Medicare MINUS Choice:

How HMO Withdrawals Affect Rural Beneficiaries

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Prepared by:

Rural Health Research Center

Division of Health Services Research and Policy

School of Public Health

University of Minnesota

Minneapolis, Minnesota

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Rural Health Research Center
Division of Health Services Research and Policy
School of Public Health
University of Minnesota
Mayo Mail Code 729
420 Delaware St. S.E.
Minneapolis, MN 55455-0392

Single copies are available from:
Jane Raasch
Phone: 612.625.0955
Fax: 612.624.2196
or at:
http://www.hsr.umn.edu/rhrc

Principal Investigator:
Ira Moscovice, PhD

Research Staff:
Michelle Casey, M.S.
Astrid Knott, Ph.D.

Design:
Aldrich Design

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Table of Contents

Chapter One

Introduction

As a result of HMOs' decisions to withdraw from the Medicare managed care program or to reduce the areas they serve, over 770,000 Medicare beneficiaries lost their HMO coverage during 1999 and 2000, and over 925,000 lost it on January 1, 2001 (HCFA, 1998a; GAO, 2000; HCFA, 2000a). Although rural beneficiaries represent a small proportion of Medicare HMO enrollees, a disproportionate number of the beneficiaries losing coverage as a result of the HMO withdrawals and service area reductions have lived in rural areas. Almost 100,000 rural beneficiaries were dropped in 1999 and 2000, and over 65,000 were dropped in 2001.

The purpose of this study is to assess the impact of the January 1, 1999 Medicare HMO withdrawals and service reductions on rural Medicare beneficiaries. The study's focus on rural beneficiaries arose from a concern that the loss of HMO coverage would have a greater impact on rural beneficiaries, who were much less likely than urban beneficiaries to have another Medicare managed care plan available in their county. The study used data from a survey of Medicare beneficiaries to address both the immediate impact of the loss of coverage, and the longer term impact 13 to 16 months later.

Chapter Two describes the characteristics of the surveyed rural beneficiaries who lost HMO coverage on January 1, 1999, and the HMO coverage that they lost.

Chapter Three describes the replacement coverage obtained by beneficiaries immediately after losing their HMO coverage.

Chapter Four addresses changes in beneficiaries' coverage from the time they initially lost their HMO coverage until the time of the survey, 13 to 16 months later.

Chapter Five reports on the process used by the beneficiaries to obtain replacement coverage, and describes the problems experienced by some beneficiaries in obtaining replacement coverage.

Chapter Six discusses the impact of the loss of HMO coverage on the beneficiaries, including changes in premiums and prescription drug coverage.

Chapter Seven describes anticipated changes in beneficiaries' health insurance coverage in the near future.

Chapter Eight discusses the policy implications of the survey results for the future of Medicare managed care in rural areas.

Each chapter presents key results based on the survey data and briefly discusses the implications of those results. Several chapters also include a selection of representative comments from beneficiaries to help readers better understand the impact of the HMO withdrawals on individual rural beneficiaries. These comments were drawn from 280 open-ended comments beneficiaries made about their health insurance coverage at the end of the survey, and numerous additional comments made by beneficiaries throughout the survey to further explain their responses to closed-end questions.

Background

The recent Medicare HMO withdrawals and service reductions have generated considerable attention from the media, advocates for senior citizens, and federal and state policymakers (Benko, 2000a; Benko, 2000b; GAO, 1999; GAO, 2000). A mail survey commissioned by the Kaiser Family Foundation examined the impact of HMO withdrawals at year end 1998 on a national sample of 1,830 Medicare beneficiaries (Laschober, Langwell, Topoleski, et. al., 1999; Laschober, Neuman, Kitchman, et. al., 1999). The Kaiser study did not indicate the proportion of beneficiaries who were rural. However, since it used a nationally representative sample weighted to represent all beneficiaries who lost their Medicare HMO coverage at year end 1998, presumably the vast majority of beneficiaries in the study were urban. The Office of the Inspector General conducted a phone survey of 502 beneficiaries who lost their Medicare HMO coverage at year end 1999 (OIG, 2000). The OIG sample was stratified by whether or not the beneficiaries had another HMO available to join after losing their HMO coverage, but the report did not indicate the proportion of beneficiaries who were rural.

The Kaiser study found that a substantial share of the beneficiaries who lost coverage experienced a decline in their supplemental benefits, an increase in premiums, and some disruption of their medical care arrangements. Beneficiaries who enrolled in another HMO were less likely to lose benefits and incur higher premiums, in contrast to those who returned to traditional Medicare, especially without supplemental coverage. The OIG study concluded that the majority of beneficiaries surveyed encountered few transition problems when they lost their HMO coverage; a higher percentage of those with another HMO available said their transition was easy or somewhat easy. The financial impact of changing coverage was greater for beneficiaries who went to traditional Medicare fee-for-service than those who joined another HMO.

Chapter One

Study Design

Data for this study were collected through a telephone survey of a nationwide random sample of 1,093 rural Medicare beneficiaries who lost their Medicare HMO coverage as of January 1, 1999 because their HMO either dropped its Medicare contract or withdrew from a portion of its service area. The survey was developed by the University of Minnesota Rural Health Research Center (UMRHRC), and the phone interviews were conducted by the Survey Research Center of the Division of Health Services Research and Policy at the University of Minnesota. The survey was pretested in January 2000. Minor revisions were made, and the survey was conducted from February to May 2000.

Survey questions addressed:

- the type of Medicare HMO coverage held by the beneficiary prior to January 1, 1999;
- the beneficiary's awareness of the availability of other Medicare HMO products, if any, to replace the lost coverage;
- problems, if any, experienced by the beneficiary in obtaining replacement coverage and how they were resolved;
- factors that influenced the beneficiary's choice of replacement coverage for the Medicare HMO product;
- beneficiaries' future willingness to enroll in an HMO product;
- the type of replacement coverage obtained by the beneficiary on January 1, 1999 and at the time of the survey, 13 to 16 months later; and
- demographic characteristics and the health status of the beneficiary.

UMRHRC obtained HCFA data from the Group Health Plan file on all beneficiaries who had ever been enrolled in a Medicare risk HMO in the 135 rural counties where HMOs dropped their Medicare risk product as of December 31, 1998. HCFA also provided matching records from the Name and Address File for those beneficiaries who were in the file as of November 1999 (i.e., were not deceased). The HCFA data included the beneficiaries' names and addresses, age, gender, and race; as well as data regarding their HMO enrollment, including the contract number(s) of the HMO(s) in which the beneficiaries had been enrolled and the dates of enrollment and disenrollment.

The sample for the study was selected from Medicare beneficiaries aged 65 and over who disenrolled from one of the HMOs that dropped enrollees residing in a rural county as of December 31, 1998.[1] An initial

1 Beneficiaries who disenrolled after the HMOs had announced their decisions to leave these counties, but prior to December 31, 1998 were not included, since it was possible that these enrollees left the HMOs for other reasons. Disabled Medicare beneficiaries under age 65 were also excluded, because of the expectation that there would be an insufficient number of beneficiaries in this category to conduct statistical analyses.

random sample of 1,086 beneficiaries and a replacement sample of 700 beneficiaries were selected. According to HCFA protocols, a letter signed by the HCFA administrator was sent to each of these individuals explaining the purpose of the survey, requesting their participation, and notifying them of their right to refuse to participate in the survey.

Since the HCFA data did not include beneficiaries' phone numbers, a multistep process was used to obtain phone numbers for the sample of beneficiaries. UMRHRC contracted with a national sampling firm to match beneficiary names and addresses with phone numbers, using a computer program and a national database. The firm manually looked up names and addresses that did not initially match with phone numbers, using the national database and directory assistance. Several attempts then were made to locate beneficiaries whose phone numbers either were not obtained through the computer match or manual lookup, or were disconnected. A second letter was sent to those beneficiaries, stating that we had been unable to contact them by phone, and asking them to call a toll-free number at the University of Minnesota Survey Research Center. Survey Center staff also checked with directory assistance; contacted other individuals listed on Internet phone directories as residing at the beneficiary's address; called neighbors' numbers to determine if a beneficiary had moved or was deceased; and verified with the operator the working status of numbers that were unanswered over a period of time. A total of 435 beneficiaries were removed from the sample because we could not obtain phone numbers to reach them (*Figure 1-1*).

At the start of each interview, the beneficiary was asked a screening question to determine if he or she recalled being dropped on December 31, 1998 by the specific HMO that was listed in his or her HCFA file. The results of the pretest showed that some beneficiaries were more familiar with the name of the Medicare product in which they had been enrolled than with the name of the HMO itself. Therefore, the survey interviewers were provided with a list of Medicare products offered by the relevant HMOs, and beneficiaries who did not recognize the name of the HMO in which they were previously enrolled according to HCFA data were asked if they had been enrolled in the Medicare product. Beneficiaries who said that they had been dropped from either the HMO or the Medicare product were surveyed. Thirty-nine individuals were removed from the sample because they stated they had not been enrolled in the HMO or the Medicare product.

Fourteen beneficiaries were deceased. Forty-five beneficiaries could not participate in the survey because of hearing or language problems, illness, or mental confusion, and did not have a relative available to function as a proxy. One hundred thirty-one persons refused to participate in the survey, and 29 surveys were in progress at the end of the survey period. A total of 1,093 usable surveys were completed, yielding a response rate

of 87.2 percent. The respondents included 954 beneficiaries who responded to the survey themselves, and 139 proxies who responded to the survey on behalf of beneficiaries who had problems (e.g., hearing loss) that made responding to a phone survey difficult.

Survey respondents and non-respondents were compared, using demographic data from the HCFA files. The two groups did not differ significantly with regard to gender, race, or Medicaid status. However, the mean age of non-respondents (76.2 years) was significantly greater ($p < .01$) than that of respondents (74.1 years). The age difference between the two groups may reflect the greater likelihood that older beneficiaries have health problems or functional disabilities such as hearing losses that interfere with survey participation.

Figure 1-1

Sample and Response Rate for Survey

Total Sample		1786
OUT OF SAMPLE:		
No phone number	435	
Deceased	14	
Language Problems	12	
Illness/Dementia	33	
Said were not enrolled in HMO	39	
Total Out ofSample	533	
Total Usable Sample		1253
Refusals		131
In Progress at the End of Survey Period		29
Completed Usable Surveys		1093

Response rate = 87.2%

Characteristics of Survey Respondents

Using national data from the 1997 Medicare Current Beneficiary Survey (MCBS) (HCFA, 1997), the survey respondents were compared to all Medicare HMO enrollees and to all non-institutionalized Medicare beneficiaries on several demographic characteristics.

Chapter Two

Key Results

Overall, the rural survey respondents who lost their HMO coverage were similar to Medicare HMO enrollees and Medicare beneficiaries nationally in terms of their education and income (*Figure 2-1*).

- Compared to the survey respondents, who were all rural, 24 percent of Medicare beneficiaries nationally and three percent of Medicare HMO enrollees were rural.

- Seventy-two percent of survey respondents had at least a high school education, which was similar to the percentages of Medicare HMO enrollees (68 percent) and Medicare beneficiaries nationally (70 percent).

- Similar proportions of all three groups had annual household incomes below $20,000. However, higher proportions of Medicare beneficiaries nationally were in the lowest and highest income groups, compared to the survey respondents and all Medicare HMO enrollees.

The rural survey respondents were similar to other Medicare HMO enrollees, and somewhat healthier than Medicare beneficiaries nationally.

- Both the survey respondents and all Medicare HMO enrollees were somewhat healthier than all Medicare beneficiaries. Twenty percent each of survey respondents and Medicare HMO enrollees reported that they were in fair or poor health, compared to 28 percent of Medicare beneficiaries nationally.

- Similar proportions of all three groups reported having diabetes. Survey respondents and Medicare HMO enrollees were somewhat less likely than all Medicare beneficiaries to have had a stroke, pulmonary disease, or cancer.

Most respondents purchased their HMO coverage individually, and did not have additional coverage while enrolled in the HMO (*Figure 2-2*).

- Eighty-eight percent of respondents obtained their previous Medicare HMO coverage by purchasing it individually; nine percent obtained it through their own or their spouses' current or previous employer or union; and two percent purchased it through a group.

- The vast majority of beneficiaries (92 percent) did not have additional health care coverage while they were covered by the HMO. Four percent of respondents had supplemental plans in addition to the HMO coverage, while three percent had additional coverage in the form of employer-provided plans, Veterans benefits, Medicaid, or other plans.

Just over half of the beneficiaries reported paying a monthly premium for their Medicare HMO coverage (in addition to their Medicare Part B premium).

