SERVING RURAL MEDICARE RISK ENROLLEES: HMOs' DECISIONS, EXPERIENCES, AND FUTURE PLANS

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EXECUTIVE SUMMARY

This study has three purposes: first, to identify factors that influence HMOs' decisions whether or not to offer a Medicare risk product in rural areas; second, to describe HMOs' recent experiences serving rural Medicare risk enrollees; and third, to assess the potential impact of changes in the Medicare program on the future willingness of HMOs to offer a Medicare risk product in rural areas.

Data for the analysis were collected through structured phone interviews with a national sample of twenty-seven HMOs. The surveyed HMOs include fifteen HMOs that are currently serving rural Medicare risk enrollees, one HMO that recently dropped its Medicare risk contract to serve rural enrollees, and eleven HMOs that are serving commercial HMO enrollees in five or more rural counties, but are not serving rural Medicare risk enrollees.

The HMOs serving rural Medicare risk enrollees report that adjusted average per capita costs (AAPCC) rates are one of several factors they consider in deciding whether to include rural counties in their Medicare risk service areas. Other factors that influence HMOs include experience with commercial HMO products in the rural area; having established provider networks in the area; the presence of significant senior populations; employer demand for retiree coverage; competition from other HMOs or the desire to develop a presence with the Medicare product in rural areas before competitors do; corporate mission; and HCFA's requirement that Medicare risk contractors have a contiguous service area.

The majority of interviewed HMOs with rural Medicare risk enrollees have a rural service area for their Medicare risk product that is smaller than their commercial service area. The reasons cited for having smaller Medicare service areas include low AAPCC rates, the HMO's inability to develop a sufficient provider network or an insufficient number of Medicare beneficiaries in some rural counties, and the HMO's desire to gain Medicare risk contract experience with a small area that is easier to serve. Three HMOs are not actively marketing their Medicare risk products in rural counties, and three HMOs indicate that the Medicare risk product they offer in rural counties differs from the product offered in urban counties.

Several HMOs report that rural physicians and hospitals opposed the HMO's initial efforts to offer a Medicare risk product in rural areas. In other cases, rural providers were neutral, or provider response varied from one county to another. A number of HMOs report having difficulty negotiating capitated contracts in rural areas. The HMOs report using a variety of reimbursement methods for their Medicare risk products, depending on the HMO model type, the HMO's ability to negotiate capitated contracts, and/or the volume of Medicare risk patients. Several HMOs use a combination of reimbursement methods for physicians and for hospitals. Most frequently, the HMOs report paying urban physicians on a capitated basis and some or all rural physicians on a discounted fee-for-service basis. The majority of HMOs with rural Medicare risk enrollees report that their Medicare risk products are either losing money or breaking even in rural areas. Most indicate that the Medicare risk product is less profitable in the rural portion of their service area than in the urban areas.

Four of the fifteen HMOs with Medicare risk products have definite plans to expand their rural Medicare service areas in the near future. One HMO says it is "likely" to add one rural county to its Medicare service area, and another HMO will only be adding enrollees from nearby rural areas who obtain care in urban areas. Four HMOs have no plans to expand their rural Medicare service areas, while three HMOs indicate that their future expansion in rural areas depends on changes in AAPCC rates. An additional two HMOs have no specific plans to expand in rural areas, but indicate that they would be open to Medicare expansion in the future, for example, as they expand their commercial service areas.

HMOs that are serving rural commercial enrollees, but not serving rural Medicare risk enrollees are concentrated in the Midwest and South census regions. Compared to the group of HMOs serving rural Medicare risk enrollees, these plans have smaller enrollment and are younger, and a greater percentage are IPA models. Four of these HMOs are serving rural Medicare beneficiaries through health care prepayment plans, Medicare Select, and/or Medicare supplemental products. Two plans are serving urban Medicare risk enrollees, and three more have either submitted or plan to submit applications to serve urban Medicare risk enrollees.

Several of the HMOs that are not currently offering a Medicare risk product in the rural portions of their commercial service areas have seriously considering doing so. Many describe low reimbursement rates in rural counties as the sole reason why they are not serving rural Medicare risk enrollees. Other HMOs cite a combination of factors, including AAPCC rates, the ability to develop a sufficient provider network, and the number of Medicare beneficiaries in the area. Many of the HMOs indicate that a minimum AAPCC rate of $367 would be an increase over current rates in some or all of the rural counties in their commercial service area, and most indicate that changes in the AAPCC rates will positively influence their willingness to serve rural Medicare beneficiaries with a risk product in the future.

INTRODUCTION

In 1990, Mathematica Policy Research, Inc. analyzed HMOs serving Medicare beneficiaries in rural areas under risk contracts and concluded, "The surprising fact is not that so few HMOs offer a Medicare risk plan in rural counties but rather that any do" (Serrato, Brown, and Bergeron, 1995, p. 95). Although the number of HMOs serving rural Medicare beneficiaries has increased since 1990, Medicare risk enrollment in rural areas still lags far behind urban areas. At the end of 1995, 0.7 percent of rural Medicare beneficiaries were enrolled in risk plans, compared to 10.8 percent of urban Medicare beneficiaries (Moscovice, Casey, and Krein, 1997).

