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Inequitable Access: Medicare+Choice Program Fails to Serve Rural America

Authors:
Timothy D. McBride, Ph.D.
Keith J. Mueller, Ph.D.

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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

The Medicare+Choice (M+C) program, created by the Balanced Budget Act of 1997 (BBA), was much anticipated, for reasons that included its potential to spur managed care growth in areas that previously had low rates, especially rural areas. The BBA had several policy goals for the provisions affecting M+C plans, including some directly relevant to rural beneficiaries and providers:

- Reduce inequity in payment, especially between rural and urban areas.[1]
- Increase choice of plans and benefits, especially for rural Medicare beneficiaries.
- Achieve cost savings by reducing perceived overpayment to M+C plans.

Most observers conclude that the BBA has failed to meet these policy goals. In particular, a number of key points characterize the M+C program:

- Few rural residents have access to M+C plans: only 16 percent of Medicare recipients living in rural areas had access to an M+C plan[2] in their area in 2001, as compared to 82 percent of urban residents.[3]

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[1]It is important to note that the goal of reducing inequity in payment is not the same as achieving equality in payment across geographic areas. The notion of equity described here is a "fairness" notion of equity. See RUPRI (2001) for a fuller discussion of the equity issue. The differences in payments rates across counties in the U.S. prior to the passage of the BBA were perceived to be unfair and excessive even by those observers who believed that rates should not be equal across counties due to differences in prices, service patterns, and other market characteristics.

[2]These data exclude the fee-for-service M+C plan operated by Sterling Life Insurance, which is offered in rural counties in 35 states. That plan does not include a covered benefit for prescription medications.

[3]The source for all data cited in this report, unless otherwise indicated, is the RUPRI Medicare County Capitation Data files. These files are described more fully in other RUPRI publications, such as RUPRI (PB2001-7, March 2001). These files are compiled from a variety of official government sources (e.g., the Centers for Medicare and Medicaid Services) and supplemented by other data sources.

- ☐ Enrollment of rural beneficiaries in M+C plans is declining. It fell from a peak enrollment of 232,790 in October 1999 to 150,648 in October 2001–a drop of 35 percent. Enrollment in M+C plans was actually lower in October 2001 than it was prior to the BBA in December 1997 when 183,247 were enrolled.

- ☐ Average Medicare payments to M+C plans in rural areas are 10 percent lower than average payments in urban areas, after adjusting for price differences. In 2001, only 4 percent of the total funds allocated to the M+C program flowed to rural areas, while 24 percent of the Medicare eligibles lived in those areas.

- ☐ Rural residents have limited access to additional benefits under the M+C program. Only three percent of people living in rural areas not adjacent to an urban area have access to an M+C prescription drug plan as compared to 86 percent of people living in large urban areas. Similarly, only 1 percent of people living in rural areas not adjacent to an urban area have access to an M+C plan with a zero premium as compared to 66 percent of people living in large urban areas (Medicare Payment Advisory Commission, 2001, Tables 7-1 and 7-2).

As this evidence shows, the M+C program has not achieved the BBA's goals of expanding enrollment, reducing inequity in payment, or increasing choice of benefits. The BBA was also designed to achieve significant cost savings. Analysis suggests that the BBA's M+C provisions led to spending that was 4 percent lower than what would have been spent had the BBA not been implemented. In part, large budget savings have not materialized because the provisions of the BBA specifying M+C payments have actually led to <u>higher</u> payment for M+C plans than would have occurred had these provisions not been included. In particular, the BBA guarantees M+C plans a "minimum update" of at least 2 percent growth every year, but the rate of growth in Medicare per capita payments grew at a slower rate in the 1998-2000 period, because of other provisions that slowed the rate of growth in payments to hospitals, physicians, home health agencies, skilled nursing facilities, and other health providers. (In fact, the growth rate was negative in the 1998-1999 period.) In addition to the minimum update of 2 percent, payment growth was even higher in some counties because amendments to the BBA instituted a payment floor that in 2001 was set at $475 in rural counties and $525 in urban counties.