- More than half (53 percent) of those who paid a premium paid less than $50 per month; 31 percent paid $50 or more; and 16 percent did not know what their monthly premium had been.

- Nationally, 64 percent of enrollees did not pay a premium for their Medicare HMO coverage in 1999; six percent paid $25 or less; 19 percent paid $26 to $45 a month; and 11 percent paid more than $45 a month (Langwell et. al., 1999).

Implications

- The better health status of the survey respondents and all Medicare HMO enrollees, compared to all Medicare beneficiaries, is consistent with previous research indicating that Medicare HMO enrollees tend to be in better health than beneficiaries in the fee-for-service sector (PPRC, 1996).

- Similarities between the survey respondents and all Medicare HMO enrollees in terms of education, income, and health status suggest that the results of this study will be generalizable to other HMO enrollees who lose coverage and have similar replacement coverage options.

Figure 2-1

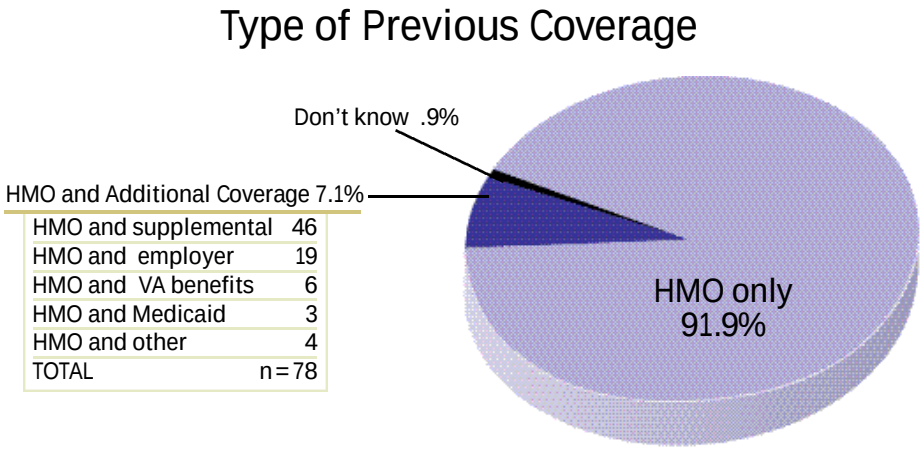
Characteristics of Survey Respondents Compared to All Medicare HMO Enrollees and All Medicare Community Residents

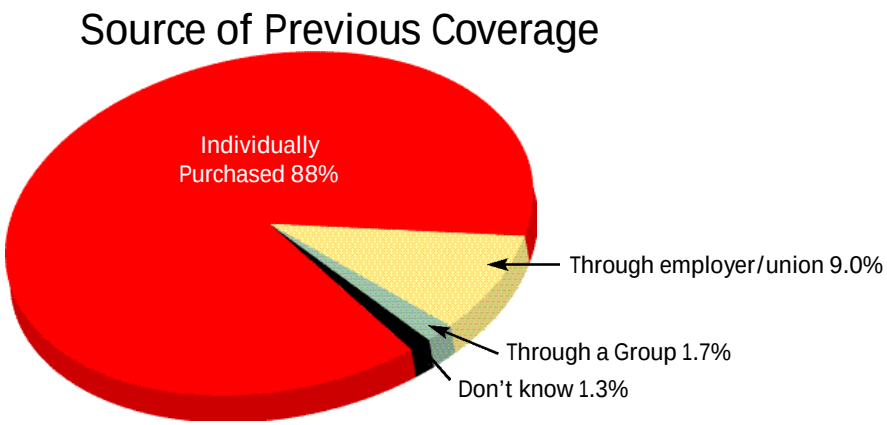
	Survey Respondents	All Medicare HMO Enrollees (1997 MCBS)	All Medicare Community Residents (1997 MCBS)
RURAL	100.0	3.3	24.3
GENDER			
Female	49.0	55.4	56.2
Male	51.0	44.6	43.8
EDUCATION			
0-8 years	12.5	16.1	20.4
9-11 years	15.4	16.3	16.2
HS graduate	43.0	35.2	33.4
Some college	19.1	18.0	15.7
College grad or more	10.1	14.4	14.3
INCOME			
Less than $10,000	17.9	29.5	31.1
$10,000 to $19,999	39.0	30.6	29.3
$20,000 to $29,999	23.6	19.0	18.5
$30,000 to $39,999	9.0	10.6	5.3
$40,000 and over	10.4	10.3	15.8
SELF-REPORTED HEALTH STATUS			
Excellent	16.3	18.9	16.0
Very Good	30.0	30.1	26.3
Good	33.5	30.6	30.0
Fair	14.7	15.7	18.8
Poor	5.5	4.7	9.0
SELF-REPORTED HEALTH CONDITIONS			
Heart Disease	17.1	N/A	35.9
Heart Attack	13.8	N/A	N/A
Stroke	9.2	9.8	10.6
Diabetes	15.7	15.6	15.8
Pulmonary Disease	10.2	12.6	14.6
Cancer	13.1	15.5	16.9

Data Sources: University of Minnesota Rural Health Research Center Survey, and 1997 Medicare Current Beneficiary Survey (HCFA, 1997).

Figure 2-2

Characteristics of Previous HMO Coverage (n=1093)





Replacement Coverage Initially Obtained by Beneficiaries

Chapter Three

Key Results

Less than one-fifth of rural respondents enrolled in another Medicare HMO immediately after they lost their Medicare HMO coverage *(Figure 3-1)*.

- On January 1, 1999, immediately after they lost their Medicare HMO coverage, 46 percent of respondents reported having traditional Medicare and a Medicare supplemental policy. Twenty-nine percent did not have any additional coverage beyond traditional Medicare. A total of 19 percent had enrolled in another Medicare HMO (including two percent who had additional coverage). Four percent had an employer policy, and one percent had Medicare and Medicaid.

The type of replacement coverage obtained by rural beneficiaries in this study differed considerably from that of urban enrollees who lost HMO coverage in previous studies.

- In comparison to the Kaiser study of predominantly urban beneficiaries who lost their Medicare HMO coverage, the rural beneficiaries in the current study were much less likely to enroll in another Medicare HMO (19 percent versus 66 percent). They were much more likely to enroll in a Medicare supplemental policy (46 percent versus 15 percent) or to have Medicare only coverage (29 percent versus 8 percent). The proportions of beneficiaries enrolled in employer plans (4 percent) and Medicaid (1 percent) were very similar in the two studies. The rate of HMO enrollment in the current study was also much lower than that of the OIG study (55 percent).

The low HMO enrollment rate among rural beneficiaries that lost Medicare HMO coverage can be partially explained by the limited availability of Medicare HMOs in many rural areas, but beneficiary choice also played a role.

- In this study, 58 percent of respondents indicated that they did not have another Medicare HMO they could join when they were dropped by their previous HMO, while 32 percent reported having the choice of another Medicare HMO, and 10 percent of respondents were not sure.

- Beneficiary choice also played a role in the lower HMO enrollment rate, as less than half of the respondents (48 percent) who said they had a choice of another HMO reported enrolling in a HMO upon losing

their previous HMO coverage. Nationally, about half of all beneficiaries who were dropped by HMOs and had another HMO option chose to enroll in an HMO (HCFA, 1999).

- Among those who had another HMO available, the beneficiaries who enrolled in a new HMO did not differ significantly from those who did not enroll in terms of their age, education, income, health status, and diagnosis of several chronic diseases. Female beneficiaries in this group were significantly more likely to enroll in a new HMO than male beneficiaries (55 percent versus 41 percent), and persons with diabetes were significantly less likely to enroll in a new HMO than non-diabetics (31 percent versus 51 percent).

Beneficiaries differed significantly by type of replacement coverage on January 1, 1999 on a number of demographic, health status, and health utilization measures *(Figure 3-2)*.

- A three-way analysis found that beneficiaries with HMO, supplemental, and Medicare only coverage on January 1, 1999 differed significantly in terms of race, income, number of physician visits in the past year, health status, diagnosis of heart disease, and whether or not they had an overnight hospital stay during the past year. Further two-way analysis indicated that the majority of significant differences were between beneficiaries with Medicare only coverage and those with either supplemental or HMO coverage, rather than between those with supplemental coverage and those with HMO coverage.

Beneficiaries with Medicare only coverage differed significantly from those with HMO coverage by race, income, heart disease, and having had a hospitalization in the past year.

- Those with Medicare only coverage were more likely to be a minority[1] (11 percent versus 6 percent of HMO enrollees); to have lower household incomes (70 percent with incomes below $20,000 compared to 52 percent of HMO enrollees); to have a diagnosis of heart disease (21 percent versus 14 percent of HMO enrollees); and to have been hospitalized in the past year (19 percent versus 11 percent of HMO enrollees).

Beneficiaries with Medicare only coverage differed significantly from those with supplemental coverage by race, education, income, heart disease, and number of physician visits in the past year.

- Those with Medicare only coverage were more likely to be a minority[1] (11 percent versus 4 percent of those with supplemental coverage); to have less than a high school education (34 percent versus 25 percent of those with supplemental coverage); to have lower household incomes (70 percent with incomes below $20,000 com-

1 All non-white respondents were grouped in one minority category because the number of respondents were not sufficient for separate analysis of each race.

pared to 52 percent of those with supplemental coverage); to have a diagnosis of heart disease (21 percent versus 15 percent of those with supplemental coverage); and to have no physician visits in the past year (12 percent compared to 4 percent of those with supplemental coverage).

Beneficiaries with HMO coverage differed significantly from those with supplemental coverage on only one measure: they were less likely to have had a hospitalization in the past year (11 percent versus 19 percent).

Beneficiaries' Comments

Twenty-five beneficiary comments reflected frustration with geographic disparities in the availability of HMOs, premiums, and benefits.

- One of these beneficiaries stated: "I don't think it's fair that our county just because it's smaller isn't allowed HMO coverage when the people in Jefferson County are covered. We actually live only 25 miles from the border."

- Another said, "I don't understand how the same HMO can be so different in different counties. The rates and what is covered is dramatically different in the county not too far from us. I use an electric cart because I had polio. Our HMO doctor said he would lose his job if he gave me a prescription for my electric cart. We talked to the doctors in the other county and they said it was no problem for them to write prescriptions for electric carts."

Some beneficiaries who obtained additional coverage reported choosing the best option from a limited selection or the only option available, while others reported that they were unable to obtain affordable coverage.

- One beneficiary concluded, "We went with a coverage that was affordable and covered some of our prescription needs. Both my husband and I are diabetics." A beneficiary with employer-sponsored coverage stated, "We weren't given any choices by our employer, we are given the plan that the employer chooses. We can't afford to leave this employer and buy insurance as individuals." Another beneficiary said, "I went with the only one that would take me."

"We can't afford to leave this employer and buy insurance as individuals."

- Said one beneficiary, "It was too expensive for me to get anything else. I tried to get Medicaid but they turned me down. I was not able to get anything other than plain Medicare."

Implications

- The results of studies of urban enrollees who lose HMO coverage may have limited applicability to rural enrollees.
- For rural beneficiaries who lose HMO coverage, the majority of significant differences in demographic, health status, and health utilization measures are between beneficiaries who have some type of replacement coverage in addition to Medicare and those who do not.
- The greater likelihood that beneficiaries who are minorities, have lower incomes, less education, and poorer health status will not have any type of replacement coverage in addition to Medicare is a concern.