Like overall Medicare risk enrollment, rural Medicare risk enrollment is concentrated in a small number of states and health plans. Eighty-five percent of rural Medicare risk enrollees live in just seven states, and sixteen health plans enroll more than three-fourths of rural Medicare risk enrollees (Moscovice et al., 1997). Most rural Medicare beneficiaries do not have the option of enrolling in a Medicare risk plan. As of June 1996, only 22 percent of Medicare beneficiaries in rural counties adjacent to metropolitan areas and nine percent of beneficiaries in other rural counties lived in the service area of a Medicare risk plan. In contrast, 100 percent of beneficiaries in central urban counties and 68 percent of those in other urban counties had access to a Medicare risk plan(PPRC, 1997).

Several recent national studies examined the statistical relationships between AAPCC rates and Medicare risk enrollment in urban and rural areas (Physician Payment Review Commission (PPRC), 1995, 1996, 1997; U.S. General Accounting Office (GAO), 1996; Congressional Budget Office, 1997; Rural Policy Research Institute, 1997a). Using Medicare data from 1989 to 1993, PPRC (1995) found not only that AAPCC rates in rural counties were lower and more volatile over

time than rates in urban counties, but also that Medicare risk enrollment rates were influenced by both the amount and the volatility of AAPCC payments.

The Balanced Budget Act of 1997 contains several provisions designed to reduce geographic variation in AAPCC rates. The legislation phases in a blending of national and local AAPCC rates over a six-year period of time, with a goal of achieving a 50/50 blend by 2004. It establishes a minimum payment floor of $367 in 1998; 30 percent of all counties and 44 percent of rural non-adjacent counties will be raised to the minimum payment rate in 1998 (RUPRI, 1997b). The legislation also creates three options for establishing Medicare payment areas within a state: a) statewide, b) all rural counties in a state, and c) groups of noncontiguous counties.

Will these changes encourage HMOs to serve more beneficiaries in rural areas through Medicare risk contracts? A definitive answer will not be known for some time, but an analysis of HMOs' past decision making, experiences with Medicare risk contracts in rural areas, and reactions to recent changes in the Medicare program may suggest the future direction of the HMO response. Given these changes, the timing is ideal for this study. The study has three purposes: a) to identify factors that influence HMOs' decisions about whether or not to offer a Medicare risk product in rural areas; b) to describe HMOs' recent experiences serving rural Medicare risk enrollees; and c) to assess the potential impact of Medicare program changes on HMOs' future willingness to serve rural Medicare risk enrollees.

BACKGROUND

The Medicare risk contract program was authorized by the Tax Equity and Financial Responsibility Act (TEFRA) of 1982, and implemented in 1985. Prior to 1985, the Health Care Financing Administration (HCFA) contracted with a small number of health plans to serve Medicare

beneficiaries on a risk basis through demonstration projects. The number of HMOs with Medicare risk contracts grew rapidly to 152 plans in 1987, declined to a low of 86 plans in 1991, and then increased to 163 plans in 1995 (PPRC/ProPAC, 1995). As of September 1997, 303 health plans had Medicare risk contracts (HCFA, 1997).

Overall, plans that participate in the Medicare risk program differ from those that only serve the commercial market in terms of model type, ownership, size and age (PPRC/ProPAC, 1995). Group and staff model HMOs are more likely to participate than their share of the commercial market would suggest, while IPAs are less likely to participate. HMOs owned by commercial insurance companies and for-profit plans also have lower participation levels than their shares of the market. Plans with larger enrollment and those that have been operating for more than six years are more likely to participate than smaller, younger plans.

PPRC and Pro PAC (1995) hypothesized that HMOs may participate in the Medicare risk program to obtain more covered lives, especially in saturated HMO markets, and to respond to employers who want to offer HMO coverage to their retirees. They also suggested several possible reasons why plans may decide not to participate, including lack of experience serving the elderly and disabled, apprehension about the Medicare population's greater need for health care services, Medicare's administrative rules, the higher marketing and administrative costs associated with serving individual Medicare beneficiaries, and low capitation rates.

A recent GAO analysis of predominantly urban markets found several factors in addition to AAPCC payment rates that influence HMOs to offer Medicare risk products: the number of Medicare beneficiaries, the presence of multiple HMOs in the health care market, employers' policies on retiree health benefits, and HMOs' individual business strategies(GAO, 1997).

Research on Medicare risk plans in rural areas has been limited. Nycz, Wenzel, Freisinger, and Lewis (1987) described the financially unsuccessful experience of the Greater Marshfield Community Health Plan (GMCHP), one of the largest rural prepaid health plans in the country, with a Medicare risk demonstration project during the early 1980s. While GMCHP enrolled 37 percent of the Medicare beneficiaries in its service area, aggregate losses for the plan and its sponsors exceeded $3 million over the 28 months of the demonstration project. Nycz et al. (1987) concluded that the AAPCC reimbursement method does not adequately control for enrollment selection, unmet medical need, or regional cost variations, and that these problems are more likely to create losses for risk contractors in low-cost rural areas, where there is less room for error.