IMPLICATIONS FOR FUTURE PAYMENT POLICY CHANGES

The experience of the 1997-2001 period presents a cautionary tale for those interested in using the M+C program as a means of reforming the Medicare program. As indicated, enrollment in M+C has declined and the number of M+C contracts has plummeted. Furthermore, analysis suggests that further increases in M+C payment rates by the U.S. Congress may not significantly lower the likelihood of withdrawals from the M+C program. In the 1997-2001 period, the plan exit rate from M+C service areas was 46.4 percent. However, simulation analysis suggests that if payment increases to M+C plans

had continued at a pace similar to those occurring before passage of the BBA, the rate of exit from the M+C program would have decreased to only 45 percent (McBride et al., 2001). This surprisingly small change reflects the fact that the BBA has had a small impact on payment rate relative to what would have occurred had the BBA not passed (the 4 percent difference noted earlier). Also, market factors–such as the declining enrollment in HMOs noted in recent months–are probably the primary driver behind the M+C withdrawals. In addition, recent legislative changes have not led to significant new entry into the M+C program, with only 15 counties affected by expanded plan availability (U.S. GAO, 2001). Evidence that payments to M+C plans, especially the minimum increase, are insufficient to sustain the economic viability of M+C plans may suggest that overall Medicare spending is not keeping pace with underlying inflationary pressures in health care delivery. In such circumstances, managed care organizations should be expected to withdraw from markets, because, unlike traditional Medicare, providers are not compelled to accept M+C plan rates.

The recent experience also presents a cautionary tale for those interested in using private market competition to reform the Medicare program. Almost half of the M+C plans that existed in late 1998 exited from the M+C program by 2001, and in the latest round of M+C exits in 2001, a significant share of rural Medicare recipients were left without any access to an M+C plan. Significant market entry and exit are of course the hallmarks of private market competition, representing changes in the marketplace and attempts by managed care plans to achieve market efficiency. However, the turmoil in the M+C program has disturbed beneficiaries and politicians, especially beneficiaries who must change health providers or who face significantly greater out-of-pocket costs. This market turmoil also suggests that Medicare reform using a proposal modeled on the Federal Employees Health Benefit Plan and market competition, as recently proposed by President Bush (Thompson, 2001) or by the National Bipartisan Commission on the Future of Medicare which met in 1998, is unlikely to yield positive results. The experience of the M+C program has not led to significant market competition in many areas of the country, especially in rural areas (Rural Policy Research Institute, 2001). However, before concluding that the M+C experience bodes ill for reform of Medicare based on participation by private plans, it is important to note that the payment to M+C plans is made using a far different procedure than that which would be used under a managed competition approach to Medicare (National Bipartisan Commission, 1999) or through other proposals to reform Medicare that rely on competitive bidding for price setting in Medicare (Dowd et al., 1996). The managed competition approach, or the competitive bidding approach, may result in vastly different outcomes because these approaches would not rely on paying plans according to historical payment patterns. Paying according to historical payment patterns is a weakness of the current M+C approach that penalizes rural areas.

One of the goals of the M+C program was to expand the range of benefits offered to Medicare beneficiaries. If that remains a goal of policymakers, other avenues for expanding benefits available to beneficiaries may need to be followed. For example,

additional benefits (such as prescription drug coverage or additional preventive care services) could be added to the traditional Medicare program and, therefore, automatically to the M+C program. Given the experience to date with the M+C program, this may be the only way prescription drug coverage may become widely available under Medicare in rural areas. Short of adding a prescription drug benefit explicitly to the Medicare program, the Medicare Payment Advisory Commission recently concluded that an even more direct policy intervention may be needed because "rural beneficiaries are unlikely to see more generous benefits without an explicit or implicit subsidy" (Medicare Payment Advisory Commission, 2001, p. 122).

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