Figure 3-1

Type of Replacement Coverage in January 1999

(n=1093)

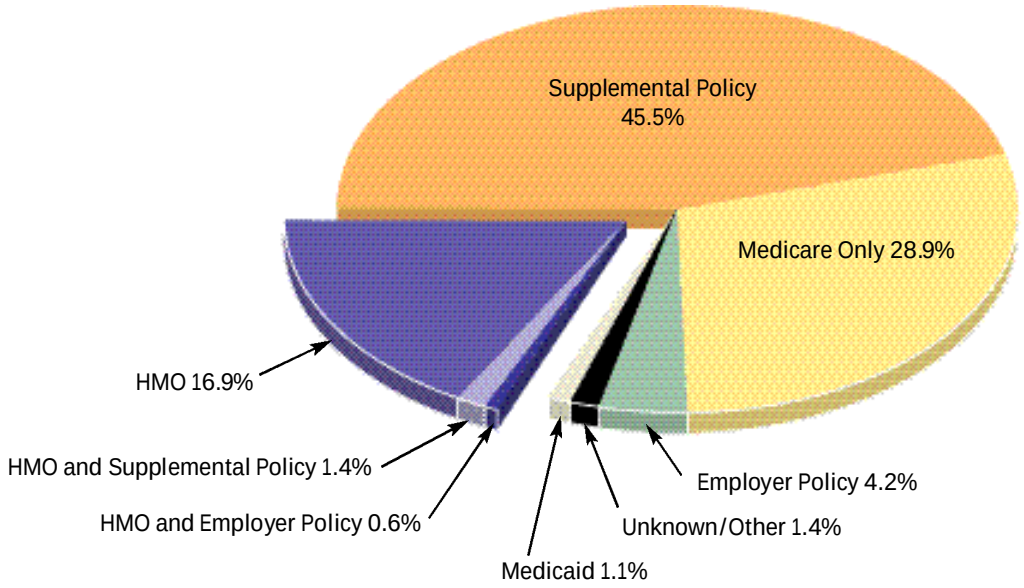


Figure 3-2

Characteristics of Respondents by Type of Replacement Coverage on January 1, 1999 for those with HMO, Supplemental, or Medicare Only Coverage (n=1093)

	HMO (n=207)	Supplemental (n=497)	Medicare Only (n=316)
AGE			
65-74 years	63.8	59.0	60.4
75-84 years	30.4	35.0	33.2
85 years and over	5.8	6.0	6.3
GENDER			
Female	45.9	51.7	54.4
Male	54.1	48.3	45.6
RACE***			
White	93.7	96.4	88.6
Other Races	6.3	3.6	11.4
EDUCATION			
Eighth Grade	11.2	10.6	15.2
Some High School	14.8	14.4	18.7
High School Grad	42.4	43.8	41.2
Some College	20.4	19.8	18.0
College Grad or Higher	11.2	11.5	6.9
HOUSEHOLD INCOME***			
Less than $10,000	18.8	12.3	26.3
$10,000 to 19,999	33.1	39.4	43.9
$20,000 to 29,999	29.4	26.3	14.9
$30,000 to 39,999	8.1	8.4	10.1
Over $40,000	10.6	13.7	4.8
HEALTH STATUS*			
Poor/Fair	17.0	19.2	24.7
Good	33.0	33.3	32.8
Very Good/Excellent	50.0	47.5	42.5
DISEASE DIAGNOSES			
Cancer	15.3	14.1	11.4
Heart Attack	12.9	12.7	15.3
Heart Disease*	13.7	14.9	21.2
Stroke	10.3	8.0	9.9
Diabetes	11.8	17.1	15.8
Emphysema	12.9	9.8	8.5
NUMBER OF PRESCRIPTIONS IN PAST YEAR			
None	20.1	20.6	24.2
1 to 2	45.6	40.5	39.5
3 to 5	27.5	29.9	27.8
6 or more	6.9	9.0	8.5
NUMBER OF PHYSICIAN VISITS IN PAST YEAR**			
None	7.5	4.1	11.6
One	9.0	12.4	13.7
2 to 4	47.8	45.5	45.4
5 to 9	19.9	22.0	18.4
10 or more	15.9	16.1	10.9
OVERNIGHT HOSPITAL STAY IN PAST YEAR*	11.4	19.4	18.8

The three way analysis found significant differences at the following levels: *p<.05, **p<.01, ***p<.001

Beneficiaries with employer coverage, Medicaid, and other coverage were excluded from this analysis because of the small numbers in these categories.

Additional two-way chi-square analysis found significant differences between 1) beneficiaries with HMO coverage and those with supplemental coverage in the overnight hospital stay measure; 2) between those with HMO and Medicare only coverage in the race, income, heart disease, and overnight hospital stay measures; and 3) between Medicare only and supplemental coverage in the race, education, income, heart disease, and number of physician visits measures.

Changes in Beneficiaries' Coverage Over Time

Key Results

Comparing respondents' coverage in the period immediately after losing their Medicare HMO coverage to their coverage in February to May 2000, 13 to 16 months later, reveals that supplemental coverage increased and Medicare only coverage decreased *(Figure 4-1)*.

- The proportion of beneficiaries with supplemental policies increased from 46 percent to 54 percent, while the proportion of beneficiaries with Medicare only coverage declined from 29 percent to 22 percent. Medicare HMO coverage also declined during this time period, while employer-sponsored coverage increased slightly and Medicaid coverage was stable.

- These changes resulted in a net decrease in the number of beneficiaries with Medicare only coverage and a net increase in other kinds of coverage. However, some beneficiaries who initially had HMO or supplemental coverage on January 1, 1999 later had Medicare only coverage. These included beneficiaries in counties that experienced another round of Medicare HMO withdrawals on December 31, 1999.

- Thirty-five beneficiaries with Medicare only coverage and 68 beneficiaries with additional coverage also reported having Veterans Administration (VA) health care benefits. Twenty-three percent (N=15) of the beneficiaries with supplemental or HMO coverage and VA benefits indicated that their VA benefits were their primary coverage, i.e., the plan used to cover most of their health care expenses.

At the time of the survey, 13 to 16 months after losing their HMO coverage, beneficiaries with HMO, supplemental, and Medicare only coverage differed significantly on several characteristics, including race, education, income, living arrangement, health status, and the number of physician visits in the past year *(Figure A-1)*.

- Survey respondents who had Medicare only coverage differed significantly from those with other types of coverage on several characteristics, including race, education, income, living arrangement, self-reported health status, and number of physician visits during the past year (*Figure 4-2*). Respondents with Medicare only coverage were significantly more likely to be a minority, have less than a high

school education, have a household income less than $10,000, live alone, and have no physician visits during the past year. They were also significantly more likely to report being in poor or fair health than beneficiaries with additional coverage.

Respondents' type of coverage at the time of the survey differed significantly from that of rural Medicare beneficiaries nationally.

- Compared to rural Medicare beneficiaries nationally, the rural respondents in this survey were much more likely to have supplemental coverage (54 percent versus 35 percent), Medicare only coverage (22 percent versus 15 percent) or HMO coverage (13 percent versus 2 percent) *(Figure 4-3)*. The survey respondents were much less likely to have employer-sponsored coverage (5 percent versus 26 percent) or Medicaid (one percent versus 16 percent).

Beneficiaries' Comments

- A beneficiary who had been dropped a second time by another HMO just prior to being surveyed said: "We don't know who to trust anymore—we've had coverage dropped in our county two times now."

- A few beneficiaries stated that they had supplemental plans when they first lost their HMO coverage but dropped them because they were too expensive.

"We don't know who to trust anymore—we've had coverage dropped in our county two times now."

Implications

- Rural beneficiaries continued to experience changes in their health insurance status several months after losing their HMO coverage. It is important to examine the impact of HMO withdrawals over time as well as immediately after they occur, in order to identify these trends.

- The higher rate of HMO coverage among respondents at the time of the survey, compared to rural Medicare beneficiaries nationally, is the result of greater availability of HMO coverage. Almost one-third (32 percent) of survey respondents had access to a Medicare HMO compared to 23 percent of rural beneficiaries nationally in 1999 and 21 percent in 2000 (MedPAC, 2000).

- Beneficiaries who have access to employer-sponsored coverage have less incentive to purchase individual supplemental or Medicare HMO coverage, since employer-sponsored coverage usually has much more comprehensive benefits and lower premium costs than individually purchased Medicare supplemental coverage (Jensen and Morrissey,1992). The much lower rate of employer-sponsored coverage among survey respondents, compared to rural beneficiaries nationally, suggests that the vast majority of survey respondents purchased their previous HMO coverage because they did not have access to employer-sponsored coverage. Similarly, beneficiaries with Medicaid coverage would also have little incentive to obtain Medicare HMO coverage. Thus, beneficiaries with employer-sponsored coverage and those with Medicaid coverage were under-represented among beneficiaries who lost Medicare HMO coverage, compared to rural beneficiaries nationally.

Figure 4-1

Type of Replacement Coverage in February-May 2000 (n=1093)

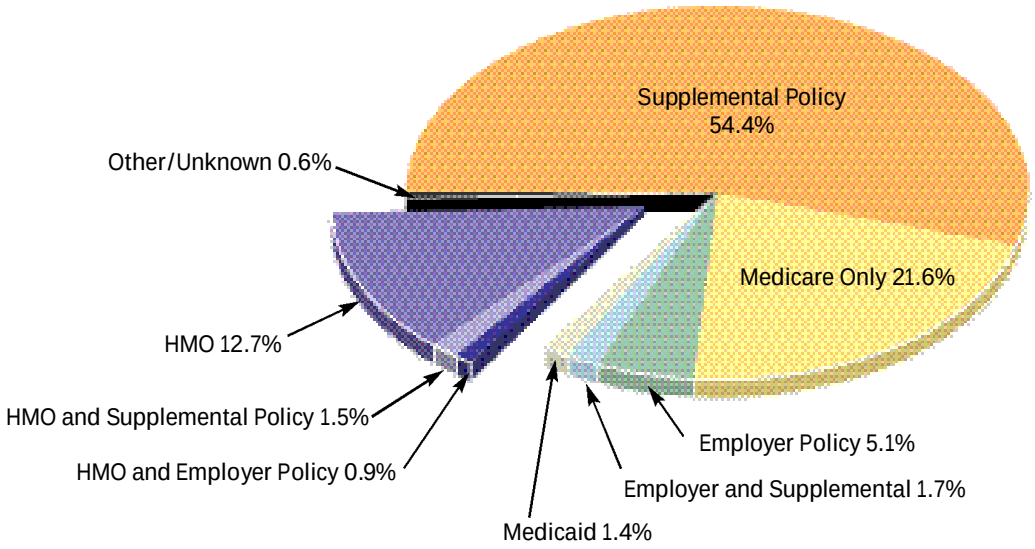


Figure 4-2

Characteristics of Respondents with Medicare Only Coverage Compared to Respondents with Other Types of Coverage in February-May 2000

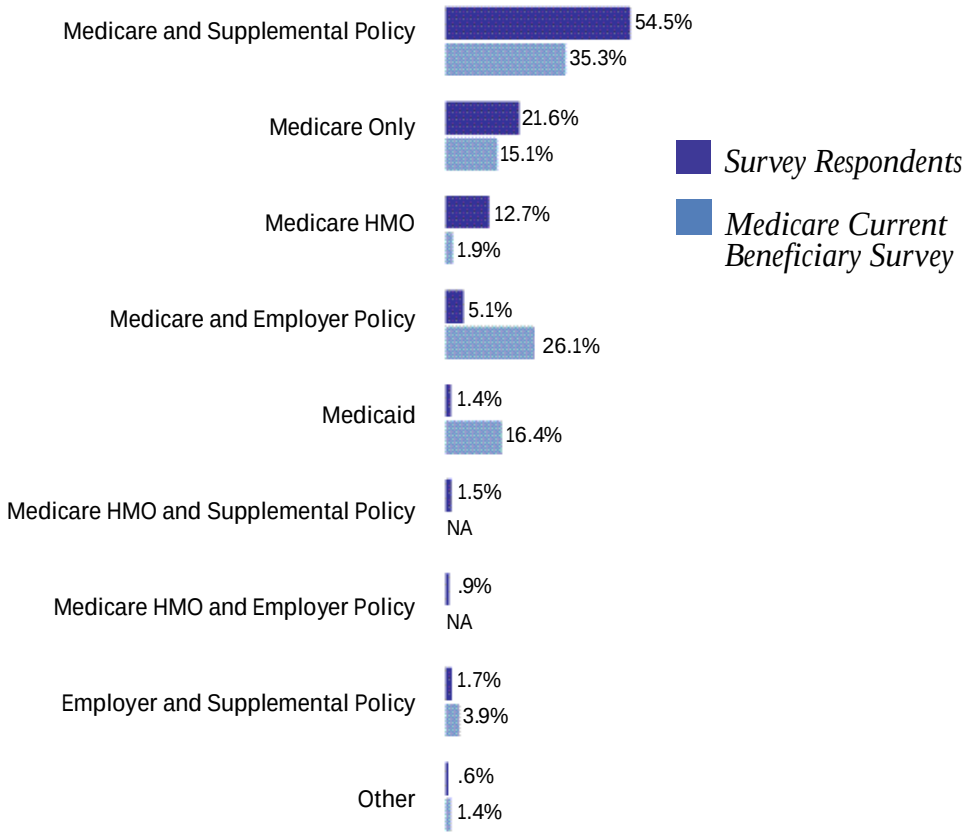
	Medicare Only (n=236)	Supplemental (n=857) [1]
AGE		
65-74 years	59.3	60.6
75-84 years	33.9	33.7
85 years and over	6.8	5.7
GENDER		
Female	53.8	50.3
Male	46.2	49.7
RACE**		
White	86.4	95.4
Other Races	13.6	4.6
EDUCATION**		
Eighth Grade	17.5	11.1
Some High School	19.8	14.3
High School Grad	40.1	43.7
Some College	16.1	19.9
College Grad or Higher	6.5	11.0
HOUSEHOLD INCOME**		
Less than $10,000	32.0	14.2
$10,000 to 19,999	40.2	38.6
$20,000 to 29,999	17.8	25.2
$30,000 to 39,999	5.9	9.9
$40,000 to 49,999	3.0	5.9
Over $50,000	1.2	6.2
LIVING ARRANGEMENT**		
Alone	27.7	22.8
With spouse	60.3	70.2
With other relatives	10.3	5.4
With non-relatives	0.9	1.7
Nursing home	0.9	0.0
SELFREPORTED HEALTH STATUS*		
Poor	8.6	4.7
Fair	18.1	13.8
Good	35.3	33.0
Very Good	25.9	31.1
Excellent	12.1	17.5
NUMBER OF PRESCRIPTIONS TAKEN ON REGULAR BASIS		
None	25.3	20.0
1 to 2	42.8	40.3
3 to 5	22.7	31.2
6 or more	9.2	8.5
NUMBER OF PHYSICIAN VISITS IN PAST YEAR**		
None	12.3	5.8
One	15.0	10.9
2 to 4	45.0	47.0
5 to 9	16.8	21.0
10 or more	10.9	15.3
OVERNIGHT HOSPITAL STAY IN PAST YEAR		
YES	17.1	18.7
No	82.9	81.3

*p<.05, **p<.01

[1]Includes beneficiaries with supplemental, HMO, employer, and other coverage.