When Mathematica conducted its assessment of the barriers to expansion of Medicare risk contracts in rural areas in 1990, only eighteen HMOs served rural Medicare risk enrollees (Serrato and Brown,1992; Serrato, Brown and Bergeron, 1995). Using statistical comparisons and interviews with HMOs, the authors identified low AAPCC rates as the primary reason why HMOs did not offer a Medicare risk plan in rural counties. The volatility of rural AAPCC rates also made it difficult to plan and control risk, and the high fixed costs of marketing to individuals and administering a Medicare risk plan were a deterrent to risk contracting in rural areas with small populations. In addition, the HMOs perceived that they were more likely to encounter adverse selection in rural areas because a higher proportion of rural beneficiaries lack adequate access to care. They also believed that the small number of physicians in rural areas and the market power these physicians possessed, limited HMOs' ability to find physicians with whom to contract, and made physicians less willing to participate in Medicare risk plans.

STUDY DESIGN

Two groups of HMOs were interviewed for this study: 1) HMOs serving rural Medicare risk enrollees (the risk sample) and 2) HMOs serving rural commercial enrollees, but no rural Medicare risk enrollees (the commercial sample).

To select the risk sample, we identified the HMOs nationally that were serving 100 or more rural Medicare risk enrollees as of December 1995.[1] These 50 HMOs were grouped into three categories according to their rural Medicare risk enrollment (Figure 1). We selected a Minnesota HMO for a pre-test site, and then randomly selected four HMOs from each size category, for a total of thirteen HMOs in the risk sample. Four originally selected HMOs were replaced because they had no rural counties in their Medicare risk service areas (HCFA, 1996) and appeared only to be serving rural enrollees who obtained medical care in adjacent urban counties. An HMO that dropped its Medicare risk contract as of December 31, 1996 was interviewed about its reasons for dropping the contract and replaced. Two HMOs were moved to the risk sample from the commercial sample because they began serving rural Medicare risk enrollees in 1996. Thus, the risk sample consisted of 16 HMOs.

To select the commercial sample, we identified 256 HMOs with five or more rural counties in their commercial service areas as of 1995.[2] After excluding HMOs with rural Medicare risk

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[1]Rural areas were defined as counties located outside of metropolitan statistical areas. The enrollee data were from the Medicare Managed Care Market Penetration Report(HCFA, 1995).

[2] Since county-level data on commercial HMO enrollment are only available for eight states (Moscovice et. al.,1997), the presence of five or more rural counties in an HMO's commercial service area was used as a proxy for rural commercial enrollment. The commercial service area data were from the InterStudy National HMO Census (InterStudy, 1995).

Figure 1
Sample of HMOs with Rural Medicare Risk Enrollees

HMOs with >100 Rural Medicare Risk Enrollees as of 12/95	
100 - 299 enrollees	19
300 - 999 enrollees	15
> 1000 enrollees	16
Total	50
HMOs in Initial Sample	
100 - 299 enrollees (Includes one pre-test site)	5
300 - 999 enrollees	4
> 1000 enrollees	4
Total	13
Four HMOs with no rural counties in Medicare service area, replaced	
Round 1 (3 HMOs)	
Round 2 (1 HMO)	
Additional HMO added because one HMO dropped risk contract	1
Two HMOs started serving rural Medicare risk enrollees after 12/95 (Moved from non-risk sample)	2
Final Sample	16

enrollees in 1995 and HMOs that began Medicare risk contracts in 1996-97,[3] 182 HMOs remained, concentrated in the Midwest and South census regions (Figure 2). We chose a Minnesota HMO for a pre-test site, and then selected a random sample of twelve HMOs stratified by census region. The commercial sample reflected each region's proportion of HMOs serving five or more rural counties, but not serving rural Medicare risk enrollees: one HMO each in the Northeast and West, and five HMOs each in the South and Midwest census regions. After moving two HMOs with rural Medicare risk enrollees as of 1996 to the risk sample, the commercial sample consisted of eleven HMOs.

Interview protocols were developed using the literature on HMOs and Medicare risk contracts, especially the Mathematica study (Serrato and Brown, 1992). The pre-test interviews were conducted in February 1997, and the remaining interviews from May to September 1997. We interviewed senior managers who were knowledgeable about the HMO's Medicare risk product or the HMO's decision not to offer the product.

RESULTS: HMOS SERVING RURAL MEDICARE RISK ENROLLEES

Of the sixteen Medicare risk HMOs interviewed, three had pre-TEFRA demonstration projects, five HMOs began their Medicare risk contracts between the mid-1980s and 1991, and eight HMOs signed contracts after 1993 (Table 1). The fifteen HMOs with current rural Medicare risk enrollees range in organizational age from eight to 51 years, with a median age of thirteen years (Table 2). Six are mixed-model HMOs, seven are IPAs, one is a group model, and one is a staff model. Ten of the HMOs are for-profit entities.

