 plans, the interpretation is that there are 3 to 5 plans in which federal employees in that county are enrolled. As shown in Table 3, federal employees in rural counties were less likely to exercise a wide variety of choices among plans—while 45% of all counties and 86% of metropolitan counties had 10 or more plans selected, this was true in only 30% of rural counties.

Map 2
Number of Commercial HMOs Available in Rural Areas
January 1999



Source: RUPRI Center for Rural Health Policy Analysis.

Map 3
Number of FEHBP Plans With Enrollment in Rural Areas
2001



State Boundaries
Metropolitan Counties
Number of FEHBP Plans With Enrollment in County
1 - 2 Plans
3 - 5 Plans
6 - 9 Plans
10 or More Plans

Source: RUPRI Center for Rural Health Policy Analysis.

Table 3. FEHBP Plan Activity by County, 2001

	Rural Counties	Metropolitan Counties	All Counties
No plans	0%	0%	0%
1-2 plans	2%	2%	2%
3-5 plans	11%	2%	8%
6-9 plans	57%	12%	45%
10 or more plans	30%	86%	45%

Source: Office of Personnel Management, Office of Actuarial Data, based on enrollment by federal employees.

Factors Associated With Plan Availability

Why are some areas more likely than others to have plans available? Analysis of this question[3] leads to the conclusion that M+C plan availability is significantly associated with payment to M+C plans, as has been found in previous analysis of Medicare payment policy.[4] However, the results also show that volatility in payment rates leads to lower plan availability. Even after controlling for payment to M+C plans and other factors, however, plans are less likely to locate in rural areas. Other factors are also important, including population in the county over age 64, percent change in population, percent of population employed in health services, and poverty rate in the county.

Commercial HMOs are likely to be available in areas with a higher population (and areas with positive changes in the population), urban areas, and rural-adjacent areas, indicating that plans are responding to economies of scale. Plans are more likely to be available in areas with higher per capita incomes or lower poverty rates, indicating that plans are seeking a favorably selected population. Plans are less likely to be available in areas with more hospitals or general physicians, indicating that plans are reluctant to locate where there is a great deal of excess capacity, which might result in greater utilization once the plan locates there, driving up costs.

Plan activity in FEHBP is also positively associated with the size of the population in the area, the percent change in population, the population density (per square mile), and urban county designation, again reflecting the economies of scale that population size affords. In addition, FEHBP plans are more likely to be active in areas with higher per capita incomes, reflecting the favorable selection of the persons living in these locations. But plans are less likely to be active in areas with more hospital beds and general physicians, indicating that plans are concerned about the pent-up demand that might be associated with the excess capacity represented by these figures.

Policy Implications

The data presented in this *Policy Brief* show two patterns of availability of multiple choices of insurance plans: that there is much greater choice within metropolitan counties, and that the West Central and Mountain state regions have fewer choices available. These generalizations hold for all three types of insurance choice examined here: M+C, commercial HMOs, and FEHBP.

Of special relevance to the development of alternatives to traditional fee-for-service Medicare, even bringing everyone into the FEHBP system would not assure a wide variety of choices. During a time of growing popularity of the argument that consumer choice among health plans would improve offerings and lower cost, these findings indicate that differences in markets would need to be considered in any policy grounded in such assumptions. Policies could include incentives and/or mandates to bring more competing plans into those areas or guarantee the assumed benefits of competitive markets (for example, access to enriched benefits) through a basic plan that would be offered everywhere. Further research will be needed to elaborate on the factors that contribute to, or inhibit, growth in markets for managed care and FEHBP plans in rural areas. Such research will help guide policymakers in the setting of these policy incentives and mandates.

Notes

[1]Medicare+Choice HMOs, PSOs, and PPOs.

[2]The results presented here are part of a larger volume of work on the subject being completed by the RUPRI Center for Rural Health Policy Analysis.

[3]The analysis described here was done using multivariate analysis of plan availability. A multinomial logistic regression was used for the M+C availability model because of the discrete nature of the dependent variable. In contrast, a standard ordinary least squares regression model was used in the commercial HMO and FEHBP models because of the relatively continuous distribution of plans. Full regression results are available from the RUPRI Center for Rural Health Policy Analysis (www.rupri.org/healthpolicy).

[4]McBride, T. D., Penrod, J., & Mueller, K. (1997). Volatility in Medicare AAPCC rates: 1990-1997. *Health Affairs, 16*(5), 172-180.