Figure 4-3

Comparison of Coverage Among Survey Respondents February–May 2000 and Rural Medicare Beneficiaries in the Medicare Current Beneficiary Survey, 1997



The Process of Obtaining Replacement Coverage

Key Results

Friends and family members, senior advocacy groups and senior centers were the most frequently cited sources of information used by rural beneficiaries to choose their replacement coverage.

- Beneficiaries identified an average of 1.5 sources of information about plans they could use to replace their HMO coverage. About two percent of beneficiaries reported that they did not receive any information. Another two percent said they just decided to return to their previous plan or Medicare only coverage *(Figure 5-1)*.

- The most frequently cited sources of information were friends and family members; AARP, senior advocacy groups, and senior centers; former Medicare HMOs; media and advertisements; insurance agents; and insurance companies or other HMOs. Relatively few respondents reported using information from HCFA or medical providers.

Ten percent of respondents (n = 105) said they did not receive information that they think would have helped them choose a new plan.

- The types of information that respondents thought would have helped them included information about the costs of plans, the benefits offered, other options in general and HMO options specifically *(Figure 5-1)*.

Beneficiaries rated overall benefit coverage and premium costs as the most important factors in their choice of replacement coverage *(Figure 5-2)*.

- Beneficiaries with coverage in addition to regular Medicare at the time of the survey rated several factors in their choice of health insurance coverage on a scale from 1 to 5, from not at all important to very important. Overall benefit coverage (4.6), monthly premium costs (4.5), and choice of physicians (4.2) received the highest mean scores.

Beneficiaries voluntarily identified several other factors as important in their choice of health insurance coverage that reflect their recent experience of being dropped from a Medicare HMO.

- These factors included prior experience with a company or product; the stability of the company; the reputation of the company; and local availability of the plan.

Beneficiaries' ratings of the importance of factors in their choice of health insurance coverage varied significantly by certain beneficiary characteristics *(Figure A-2)*.

- Beneficiaries' ratings of the importance of monthly premium costs varied significantly by age, gender, and income. Older beneficiaries, women, and beneficiaries with lower household incomes were more likely to rate premium costs as very important.

- Beneficiaries with self-reported poor or fair health were more likely to rate choice of physician as a very important factor, compared to those in good, very good or excellent health.

- Coverage of pre-existing conditions was more important to beneficiaries in fair or poor health, and to those with cancer, heart attack, heart disease, stroke, or diabetes. Those in the middle income range rated coverage of pre-existing conditions as more important than either lower or higher income beneficiaries.

- Women, beneficiaries with less than a high school education, and those with lower incomes were more likely to rate recommendations from family members or friends highly.

Almost one third (31 percent) of beneficiaries identified monthly premium costs as the single most important factor in choosing their replacement coverage *(Figure A-3)*.

- Just under one-fourth (24 percent) of beneficiaries said that the overall benefit package was the most important factor in their choice. Physician choice was third in importance (12 percent). Very few beneficiaries indicated that choice of hospital or recommendation from a family member or friend was the most important factor in their choice.

The most important factor influencing beneficiary choice of coverage varied by their primary type of replacement coverage.

- Almost two-thirds of those with supplemental coverage chose either premium costs or overall benefit coverage as their most important factor, compared to 43 percent of HMO enrollees *(Figure A-3)*. Half of the beneficiaries with employer-sponsored coverage chose "plan offered by employer or union" as the most important factor.

Three-fourths of beneficiaries who did not have health insurance coverage in addition to Medicare said the reason was that additional coverage was too expensive *(Figure 5-3)*.

- Thirteen percent did not feel that they needed additional coverage. Small numbers of beneficiaries did not know how to get coverage, were in the process of trying to get it, or stated that there were no plans available.

Fifteen percent of respondents reported having problems obtaining replacement coverage immediately after losing their HMO coverage.

- The most frequently cited problem for those who had difficulty obtaining replacement coverage was the cost of replacement plans *(Figure 5-4)*. Sixty-five percent of respondents with problems said that replacement coverage was too expensive, and 28 percent said no comparable coverage was available. Additional problems cited by these respondents included not having another health plan available in their area (7 percent); problems obtaining coverage for a pre-existing condition (5 percent), and being refused coverage by an insurance company (4 percent).

Over 40 percent of the 162 respondents who reported having problems obtaining replacement coverage described their problems as unresolved at the time of the survey, 13 to 16 months later.

- The remaining respondents described the resolution of their problems in terms of their current coverage *(Figure 5-4)*. The most common responses were: ended up with Medicare only coverage because unable to obtain or afford additional coverage (28 percent); obtained a supplemental policy (14 percent); and enrolled in an unspecified type of health plan (11 percent).

Rural beneficiaries who reported having problems obtaining replacement coverage differed significantly from those who did not in terms of race, education, income and health status *(Figure 5-5)*.

- Minority beneficiaries were twice as likely as white beneficiaries to report problems obtaining replacement coverage. Those with an eighth grade education or less were more likely than those with more education to have problems. The percentage of beneficiaries reporting problems was inversely related to household income, ranging from 25 percent of those with income less than $10,000 to five percent of those with incomes over $50,000. Twenty percent of beneficiaries in fair or poor health had problems, compared to 13 percent of those in very good or excellent health.

Respondents who reported problems obtaining replacement coverage were significantly more likely than those who did not report problems to have Medicare only coverage.

- Immediately after the loss of their HMO coverage, more than three-quarters (77 percent) of the respondents with problems had no coverage beyond Medicare, compared to less than one-fifth of respondents without problems. Although some respondents with initial problems obtaining coverage were able to obtain a supplemental policy or new HMO coverage by the time of the survey, they were still significantly more likely to have Medicare only coverage than those

who did not initially have problems (57 percent versus 16 percent). They were about half as likely to have Medicare supplemental policies (31 percent versus 60 percent) or HMO coverage (seven percent versus 16 percent).

Beneficiaries' Comments

The usefulness of the information received to help choose replacement coverage was an issue for some beneficiaries.

- One beneficiary said, "I don't know if I received all the information I needed, but based on the information I was given, I am not able to get insurance." Another stated, "We had enough information, but we couldn't decipher it, it was so much and we weren't sure what to do." A beneficiary who is blind said, "It's impossible for me to read anything sent to me because I'm blind. I would have liked to have gotten calls from insurance people giving me information."

"We had enough information, but we couldn't decipher it, it was so much and we weren't sure what to do."

The process of obtaining replacement coverage was daunting for some vulnerable beneficiaries.

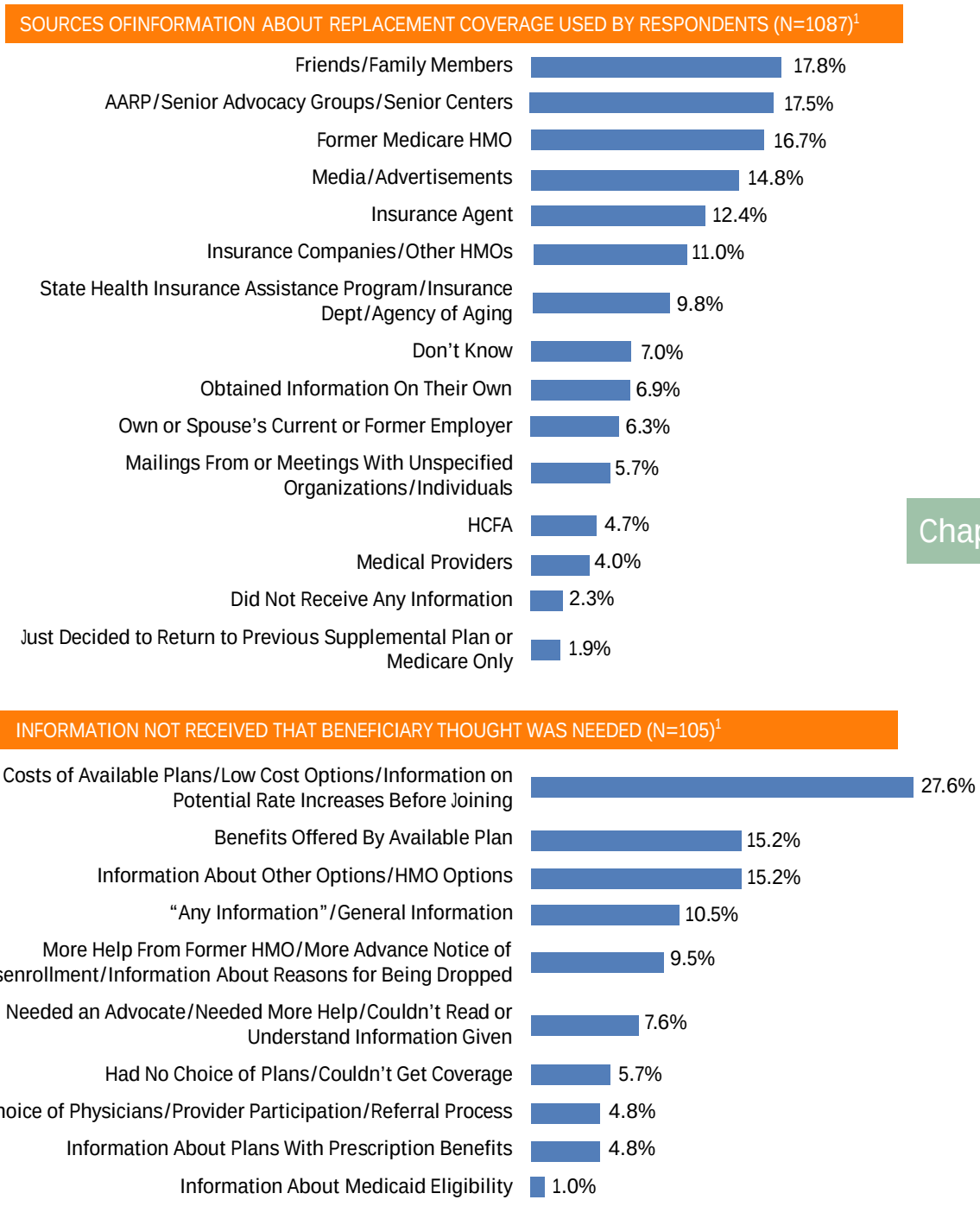
- "I didn't know where to go to get the supplemental insurance," stated one beneficiary. "I had tried to get ahold of the people from my old insurance, but they didn't call me back and I didn't follow up on it." A beneficiary whose first language is not English said, "I didn't really understand the policies. They are too complicated." Another stated, "I think I am too old to be accepted—I am 83. I could use Medicaid, but I don't want to because of the strings attached."

Implications

- Although the majority of rural beneficiaries were able to understand information they were given and seek out the additional information they needed to procure replacement coverage, a number of more vulnerable beneficiaries had difficulty understanding information about their options and obtaining affordable replacement coverage.
- The rural beneficiaries who had problems obtaining replacement coverage were more likely to be minorities, and to have lower incomes, less education, and poorer health status. Beneficiaries with disabilities and language problems also reported difficulties obtaining replacement coverage.