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[3] It was not possible to exclude all HMOs with new Medicare risk contracts because of differences between the InterStudy and HCFA lists resulting from changes in HMO ownership and the fact that some HMOs have Medicare risk contracts through affiliated corporations.

Figure 2
Sample of HMOs with Rural Commercial Enrollees
But No Rural Medicare Risk Enrollees

HMOs with >5 Rural Counties in Commercial Service Area and No Medicare Risk Enrollees	5
Northeast Census Region	76
Midwest Census Region	79
South Census Region	22
West Census Region	182
Total	
Initial Sample	
Northeast Census Region	1
Midwest Census Region (Includes one pre-test site)	6
South Census Region	5
West Census Region	1
Total	13
One HMO had no commercial enrollment, replaced	
Six HMOs refused to participate, replaced	
Round 1 (3 HMOs from South, 1 HMO from Northeast)	
Round 2 (2 HMOs from South)	
Two HMOs started serving rural Medicare risk enrollees after 12/95, moved to risk sample (2 from South)	(2)
Final Sample	11

Table 1
Participating HMOs with Rural Medicare Risk Enrollees

	Start Date of Medicare Risk Contract
Blue Care Network Health Central, Lansing, Michigan	1977
Preferred Care, Rochester, New York	1979
Medica Health Plan, Minnetonka, Minnesota (Pre-test)	1980
Kaiser FHP of Northwest, Portland, Oregon	1985
PacifiCare of Oregon, Portland, Oregon	1986
HealthSource Indiana, Indianapolis, Indiana	1989 (ended 1996)
PacifiCare of Texas, Dallas, Texas	1990
PCA Health Plans, Miami, Florida	1991
FHP of Colorado, Denver, Colorado	1993
NYL Care Health Plans of Gulf Coast, Houston, Texas	1993
Geisenger Health Plan, Danville, Pennsylvania	1994
Intergroup of Arizona, Tucson, Arizona	1994
Lovelace Health Plan, Albuquerque, New Mexico	1994
United Health Care of Louisiana, Baton Rouge, Louisiana WellCare	1994
of New York, Newburgh, New York	1995
HMO Partners, Little Rock, Arkansas	1996

Table 2
Characteristics of Participating HMOs with Rural Medicare Risk Enrollees

	Plan Age (years)	Model Type	Tax Status
Medica Health Plan	21	IPA/Network	Non-profit
Blue Care Network Health Central	18	Staff/Network	Non-profit
FHP of Colorado	8	IPA	For-profit
PCA Health Plans	8	IPA	For-profit
Preferred Care	17	IPA	Non-profit
Lovelace Health Plan	23	Staff/IPA	For-profit
PacifiCare of Texas	9	Group/IPA	For-profit
WellCare of New York	10	IPA	For-profit
NYL Care Health Plans of Gulf Coast	13	IPA	For-profit
Geisenger Health Plan	24	Group/IPA	Non-profit
Intergroup of Arizona	15	Network/IPA	For-profit
Kaiser FHP of Northwest	51	Group	Non-profit
PacifiCare of Oregon	11	Network/IPA	For-profit
HMO Partners	10	IPA	For-profit
United Health Care of Louisiana	9	IPA	For-profit

Data Source: InterStudy Competitive Edge, August 1996.

Twelve plans have more than 100,000 total enrollees (Table 3). Their overall Medicare risk enrollment ranges from less than 6,000 to more than 65,000 enrollees. Their rural Medicare risk enrollment ranges from just over 200 to almost 15,000 enrollees. Compared to HMO plans nationally (InterStudy, 1996), the HMOs in the risk sample are older, have larger total enrollment, are less likely to have for-profit tax status and are more likely to be mixed model HMOs. Their characteristics resemble those of all HMOs with Medicare risk contracts (PPRC/ProPAC, 1995).

Reasons for Offering a Medicare Risk Product in Rural Areas

Most of the risk sample HMOs cited a combination of factors in their decisions to serve rural Medicare risk enrollees. These HMOs are all well-established plans with large commercial populations, and several indicated that their decision to offer a Medicare risk product in rural areas was influenced by their experiences offering commercial products in those areas. For six HMOs, having an established provider network in rural areas was a major factor. As one HMO said, "We already had commercial products there, we had a network there, and there were seniors there."

Seven HMOs cited the presence of significant senior populations in some rural areas as a motivating factor for offering the Medicare risk product. Six HMOs reported that employer demand for retiree coverage was an important incentive. The HMOs were especially interested in contracting with major employers with large numbers of retirees in rural areas. As one HMO said, "It was important to us to have as many counties as possible in our service area, for those major employers that want the Medicare risk product available." The HMOs were also interested in retaining commercial members who retired. "We wanted our regular members to have the option of staying with the plan."