Figure 5-1

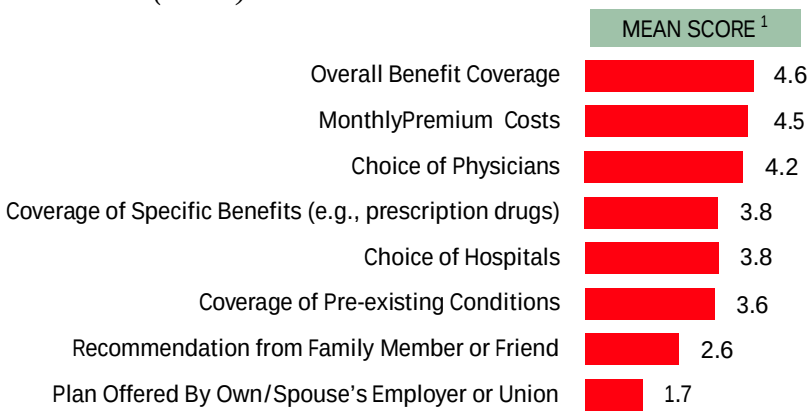
Information About Replacement Coverage Used and Needed By Respondents



[1]Multiple responses were allowed.

Figure 5-2

Importance of Factors Affecting Choice of Replacement Coverage for Respondents with Coverage in Addition to Medicare (n=794)



1 On a scale from 1–not at all important to 5–very important.

Figure 5-3

Reasons for Not Getting Any Coverage in Addition to Medicare, February–May 2000 (n=194)

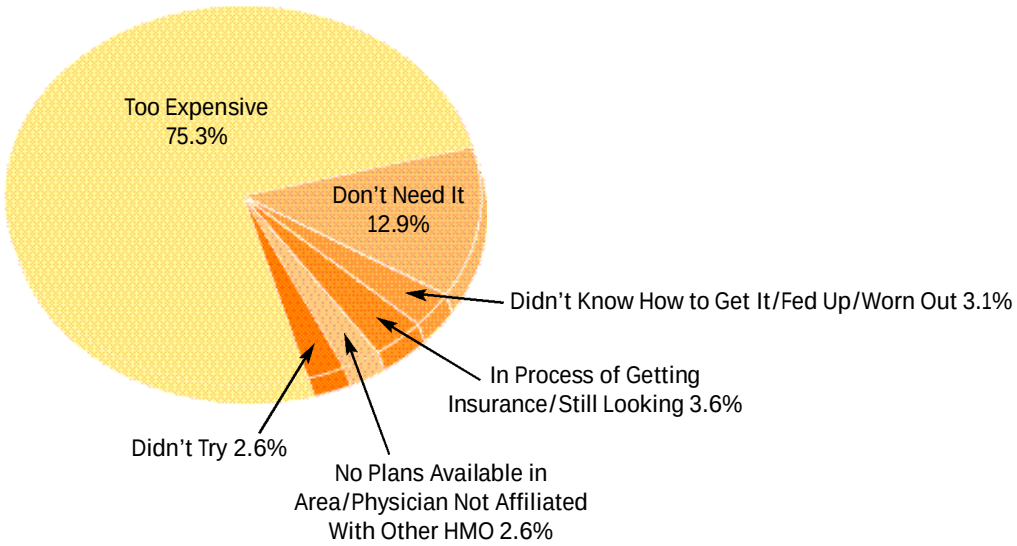
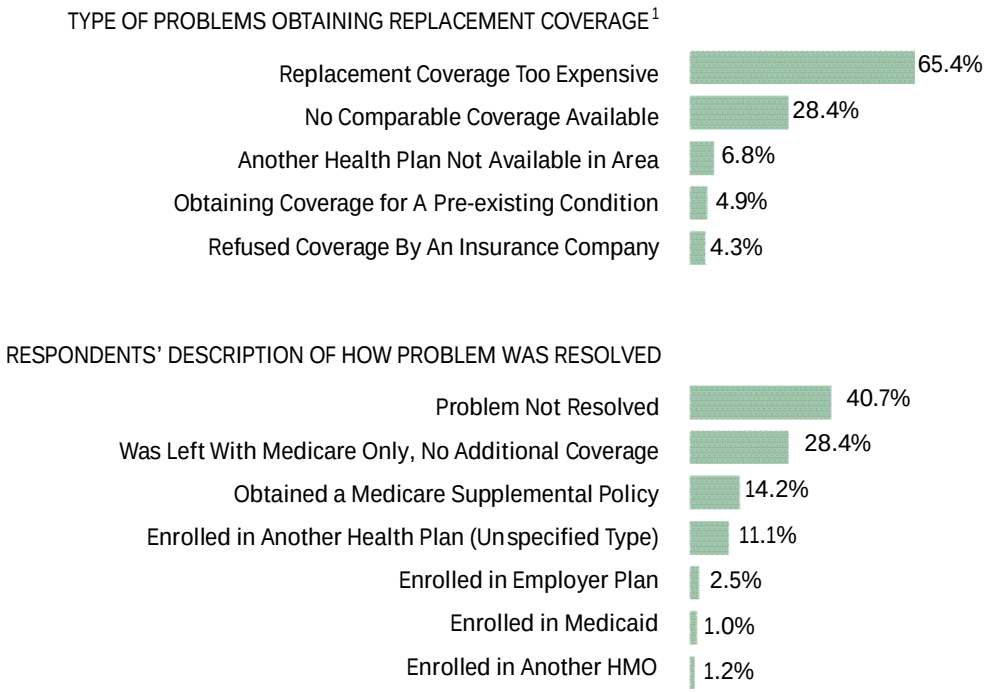


Figure 5-4

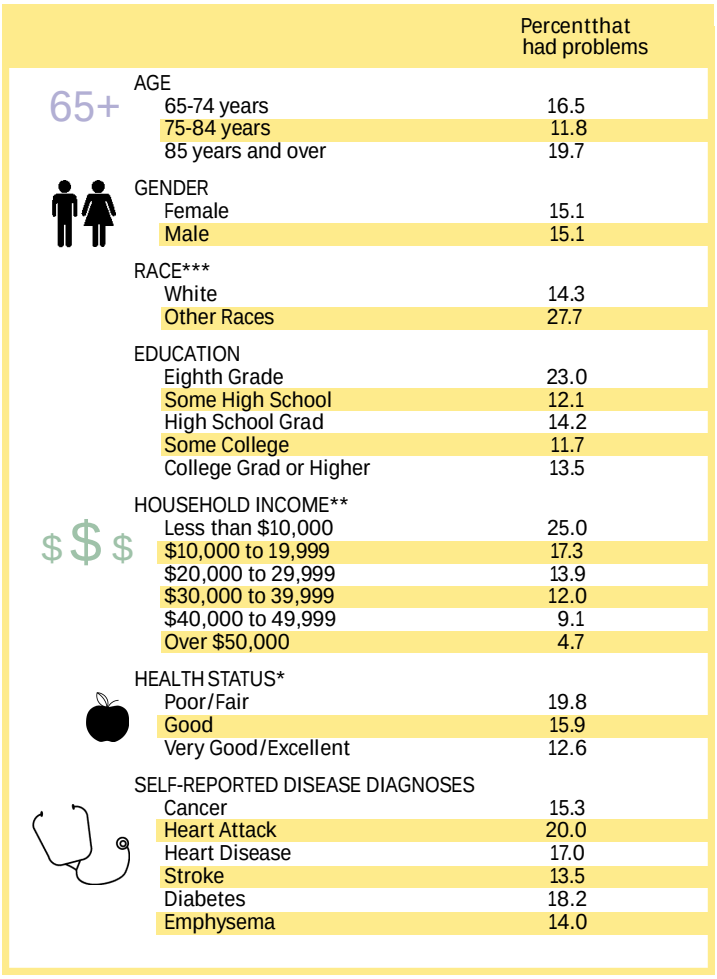
Problems Obtaining Replacement Coverage (n=162)



[1]Multiple responses were allowed.

Figure 5-5

Characteristics of Respondents Who had Problems Obtaining Replacement Coverage (n=162)



Differences between those who had problems obtaining replacement coverage and those who did not are significant at the following levels: *p<.05, **p<.01, ***p <.001

Impact of Loss of HMO Coverage

Key Results

Fourteen percent of rural beneficiaries had to change their primary care physician or other primary care provider, and nine percent of the beneficiaries who used a specialist had to change some or all of their specialists as a result of losing their HMO coverage *(Figure A-4)*.

- Of those who had to change primary care providers, 41 percent said that the change was a problem for them.

- Of those who had to change some or all of their specialists, more than two-thirds said that this was a problem for them.

- Beneficiaries with supplemental coverage were significantly less likely than beneficiaries who enrolled in another HMO to have to change their primary care physician (10 percent versus 21 percent) or specialists (5 percent versus 15 percent) *(Figure A-5)*.

The proportion of rural beneficiaries paying a premium for their health care coverage increased significantly, as did the proportion paying higher premiums *(Figure 6-1)*.

- The proportion of beneficiaries paying a premium for their health care coverage increased from 48 percent while enrolled in their previous HMO to 67 percent at the time of the survey. If beneficiaries without any coverage in addition to Medicare are excluded from the analysis, the proportion of beneficiaries paying a premium for replacement coverage increases to 85 percent.

- Almost half (49 percent) of beneficiaries were paying monthly premiums of $75 or more for their replacement coverage, compared to nine percent who paid that amount while enrolled in their previous HMO.

There were significant differences in the amount of monthly premiums paid by the primary type of replacement coverage *(Figure A-6)*.

- Over half of beneficiaries with supplemental coverage were paying $100 or more in monthly premiums, compared to 13 percent of beneficiaries with employer-sponsored coverage and nine percent of beneficiaries with HMO coverage.

The loss of HMO coverage had a significant negative effect on rural beneficiaries' prescription drug coverage *(Figure 6-2)*.

- Fifty-five percent of beneficiaries had prescription drug coverage while they were enrolled in their previous HMO. This proportion declined sig-

nificantly after the loss of the HMO coverage, with only one-third of beneficiaries having drug coverage at the time of the survey.

There were significant differences between beneficiaries with drug coverage and those without coverage in terms of age, type of supplemental coverage, number of prescriptions taken on a regular basis, and having a diagnosis of certain chronic diseases *(Figure 6-3)*.

- Prescription drug coverage declined with advancing age. Eighty-one percent of respondents with employer-sponsored coverage and 73 percent of those with HMO coverage had some type of prescription drug coverage, compared to 24 percent of respondents with supplemental coverage, and eleven percent of those with Medicare only coverage (these beneficiaries had VA benefits, which provide some prescription drug coverage). The likelihood of having drug coverage ranged from 27 percent of beneficiaries who were not taking any prescription drugs on a regular basis to 47 percent of those who were taking six or more medications, providing some evidence of adverse selection for insurance products offering prescription drug coverage.

The proportion of rural beneficiaries with prescription drug coverage was considerably lower than that of urban beneficiaries in previous research.

- The proportions of rural beneficiaries with prescription drug coverage, both while they were enrolled in their previous HMO and after losing their HMO coverage, were considerably lower than the prescription drug coverage rates for the predominantly urban enrollees who lost their Medicare HMO coverage as reported in the Kaiser study. In the Kaiser study, 84 percent of beneficiaries had prescription drug coverage while enrolled in their previous HMO, and 70 percent had it after losing their initial HMO coverage.

For beneficiaries who obtained coverage in addition to Medicare, satisfaction ratings for their replacement coverage were comparable to those under their previous HMO coverage *(Figure 6-4)*.

- Overall, respondents with coverage in addition to Medicare rated their coverage positively; with 59 percent rating it as excellent or very good. These ratings were very similar to beneficiaries' ratings of their previous HMO.

- Beneficiaries with HMO replacement coverage rated their coverage significantly less favorably than those with supplemental coverage *(Figure A-7)*. Differences in ratings between HMO and employer coverage, and between supplemental and employer coverage were not significant.

Beneficiaries' Comments

Sixty-five beneficiaries described problems with inadequate coverage of needed benefits in their replacement coverage.

- Nearly all of these comments focused on prescription drug coverage; a few beneficiaries also mentioned problems with dental care and eye care.

Sixty beneficiaries offered comments on the costs of health insurance.

- Many respondents echoed the frustration expressed by this beneficiary, who said: "It is so unfair that old people who have worked all their lives now have to suffer because insurance is so high and our income is so low."