Table 3
Total and Medicare Enrollment of Participating HMOs with Rural Medicare Risk Enrollees

		Medicare Risk Enrollees		
	Total Enrollees	Total	Rural	Rural as Percent of Total
Preferred Care	178,652	17,258	206	1.2
Medica Health Plan	586,265	40,637	233	0.6
Blue Care Network Health Central	67,536	5,901	304	5.2
PCA Health Plans	111,230	38,236	1,149	3.0
FHP of Colorado	311,133	49,628	1,255	2.5
United Health Care of Louisiana	110,794	18,433	1,582	8.6
Lovelace Health Plan	102,475	16,159	1,626	10.0
NYL Care Health Plans of Gulf Coast	347,988	37,935	1,839	4.8
HMO Partners	55,709	6,658	2,475	37.2
PacifiCare of Texas	151,698	65,349	2,657	4.1
WellCare of New York	92,892	7,825	3,860	49.3
Kaiser FHP of Northwest	394,131	33,075	4,394	13.3
PacifiCare of Oregon	174,256	40,330	6,883	20.6
Intergroup of Arizona	318,752	46,027	8,523	18.5
Geisenger Health Plan	155,276	27,374	14,755	53.9

Data Sources: InterStudy Competitive Edge, August 1996, and
HCFA Medicare Managed Care Market Penetration File, June 1997.

For three HMOs, corporate mission influenced their decision. One HMO stated: "We wanted to have a well-rounded offering, from a provider and consumer perspective, by covering Medicare and Medicaid as well as commercial. The HMO has a corporate mission to serve all populations." This HMO added that it did not enter the Medicare risk business thinking it would make money.

Two HMOs described HCFA's requirement that a Medicare risk service area be contiguous as a factor in their decisions. One of these HMOs was serving an urban area and wanted to expand into two other urban areas. The HMO included rural counties in order to have a contiguous area that could be served by one Medicare risk contract. It met the "50/50 rule" with its existing commercial enrollee base, and could add Medicare risk enrollees in the new areas without having commercial enrollment there first.[4] One HMO began serving rural Medicare risk enrollees after it purchased a plan with commercial enrollees and acquired an administrative and sales structure as well as a provider network in the rural area.

Two HMOs specifically mentioned competition from other HMOs in rural areas as a motivating force for serving rural Medicare enrollees. Geographic necessity, i.e., the desire to expand in a state that is mostly rural, played a role in one HMO's decision to expand to rural counties. For one HMO, serving rural Medicare risk enrollees was a "secondary effect"; it chose to serve urban areas and "portions of the nearby rural counties just came with them."

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[4] The 50/50 rule required HMOs with Medicare risk contracts to have at least 50 percent commercial enrollment. The Balanced Budget Act of 1997 eliminates the rule after January 1, 1999; removes Medicaid enrollees from the 50 percent limit; and allows waiver or modification of the requirement if the Secretary of DHHS finds it is "in the public interest" (P.L.105-33,Sec. 4002).

Another HMO chose to offer its Medicare risk product initially in a small number of urban and rural counties containing a significant proportion of the state's Medicare population.

Four HMOs described AAPCC rates as one of several factors they considered in their decisions to serve rural counties. One HMO selected rural counties where AAPCC rates were "not outrageously low" compared to the urban counties in its service area; other HMOs indicated that they were serving rural areas in spite of low AAPCC rates. These HMOs balanced low rural AAPCC rates with other factors such as capacity in the provider network, provider willingness to work with the plan, the growing number of retirees in some rural areas, and a desire to establish their Medicare risk products in advance of the competition.

Rural Service Areas and Medicare Risk Products

The fifteen HMOs with rural Medicare risk enrollees have rural Medicare service areas that range in size from one county to twenty counties, with a median of five rural counties. Twelve of these HMOs currently have a rural Medicare service area that is smaller than their rural commercial service area. The differences between the HMOs' Medicare and commercial service areas range from one county to the majority of rural counties in a state.

These HMOs most frequently cited low AAPCC rates and difficulty contracting with providers in some counties as reasons for excluding rural counties in their commercial service area from their Medicare service area are. Other reasons for selective exclusion include insufficient numbers of Medicare beneficiaries in some rural counties, the desire to gain experience in a small area, the inability to underwrite and price Medicare products, and

the requirement that Medicare enrollees live in the service area, while commercial enrollees can either live or work in the service area.

Three HMOs are not "actively" marketing their Medicare risk products in the rural portions of their service areas. The reasons given by the HMOs include large financial losses in the rural counties, unfavorable contractual arrangements with providers in those counties, low AAPCC rates, and, for one plan that only serves rural enrollees in urban facilities, the fact that rural enrollment has never been a primary focus for the plan.

Three HMOs responded to low AAPCC rates by offering a different Medicare risk product than they offer in urban counties. The products offered in lower AAPCC counties have higher premiums or higher office copayments and inpatient hospital deductibles, and lower benefits, e.g. in pharmacy or "wellness" services.

Rural Provider Networks and Reimbursement

Two of the risk sample HMOs only serve rural enrollees that obtain care from the HMO's urban providers. Of the thirteen HMOs that contract with rural providers, six have the same provider networks for their Medicare and commercial products. For the other seven HMOs, the smaller Medicare provider network results from the HMO's differing requirements for Medicare and commercial provider contracts, or from provider reluctance to contract for the Medicare risk product, or both. Two HMOs require participating providers to serve all of their lines of business. However, eleven HMOs indicated that they have had difficulty building a provider network for the Medicare risk product in some rural areas.

Several HMOs reported difficulty in negotiating capitated contracts in rural areas. According to one HMO, "Contracting is very different for the Medicare risk product. There is a real resistance to signing capitated contracts in some areas. In addition, physicians need a certain number of enrollees to make it work." Another HMO concurred: "In the rural counties, we are still paying discounted fee-for-service to the physicians. They do not want capitation, and there are no competing providers we could contract with."

The HMOs reported using a variety of reimbursement methods for their Medicare risk products, depending on the HMO model type, its ability to negotiate capitated contracts, and/or the volume of Medicare risk patients. Two of the thirteen HMOs that contract with rural providers capitate all physicians. The other eleven HMOs use a combination of physician reimbursement methods: employed physicians are salaried, and contracted physicians are paid using variations of fee-for-service and capitation. Most frequently, these HMOs pay some or all rural physicians on a discounted fee-for-service basis, while capitating urban physicians.

On the hospital side, one HMO uses global capitation for rural and urban physician and hospital services, while two others capitate urban hospitals, but do not capitate rural hospitals. The other HMOs reported using per diems, DRGs, discounted charges, or combinations of these methods to pay rural hospitals.

Federal Medicare Risk Contract Requirements

Five of the fifteen HMOs with Medicare risk contracts identified HCFA's access standards (which require that enrollees have access to primary and specialty care within

certain distance or travel times) as federal requirements that are more difficult for the HMO to meet in rural areas. Other HMOs reported that provider "monopolies" in some rural counties (e.g., counties with a single IPA or hospital that refuses to negotiate a capitated contract) make it more difficult to meet the access standards. One HMO said that "putting together a viable provider network" has been the most difficult task it has had to accomplish in order to serve rural Medicare risk enrollees. This HMO has not had any major problems with HCFA access standards, and explained that it would rather not market a Medicare risk product in areas where it cannot assemble a "good network," because enrollment would not be sufficient to make it worthwhile.

The risk HMOs reported no problems with HCFA's quality assurance requirements for Medicare risk contractors. One HMO observed that it had already met HCFA's requirements by implementing the procedures necessary to meet National Committee for Quality Assurance (NCQA) standards on the commercial side of its business. Another HMO commended HCFA for its recent quality assurance initiatives, including the move to NCQA standards and Health Employer Data and Information Set (HEDIS) measures. A third HMO described itself as an advocate of HCFA rules because "they are grounded in good sense," although it did not feel that HCFA should be involved in medical management, e.g., mandating mammography services.

Two HMOs expressed frustration with HCFA's administration of regulations governing eligibility and coverage of non-emergency care for enrollees who travel outside of the HMO service area for part of the year.

Competition, Enrollment and Service Utilization

The fifteen HMOs reported varying degrees of competition from other HMOs in their rural Medicare risk service areas. Two HMOs described the rural environment for their Medicare risk products as "competitive." Most of the HMOs, however, reported that competition is limited to one or two other Medicare risk plans in a portion of their rural service areas, in contrast to the significant competition that exists in many urban areas. For a few HMOs, competition in their rural service areas is primarily in the form of Medicare cost and/or supplemental products. One HMO with no rural competition from other Medicare risk contractors anticipated that two risk plans would be entering the market soon. Two other HMOs expected additional risk plans to expand into parts of their rural service areas.

Two-thirds of the HMOs indicated that their rural Medicare risk enrollment had either met or exceeded their expectations. Four HMOs either did not expect to obtain a significant number of rural Medicare risk enrollees, or were not trying to encourage rural enrollment. One HMO had an unfavorable enrollment level in a rural area where the hospital had terminated its relationship with the HMO. In one HMO, half of its Medicare risk enrollees were formerly enrolled in its Medicare supplemental product; the HMO had anticipated that many enrollees would move to the risk product, since it has a lower premium than the supplemental product.

One HMO attributed its success in obtaining rural enrollees to a zero premium, the inclusion of prescription benefits, and participation of local providers; another HMO felt that familiarity with the health plan in the service area was a key factor. One HMO's enrollment

was as expected in most rural counties, but exceeded expectations in a rural county where it has strong relationships with physicians and is the only Medicare risk plan.