- Another beneficiary said, "I think there ought to be something out there to prevent supplemental insurance companies from raising rates as people get older. I have had three rate increases with my present company."

- A few beneficiaries noted that they had to return to work to afford health insurance or the cost of prescription drugs that were not covered by insurance.

Thirty beneficiaries expressed anger and general frustration about losing their HMO coverage; many of these comments reflected a belief that they had been misled or deceived by their HMO.

- Said one beneficiary, "When we signed up for the Medicare HMO, we asked if they were stable and if they were going to stay in our area. The reps said definitely!" The daughter of another beneficiary said, "(The HMO) knew they were going to quit when they signed my mom up. She was only in it for a month before they pulled out."

"It is so unfair that old people who have worked all their lives now have to suffer because insurance is so high and our income is so low."

The loss of prescription drug coverage created significant hardship for a subset of beneficiaries.

- One beneficiary stated, "Our prescriptions and our insurance is much more than we can afford. Last month I couldn't even afford to buy my prescriptions so I just didn't take them." Another commented, "Between my wife and I, we have 14 different prescriptions to get a month. We have no coverage for the

prescriptions. I have no insurance other than Medicare because I can't afford the expensive supplements, and they don't cover prescriptions either."

A few beneficiaries indicated that they had started using VA benefits, state prescription drug programs, drug manufacturers' programs, or going to Mexico to obtain needed prescriptions.

- One beneficiary said, "The loss of prescriptions and dental was the most devastating to us when the HMOs left our area. Because I have such a low income, my doctor is able to get my prescriptions directly from the manufacturer. Otherwise there is no way I would be able to afford my medications."

Implications

The loss of HMO coverage had several adverse consequences for the rural Medicare beneficiaries in this study, including:

- a high proportion of beneficiaries ended up without any coverage beyond traditional Medicare;
- on average, beneficiaries who obtained replacement coverage experienced significant increases in premiums;
- the proportion of beneficiaries with prescription drug coverage decreased significantly; and
- continuity of care was a problem for a small proportion of beneficiaries who had to change their primary care physician and/or specialists.

Previous research suggests that the changes in coverage experienced by rural beneficiaries as a result of HMO withdrawals may negatively affect their access to care.

- Nationally, beneficiaries with Medicare only coverage are much more likely than those with private supplemental insurance, Medicare HMO coverage, or Medicaid to report having difficulty obtaining medical care and having delayed care due to cost (HCFA, 1997).
- Medicare beneficiaries without prescription drug coverage are less likely to obtain needed prescription drugs (Lillard et. al., 1999).

Figure 6-1

Monthly Premiums Paid Before and After Losing HMO Coverage (n=1093)

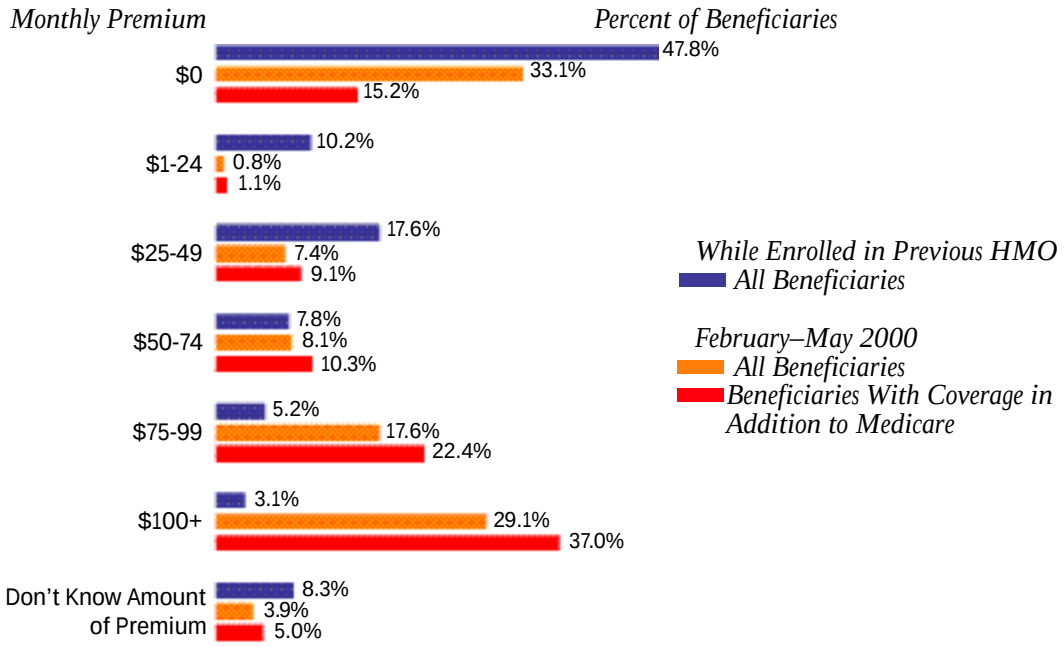
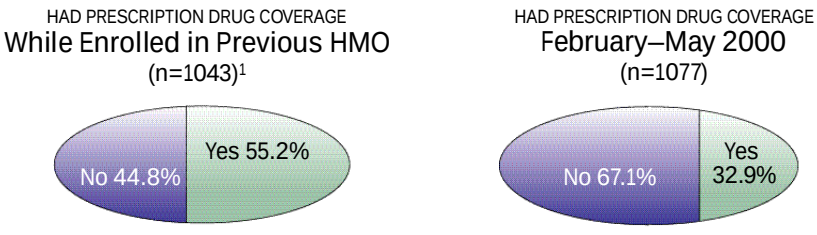


Figure 6-2

Prescription Drug Coverage Before and After Losing HMO Coverage



[1] An additional 50 beneficiaries or proxies answered "don't know" to the question about prescription drug coverage while enrolled in the previous HMO.

Figure 6-3

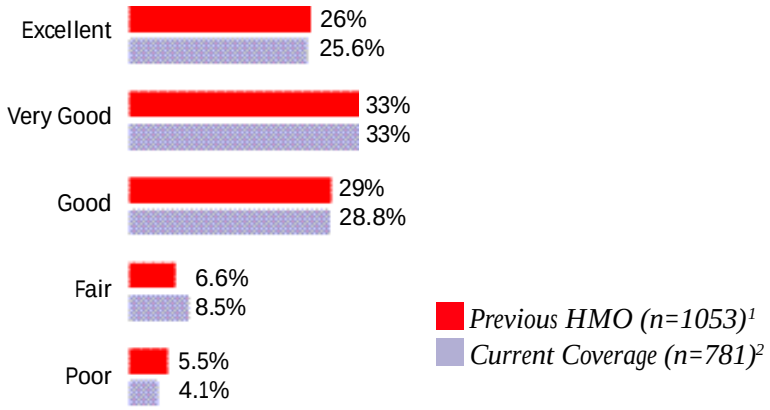
Respondents with Prescription Drug Coverage, February–May 2000 *(n=1077)*

	Percent with prescription drug coverage
AGE**	
65-74 years	35.3
75-84 years	30.5
85 years and over	21.9
GENDER	
Female	32.8
Male	33.0
RACE	
White	33.1
Other Races	29.0
EDUCATION	
Eighth Grade	28.1
Some High School	32.5
High School Grad	33.7
Some College	34.3
College Grad or Higher	36.9
HOUSEHOLD INCOME**	
Less than $10,000	28.6
$10,000 to 19,999	32.1
$20,000 to 29,999	36.2
$30,000 to 39,999	43.2
Over $40,000	32.6
NUMBER OF PRESCRIPTIONS TAKEN ON A REGULAR BASIS**	
None	27.4
1 to 2	31.1
3 to 5	35.8
6 or more	46.7
TYPEOF COVERAGE***	
Supplementalpolicy	23.7
Medicare only[1]	11.0
HMO	73.0
Employer-sponsored policy	80.8
Medicaid	58.3
Other	85.7

[1]These 26 beneficiaries had VA benefits, which provided some prescription drug coverage.
**p<.01, ***p<.001

Figure 6-4

Rating of Previous HMO Coverage and Current Health Insurance (for Respondents with Coverage in Addition to Medicare)



[1] Excludes beneficiaries who responded "don't know" or refused to this question.
[2] Excludes beneficiaries with Medicare only coverage, and who responded "don't know" or refused to this question.

Future Changes in Health Insurance Coverage

Key Results

The majority of beneficiaries do not expect to make a major change in their health insurance coverage in the near future.

- Just under four-fifths of respondents do not expect to make any major changes with respect to their health insurance in the next year, while about nine percent each expect to make a change or don't know if they will make a change *(Figure 7-1)*.

- Of the beneficiaries who expect to make a change, over half plan to either change to a less expensive plan or go back to an HMO if one is available *(Figure 7-2)*. Other expected changes include finding a plan with "better coverage," including prescription coverage; obtaining a supplemental policy; or obtaining a new plan if their doctor is part of it.

Beneficiaries who plan to make a major change in their health insurance coverage this year do not differ significantly from those who do not plan to make a change, in terms of demographic characteristics, health status, or incidence of chronic conditions. They do, however, differ by type of current coverage.

- Fourteen percent of respondents who are currently enrolled in an HMO, ten percent of those with Medicare only coverage, and seven percent of those with supplemental coverage plan to make a major change in their coverage this year *(Figure 7-1)*. No Medicaid enrollees and one percent of those with employer coverage plan to make changes. The proportion of beneficiaries who are uncertain about whether or not they will make a change also varies by type of coverage; 15 percent of those with Medicare only coverage and ten percent of those with supplemental coverage don't know if they will change their coverage.

The majority of respondents who were not enrolled in an HMO at the time of the survey reported that they were unlikely to join another HMO in the next 12 months *(Figure A-8)*.

- Four-two percent said they definitely would not join an HMO, while 22 percent indicated that they probably would not join, and 21 percent were undecided.

- There were no significant differences in the likelihood of joining an HMO in the next year between respondents who had the choice of another Medicare HMO when they were dropped by their previous HMO, and those who did not.

Chapter Seven

Among respondents with supplemental, Medicare only, and employer-sponsored coverage the likelihood of joining another HMO varied significantly by type of coverage.

- No beneficiaries with employer-sponsored coverage said they would definitely join an HMO, and less than four percent indicated that they probably would join one. In comparison, 20 percent of beneficiaries with Medicare only coverage said they probably or definitely would join another HMO.

The vast majority of respondents who did not have a supplemental policy were unlikely to purchase one in the next 12 months *(Figure A-9)*. The likelihood of purchasing a supplemental policy varied significantly by current type of coverage.

- Eight percent of beneficiaries with Medicare only coverage, four percent of those with HMO coverage, and no beneficiaries with employer-sponsored coverage said they would definitely or probably obtain a supplemental plan in the next year.

Beneficiaries' Comments

Beneficiaries' open-ended comments about their HMO experiences and their willingness to enroll in another Medicare HMO reflected a mixture of attitudes.

- Of those who volunteered comments about their HMO experiences, fourteen beneficiaries remarked negatively on HMO coverage decisions, billing procedures, or the limited choice of physicians in their previous or current HMOs, while five beneficiaries were strongly positive about their HMOs, and two gave mixed reviews.

"We will not be sucked into another HMO again, because when they drop you, it is like being dumped off a boat without a life jacket."

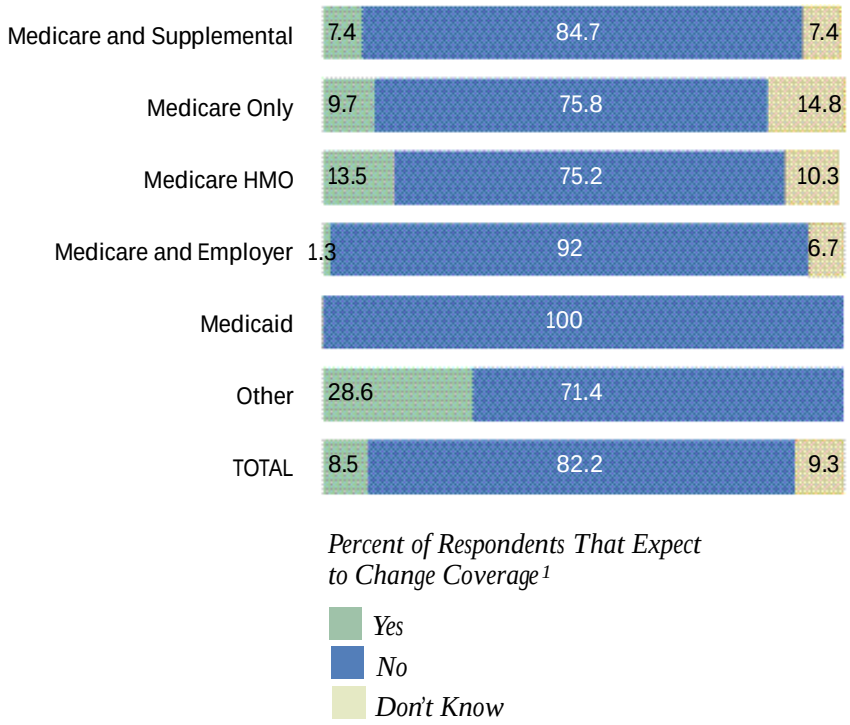
- Twenty-six beneficiaries either said that they wanted to have their previous HMO back or to have another HMO; some of these statements were qualified, for example, by a desire to have the HMO be "stable" or "affordable." One beneficiary said, "We would like to know when a Medicare HMO will come back to our area. My husband is a diabetic and we have huge hospital bills and have to pay up front when he goes into the doctor." Others, however, were not willing to risk joining another HMO; one said, "We will not be sucked into another HMO again, because when they drop you, it is like being dumped off a boat without a life jacket."

Implications

- Although most beneficiaries did not expect to make a major change in their coverage in the next year, 18 percent either expected to make a major change, or didn't know if they would make a change. Lower premiums or additional benefits, such as prescription drug coverage, are the major potential motivating factors for beneficiaries who are planning or considering a change in coverage.
- Some beneficiaries' comments indicated a strong desire to return to HMO coverage, but the unwillingness of the majority of beneficiaries to enroll in another HMO in the next year suggests that the loss of HMO coverage had a chilling effect on rural HMO enrollment, at least in the short term.

Figure 7-1

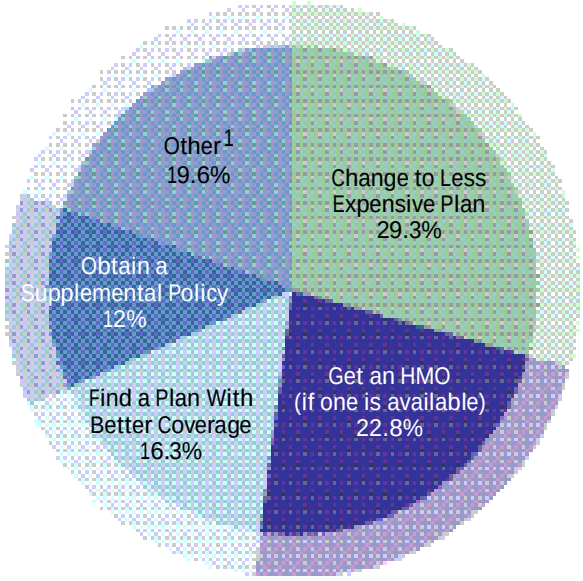
Expectations of Changing Coverage During the Next Year by Type of Coverage in February–May 2000 (n=1087)



[1] Differences in percent of respondents who plan to change coverage in the next year by type of coverage are significant at p<.05

Figure 7-2

Expected Changes for Those Who Plan to Make Changes in Coverage (n=92)



1 Other changes include obtain new plan if my doctor is part of it; plan leaving area; beneficiary moving; use VA coverage; return to Medicare only; add plan if "reliable;" and get Medicaid.

Conclusions

This study identifies three major areas of concern regarding Medicare HMO withdrawals in rural areas:

- the negative consequences that loss of HMO coverage had for rural enrollees, including a reduced likelihood of having coverage in addition to traditional Medicare; lower rates of prescription drug coverage; and higher premiums for replacement coverage;
- the problems obtaining replacement coverage experienced by some vulnerable beneficiaries; and
- the implications of these results for the future of the Medicare+Choice program in rural areas.

The Loss of HMO Coverage Had Especially Negative Consequences for Rural Enrollees

It is not possible to definitively determine whether the rural beneficiaries in the current study were worse off as a result of having and losing HMO coverage than they would have been if they had never obtained HMO coverage in the first place. However, a comparison of the study results with national data on rural Medicare beneficiaries' coverage, as well as with data from previous studies on urban beneficiaries who lost HMO coverage, suggests that the loss of HMO coverage had especially negative consequences for the rural enrollees in this study.

Twenty-nine percent of survey respondents had Medicare only coverage immediately after losing their HMO coverage, and 22 percent had Medicare only coverage at the time of the survey, 13 to 16 months later. In comparison, 15 percent of rural beneficiaries nationally had Medicare only coverage in the 1997 Medicare Current Beneficiary Survey (MCBS); eight percent of the predominantly urban beneficiaries in the Kaiser study and 12 percent of the beneficiaries in the OIG study had Medicare only coverage after losing their HMO coverage.

The high proportion of beneficiaries with Medicare only coverage in the current study is of concern.

The high proportion of beneficiaries with Medicare only coverage in the current study is of concern for two reasons. First, the beneficiaries who had Medicare only coverage were more vulnerable on several measures than those who had some type of additional coverage. They were significantly more likely to be minorities, have less education, have a lower household income, live alone, have no physician visits during the past year, and report being in poor or fair health than beneficiaries with additional coverage. Second, MCBS data show that beneficiaries nationally who only have Medicare coverage are much more likely than those with private supplemental insurance, Medicare HMO coverage, or Medicaid to report having difficulty obtaining medical care and having delayed care due to cost (HCFA, 1997).

In the current study, the proportion of beneficiaries paying a premium for their health care coverage increased from 52 percent while enrolled in their previous HMO to 67 percent of all beneficiaries and 85 percent of those with any coverage in addition to Medicare at the time of the survey. Almost half (49 percent) of beneficiaries were paying monthly premiums of $75 or more for their replacement coverage, compared to nine percent who paid that amount while enrolled in their previous HMO. In comparison, 21 percent of the urban beneficiaries in the Kaiser study were paying $75 or more in monthly premiums for their replacement coverage after losing their HMO coverage.

Prescription drug coverage declined significantly after the loss of the HMO coverage.

Prescription drug coverage declined significantly after the loss of the HMO coverage, with only one-third of beneficiaries in this study having drug coverage at the time of the survey. This proportion is much lower than the 57 percent of rural Medicare beneficiaries or the 73 percent of urban beneficiaries nationally who had some type of prescription drug coverage in 1996 (DHHS, 2000). It is also considerably lower than the 70 percent of urban beneficiaries in the Kaiser study who had prescription drug coverage after losing their initial HMO coverage.

The loss of prescription drug coverage may cause Medicare beneficiaries to delay or forego essential treatment with prescription medications. Large out-of-pocket expenditures for drugs serve as a barrier to elderly persons receiving needed medications, and chronically ill seniors are especially vulnerable (Rogowski et. al., 1997). Having prescription drug coverage decreases the financial burden on elderly persons and significantly increases the probability of prescription drug use (Lillard et. al., 1999).

Fourteen percent of beneficiaries in the current study had to change their primary care physician or other primary care provider as a result of losing their HMO coverage, and nine percent of the beneficiaries who used specialists had to change some or all of their specialists. In comparison, 22 percent of respondents in the Kaiser study had to change their “personal doctor or nurse” and 17 percent had to change specialists. The much higher proportion of beneficiaries with HMO replacement coverage in the Kaiser study probably accounts for the higher proportion of beneficiaries who had to change providers. In both studies, respondents who had HMO replacement coverage were significantly more likely to have to change providers than those who had supplemental coverage.

Inadequate Information, Lack of Choice, and Costs of Replacement Coverage Were Major Problems for Some Vulnerable Rural Beneficiaries

The Health Care Financing Administration required HMOs that were either not renewing their Medicare contracts or withdrawing from a por-

tion of their service area to send all affected enrollees information on their options to: 1) join another Medicare HMO if one was available in their area or 2) return to the traditional Medicare program and obtain a supplemental policy. Under federal law, beneficiaries who were terminated from their HMO as of December 31, 1998 had the right to buy any Medicare supplemental plan designated A, B, C, or F that was offered in their state, for a 63 day period after their HMO coverage terminated. Companies were forbidden from placing pre-existing condition exclusions on these policies or discriminating in pricing based on the beneficiary's health status or claims experience. In addition, a beneficiary who had been enrolled in an HMO for less than 12 months, was never enrolled in any other Medicare HMO, and had a previous Medicare supplemental policy, could return to that policy if the insurer still sold the policy in the state (HCFA, 1998b).

However, these protections were not sufficient for some beneficiaries. Ten percent of the respondents in this study said they did not receive adequate information to help them choose a new plan, and others reported that the information they received was not useful. Fifteen percent of respondents reported having problems obtaining replacement coverage, with the most frequently cited problem being the high cost of replacement plans. In open-ended comments, several respondents indicated that they had no choice of replacement plans, and many respondents stated that they could not obtain an affordable replacement policy that included prescription drug coverage.

A combination of factors was likely responsible for the difficulties experienced by these beneficiaries. First, the results of previous research suggest that the process of choosing replacement coverage probably was confusing for some beneficiaries, especially those who were more vulnerable. Alecxih et. al. (1997) concluded that Medicare beneficiaries may have difficulty comparing premium costs across supplemental products that are rated using attained-age, issue-age, or community rating; they may also have difficulty understanding that premiums for an attained-age product will increase as they grow older. Hibbard et. al. (1998) identified significant problems with Medicare beneficiaries' understanding of the Medicare program in general and of HMOs in particular, even among urban beneficiaries in high penetration Medicare HMO markets. Langwell et. al. (1999) found that Medicare HMOs vary considerably between and within market areas in the generosity of their benefit packages, premiums, and cost-sharing requirements. They concluded that beneficiaries choosing among HMOs, or between HMOs and supplemental policies, have a "complicated task in evaluating their choices and their implications for out-of-pocket spending." MedPAC (1998) suggested that partial standardization of Medicare HMO ben-

The process of choosing replacement coverage was confusing for some beneficiaries, especially those who were more vulnerable.

efit packages, based on requirements similar to those implemented for the Medicare supplemental market by the OBRA 1990 legislation, would allow beneficiaries to better compare Medicare supplemental and managed care alternatives.

Beneficiaries' choices of replacement coverage were limited by the lack of Medicare HMOs in many rural areas, and the absence of "guaranteed issue" supplemental plans with prescription drug coverage.

Second, in the current study, beneficiaries' choices of replacement coverage were limited by the lack of Medicare HMOs in many rural areas, and the absence of "guaranteed issue" supplemental plans with prescription drug coverage. Fifty-eight percent of respondents indicated that they did not have another Medicare HMO they could join when they were dropped by their previous HMO, and 10 percent of respondents were not sure. None of the four "guaranteed issue" supplemental plans that beneficiaries could purchase during the 63-day period following termination of their HMO coverage included prescription drug coverage.

Finally, premiums for Medicare supplemental policies have increased significantly in the past few years (Alecxih et. al., 1997; Cys, 2000). For a variety of reasons, supplemental policies tend to have higher premiums than Medicare HMOs, as well as less extensive benefits (Pourat et. al., 2000). Therefore, although insurers were prohibited from discriminatory pricing of supplemental policies based on health status or claims experience during the 63-day period after beneficiaries' HMO coverage terminated, it is likely that many beneficiaries could not obtain a supplemental policy that was comparable to their previous HMO coverage.

Study Results and Rural Medicare Managed Care Trends Raise Questions about the Future of the Medicare+Choice Program in Rural Areas

Both rural Medicare beneficiaries' access to a Medicare+Choice plan and the proportion of rural beneficiaries enrolled in a Medicare+Choice plan have declined since 1998. Twenty-one percent of rural beneficiaries lived in the service area of a Medicare+Choice plan in 2000, down from 31 percent in 1998 (GAO, 2000). As of March 2000, only 2.2 percent of rural beneficiaries were actually enrolled in a Medicare+Choice plan (McBride, 2000).

Recent data on Medicare+Choice premiums and benefits indicate that the higher premiums and less generous ben-

efits that have historically characterized Medicare managed care plans in rural areas, compared to urban areas, have not changed. In fact, the overall trend toward increased premiums and reduced benefits in Medicare+Choice plans for 2000 was especially evident in rural areas, and the number of rural Medicare beneficiaries whose only Medicare+Choice option was a relatively high cost plan increased significantly (HCFA, 1999).

It seems unlikely that rural areas will see significant growth in Medicare+Choice enrollment in the near future. HCFA is trying to encourage new Medicare+Choice organizations to enter markets that do not currently have any Medicare+Choice plans by giving these plans first priority for review, and providing bonus payments as set forth in the Balanced Budget Refinement Act of 1999 (HCFA, 2000b). The General Accounting Office, however, has concluded that the prospects of enticing additional managed care plans to participate in Medicare through "reasonable" payment rate increases are not likely in areas with relatively few beneficiaries and a limited supply of providers (GAO, 2000).