Five HMOs did not know whether the utilization patterns of their rural Medicare risk enrollees differ from those of urban enrollees. For most of these HMOs, rural enrollees comprise a small percentage of their Medicare risk enrollees, and they have not examined rural utilization patterns separately. A few HMOs have not observed any differences in rural and urban utilization patterns while others, including two HMOs with large numbers of rural enrollees, reported that utilization has been higher in rural areas. Utilization patterns have been mixed for some HMOs. One HMO has had higher utilization in a rural area where many providers did not previously accept Medicare assignment, and lower utilization in another rural area, which the HMO attributes to practice pattern differences. Another HMO has observed higher utilization in a rural area where the provider network is limited and out-of-network use has been high.

Three HMOs emphasized the importance of enrollee and provider education to address utilization differences. One HMO, which is conducting educational projects for seniors and physicians, said, "Intuitively, I think that the further you get away from the concentration of managed care, the more difficult it is to control utilization. This is both because of enrollees' lack of understanding about the philosophy and concepts of managed care, and physician practice style." Another HMO stressed the importance both of having uniform expectations of provider performance and of conducting medical management activities in rural and urban areas.

HMOs' Financial Experiences with Rural Medicare Risk Products

Of the fifteen HMOs with rural Medicare risk enrollees, eight HMOs were able to differentiate between the financial experience of their Medicare risk product in rural areas and in urban areas. Five of these eight HMOs said their Medicare risk products were unprofitable in rural areas (and either profitable or breaking even in urban areas), while two HMOs said they were breaking even in rural areas and making a profit in urban areas. One HMO reported that its financial experience in both urban and rural areas has been "moderately positive."

One HMO did not describe its financial experience with the Medicare risk product, and six HMOs described their overall financial experience without distinguishing between rural and urban areas. Two of these HMOs said their Medicare risk products were unprofitable overall, two HMOs said they were breaking even, and two reported that their financial experience varied from county to county within their service area. In addition, the interviewed HMO that dropped its Medicare risk contract did so because both the HMO and the rural clinic, its only provider in the area, were experiencing financial losses under the risk contract.

No clear relationship emerged between the HMOs' financial experience with Medicare risk products in rural areas and either the length of time the HMO has offered the product or the number of rural enrollees. The HMOs that reported unprofitable Medicare risk products in rural areas include both HMOs that have had these products for several years and HMOs that began offering them more recently. They also include some HMOs with

large numbers of rural Medicare risk enrollees, as well as HMOs with relatively fewer rural Medicare risk enrollees.

The relationship between the HMOs' self-assessed financial status and their rural AAPCC rates also is not clear. HMOs with low rural AAPCC rates (less than $375) were more likely to say their Medicare risk products are losing money in rural areas, while those with moderate rural rates ($375 to $499) were more likely to say they are breaking even or profitable. However, the group of HMOs that reported financial losses for their rural Medicare risk products included HMOs with moderate to high (over $500) rates.

One HMO with several years of Medicare risk contracting experience described its rural medical loss ratios as "incredibly bad" and indicated that its costs in one rural county are about $200 per member per month higher than the payment rate. That HMO believes that a combination of factors resulted in its large losses: "The AAPCC payment rate is lower in those counties, the health status of the enrollees is worse, and contracting is a main issue - we can't negotiate contracts where providers are at full or even partial risk."

One of the HMOs that started offering the Medicare risk product more recently has seen an improvement in the financial status of the product over time. After large financial losses, the HMO is "almost breaking even" on the product, and expects a positive financial status next year. Another HMO that recently began its risk contract attributed its financial losses to a small actuarial base, and expected more positive results as its Medicare risk enrollment grows.

Future Plans Regarding Medicare Risk Products in Rural Areas

Four of the fifteen HMOs with Medicare risk products plan to expand their rural Medicare service areas in the near future. One of these HMOs plans to add two rural counties, and the other three HMOs plan to add several rural counties. One HMO is "likely" to add one rural county, while another HMO will only add Medicare enrollees from nearby rural areas who obtain care in urban areas. Four HMOs have no plans to expand their rural Medicare service areas; one of these HMOs plans to drop some rural counties unless rates increase or contracting requirements change. For three HMOs, future rural expansion depends on AAPCC changes; one of these HMOs is also evaluating the status of some rural counties in its current service area. Two HMOs may expand their Medicare risk service areas in the future as they expand their commercial service areas.

Potential Impact of Changes in Medicare Risk Program

The risk sample HMOs suggested several changes Congress and HCFA should make to encourage additional HMOs to serve rural Medicare beneficiaries under risk contracts. Establishment of a more equitable AAPCC reimbursement system was most frequently identified as a needed change, followed by implementation of consistent standards for all Medicare risk contractors including provider sponsored organizations (PSOs); beneficiary and provider education about managed care to be conducted by HCFA and the managed care plans; and measures to encourage or require rural providers to contract with HMOs.

"The AAPCC reimbursement system is a real problem," said one HMO. "It's a figment of medical practice that is dysfunctional. It locks you into situations where

utilization is too high and also where it is too low." Another HMO concurred: "We would like to see a new methodology, rather than just adjustments to the AAPCC. The AAPCC is not reflective of what happens in rural areas. Over time as fee-for-service dwindles, it is more of a problem."