The results of this study suggest that the policy debate about the future of Medicare managed care in rural areas needs to move beyond a discussion of how to encourage HMOs to serve rural areas through improved reimbursement. More fundamentally, we need to ask whether the federal government should continue to encourage managed care plans to enter rural markets where a plan will be the only Medicare+Choice plan and its withdrawal from the program could have especially negative consequences for enrollees who lose coverage.

The Medicare+Choice program provides a very small number of rural enrollees with fewer benefits at higher premium costs than urban enrollees. Rather than devoting Medicare funds to incentives for HMOs to serve currently unserved areas, it may be more equitable to use these funds to pay part of the cost of additional benefits, such as a prescription drug benefit, for all Medicare beneficiaries, regardless of their geographic location and whether or not they have access to a Medicare+Choice plan.

We need to ask whether the federal government should continue to encourage managed care plans to enter rural markets.

Appendix

Appendix

Figure A-1

Characteristics of Respondents By Type of Replacement Coverage in February-May 2000 for Those with HMO, Supplemental, or Medicare Only Coverage

	HMO (n=165)	Supplemental (n=614)	Medicare Only (n=236)
AGE			
65-74 years	63.0	60.3	59.3
75-84 years	31.5	33.9	33.9
85 years and over	5.5	5.9	6.8
GENDER			
Female	51.5	49.2	46.2
Male	48.5	50.8	53.8
RACE***			
White	90.9	96.9	86.4
Other Races	9.1	3.1	13.6
EDUCATION*			
Eighth Grade	12.3	10.9	17.5
Some High School	18.8	13.6	19.8
High School Grad	40.9	43.6	40.1
Some College	18.2	20.3	16.1
College Grad or Higher	9.7	11.7	6.5
HOUSEHOLD INCOME***			
Less than $10,000	20.7	12.4	32.0
$10,000 to 19,999	35.5	39.7	40.2
$20,000 to 29,999	25.6	25.0	17.8
$30,000 to 39,999	11.6	9.0	5.9
Over $40,000	6.6	13.9	4.2
LIVING ARRANGEMENT**			
Alone	20.6	24.0	27.7
With spouse	70.0	70.0	60.3
With other relatives	7.5	4.2	10.3
With non-relatives	1.9	1.8	0.9
Nursing home	0.0	0.0	0.9
HEALTH STATUS*			
Poor/Fair	20.3	18.2	26.7
Good	33.5	32.5	35.3
Very Good/Excellent	46.2	49.3	38.0
DISEASE DIAGNOSES			
Cancer	13.7	14.0	10.8
Heart Attack	15.1	13.1	13.5
Heart Disease	20.4	16.9	14.9
Stroke	13.0	7.6	11.0
Diabetes	17.4	15.3	16.2
Emphysema	12.6	9.8	8.8
NUMBER OFPRESCRIPTIONSIN PAST YEAR			
None	19.8	20.0	25.3
1 to 2	40.1	40.5	42.8
3 to 5	32.1	31.2	22.7
6 or more	8.0	8.3	9.2
NUMBER OFPHYSICIAN VISITS IN PAST YEAR**			
None	8.4	4.7	12.3
One	9.0	11.5	15.0
2 to 4	48.4	46.2	45.0
5 to 9	18.1	22.7	16.8
10 or more	16.1	14.9	10.9
OVERNIGHT HOSPITAL STAY IN PAST YEAR	15.5	19.0	17.1

The three way analysis found significant differences at the following levels: *p<.05, **p<.01, ***p<.001
Beneficiaries with employer coverage, Medicaid, and other coverage were excluded from this analysis because of the small numbers in these categories.
Additional two-way chi-square analysis found significant differences between beneficiaries with HMO coverage and those with supplemental coverage in race, income, and stroke diagnosis measures.

Figure A-2

Statistically Significant Differences in Importance of Factors in Choice of Replacement Coverage (n=794)

Factors in Choice of Replacement Coverage	Statistically Significant Differences in Rating of Importance
Monthly Premium Costs	More Important to Older Beneficiaries ($p < .05$), Women ($p < .01$), and Those with Lower Household Income ($p < .01$)
Choice of Physicians	More Important to Those With Self-Reported Poor or Fair Health ($p < .05$)
Coverage of Specific Benefits (e.g. Prescription Drugs)	More Important to Those With Lower Household Income ($p < .05$)
Coverage of Pre-existing Condition	More important to Middle Income Than Lower or Higher Income ($p < .05$), Those With Poor or Fair Health ($p < .001$), Those With Diagnosis of Cancer ($p < .01$), Heart Attack ($p < .001$), Heart Disease ($p < .01$), Stroke ($p < .01$), or Diabetes ($p < .01$)
Recommendation of Family Member or Friend	More Important to Women ($p < .05$), Those With Lower Household Income ($p < .05$), Those With Less Than a High School Education ($p < .05$)

Appendix

Figure A-3

Most Important Factor in Choice of Replacement Coverage for Those With HMO, Supplemental, or Employer Coverage as Primary Coverage in February–May 2000 [1]

	HMO (n=134)	Supplemental (n=527)	Employer (n=56)	TOTAL (n=717)
Monthly Premium Costs	24.6	35.5	8.9	31.4
Overall Benefit Coverage	17.9	27.1	8.9	24.0
Other	23.1	12.3	5.4	13.8
Choice of Physicians	9.0	12.3	10.7	11.6
Coverage of Specific Benefits (e.g., prescription drugs)	14.2	6.3	14.3	8.4
Plan Offered by Employer or Union	1.5	0.6	50.0	4.6
Coverage of Pre-existing Conditions	4.5	4.6	1.8	4.3
Choice of Hospitals	2.0	0.8	0.0	1.1

[1] Excludes respondents with Medicare only, Medicaid, and other coverage. Respondents with multiple types of coverage designated the coverage that covers most of their health care expenses as their primary coverage.

Figure A-4

Changes in Primary Care Physicians/Providers and Specialists as a Result of Losing HMO Coverage

Had to Change Primary Care Physician/Other Primary Care Provider (n=1086)	14.1
Changing PCP Was a Problem (n=153)	40.5
Had to Change Specialist (Of Those Who Used a Specialist) (n=802)	9.0
Had to Change All Specialists (n=72)	52.8
Had to Change Some Specialists (n=72)	47.2
Changing Specialist(s) Was a Problem (n=72)	69.4

Figure A-5

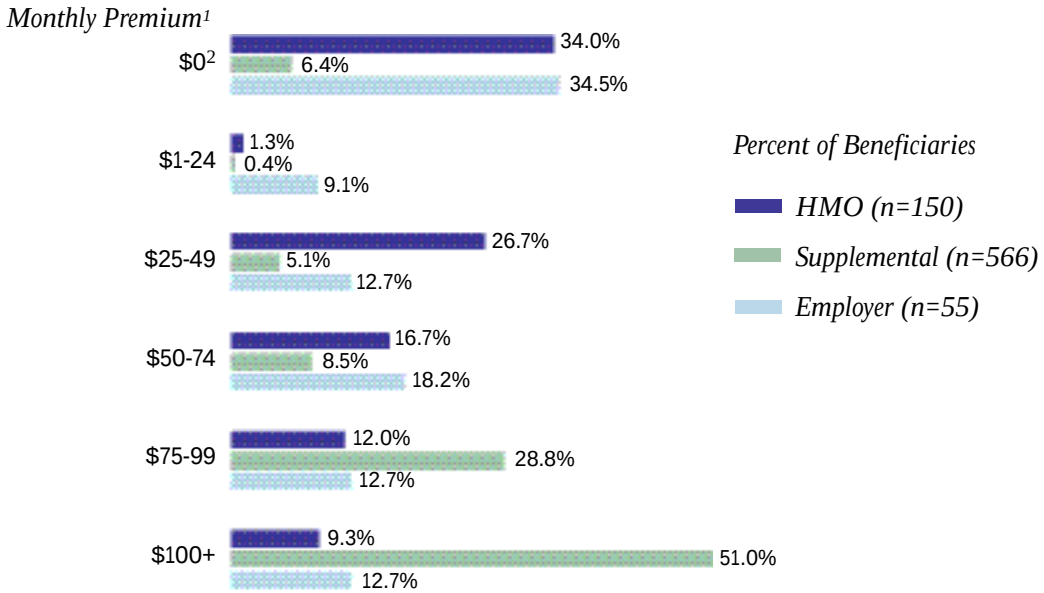
Changes in Primary Care Physicians/Providers and Specialists as a Result of Losing HMO Coverage: Comparison of Beneficiaries Who Enrolled in Another HMO With Those Who Obtained Supplemental Coverage

	Supplemental Coverage (n=497)	Medicare HMO (n=207)
Had to Change Primary Care Physician/Other Primary Care Provider	9.7*	21.3*
Changing PCP Was a Problem	29.2	47.7
Had to Change Specialist (Of Those Who Used a Specialist)	4.7*	15.3*
Changing Specialist(s) Was a Problem	82.3*	52.2*

*Differences between those with supplemental and HMO coverage are significant at p<.05.

Figure A-6

Premiums for Beneficiaries Whose Primary Type of Replacement Coverage was HMO, Supplemental, or Employer Coverage in February–May 2000 (n=771)



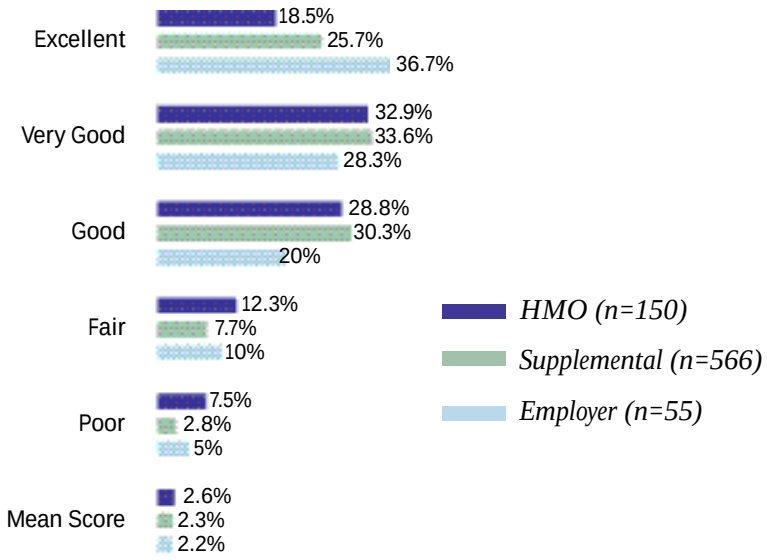
[1] Differences in monthly premium amounts by type of coverage are significant at p<.001.

[2] Supplemental products are not offered with $0 premiums, but these individuals indicated that they had supplemental coverage and were not paying any premiums.

Appendix

Figure A-7

Rating of Current Health Insurance by Beneficiaries Whose Primary Coverage was HMO, Supplemental, or Employer-sponsored in February–May 2000 (n=751)



A three way analysis found differences by type of coverage were significant at p<.05. Two-way analysis found differences between HMO and supplemental coverage significant at p<.05; differences between HMO and employer coverage, and between supplemental and employer coverage were not significant.

Figure A-8

Likelihood of Joining Another Medicare HMO in the Next Year by Type of Current Coverage (n=873)

Likelihood ofJoining HMO[1]	Medicare Only (n=230)	Supplemental (n=589)	Employer-sponsored (n=54)
Definitely Will Join	7.8%	5.1%	0
Probably Will Join	12.2%	8.2%	2.5%
Probably Will Not Join	19.1%	23.8%	6.9%
Definitely Will Not Join	38.7%	41.8%	7.9%
Undecided	22.2%	21.2%	4.1%

1 Differences in likelihood of joining another medicare HMO by type of coverage are significant at p<.05

Figure A-9

Likelihood of Obtaining Supplemental Coverage in the Next Year by Type of Current Coverage (n=420)

Likelihood of Obaining Supplemental Coverage[1]	Medicare Only (n=230)	HMO (n=138)	Employer-sponsored (n=52)
Definitely Will Obtain	.9%	1.5%	0
Probably Will Obtain	7%	2.2%	0%
Probably Will Not Obtain	27.4%	21%	17.3%
Definitely Will Not Obtain	47.8%	68.1%	73.1%
Undecided	17%	7.3%	9.6%

1 Differences in likelihood of obtaining supplemental coverage by type of coverage are significant at p<.001

Appendix

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