After enumerating the obstacles to expansion of managed care to rural areas, one HMO concluded that Medicare needs to "pump money" into rural areas if it really wants managed care to succeed. Noting that two-thirds of the HMOs in its state lost money last year, another HMO suggested that financial incentives or bonuses for HMOs to start up or expand in rural areas would be helpful.

Reduction of Geographic Variation in AAPCC Rates

Not surprisingly, the risk sample HMOs with higher proportions of rural Medicare risk enrollees and those serving rural and urban counties with low AAPCC rates tended to have the most positive reactions to changes that would reduce geographic variation in AAPCC rates. Five HMOs thought the AAPCC changes would increase their willingness and the willingness of HMOs generally to serve rural areas. One HMO stated, "We are extremely encouraged about the impending Congressional changes, especially the $367 floor - that will be an increase in rural areas of [the state served by the HMO]. The two percent minimum increase for [the urban area served by the HMO] is also good."

Two HMOs were generally positive about the proposed changes, but suggested they might not be sufficient to encourage additional rural enrollment. One HMO concluded, "A minimum [payment] is the right direction, but it would have to be at least $450 for us to

seriously look into additional rural areas in this state. I can't speak for other rural areas of the country, but we have high utilization in rural areas, higher costs, and networks that won't accept risk."

One HMO recommended that AAPCC rates be related to utilization and morbidity in the population served, and expressed concern that an AAPCC floor would bring huge profits to HMOs serving some rural areas with low utilization. Another HMO, which only serves rural enrollees in urban facilities, said AAPCC changes were unlikely to affect its willingness to serve additional rural enrollees, because the HMO believes that its model, in which physicians are exclusive contractors, would not work in rural areas.

Four HMOs expressed concern that their AAPCC rates in urban counties, where they have most of their Medicare risk enrollees, would decline. One HMO with high urban and rural AAPCC rates was uncertain about the impact of the AAPCC changes, but expected that the HMO would proceed with its planned service area expansion in rural areas because of competition.

Risk Adjustment of AAPCC Rates

Three HMOs thought that risk adjustment of AAPCC rates would increase their willingness to serve rural Medicare risk enrollees. "Most definitely this would help," said one HMO. "One reason we got slammed financially to start with on the risk product is that we had a lot of adverse selection." Several other HMOs thought risk adjustment was a good idea, but questioned how it would be implemented, and expressed reservations about the data that would be needed.

Modification of 50/50 Rule

The 50/50 rule has not negatively affected either the seven HMOs with rural Medicare risk enrollees that also have rural Medicaid enrollees, or the HMOs that are not serving Medicaid enrollees. Fourteen of the fifteen risk HMOs did not think modification of the rule would have an impact on their future willingness to serve rural Medicare beneficiaries, because they were serving large commercial populations already. One HMO with Medicare and Medicaid enrollees felt the rule might be a problem in the future. Two HMOs indicated that HMOs should have a balance of commercial enrollment and Medicare or Medicaid enrollment, whether or not it is a HCFA requirement, for financial solvency reasons. "I don't think it's wise for a company to have more than 50 percent [non-commercial] enrollment, especially if you have Medicaid," said one HMO, which plans to voluntarily limit its total Medicare and Medicaid enrollment to 40 percent.

RESULTS: HMOs NOT SERVING MEDICARE RISK ENROLLEES

We interviewed eleven HMOs that have commercial enrollees in five or more rural counties, but no rural Medicare risk enrollees (Table 4). Seven of these HMOs are IPA models, two are mixed models, one is a network model, and one is a staff model (Table 5). Seven are for-profit HMOs. The plans range in age from three to 24 years, with a median age of ten years. Their total HMO enrollment ranges from less than 20,000 to more than 277,000. Only two of these plans have more than 100,000 enrollees, compared with twelve of the fifteen plans with rural Medicare risk enrollees. The plans without rural Medicare risk

Table 4
Participating HMOs with Rural Commercial Enrollment, But No Rural Medicare Risk Enrollment

Northeast Census Region
HealthSource Maine, Freeport, Maine

Midwest Census Region
Blue Plus, Eagan, Minnesota (Pre-test Site)
DAKOTA CARE, Sioux Falls, South Dakota
North Central Health Protection Plan, Wausau, Wisconsin
Physicians Health Plan - Michigan, Lansing, Michigan
Rockford Health Plans, Rockford, Illinois
Welborn Health Plans, Evansville, Indiana

South Census Region
Advantage Care, Lexington, Kentucky
Trigon Blue Cross Blue Shield, Richmond, Virginia
United Health Care of Texas, Inc., Austin, Texas

West Census Region
Blue Shield of California HMO, San Francisco, California

Table 5
Characteristics of Participating HMOs with Rural Commercial Enrollment, But No Rural Medicare Risk Enrollment

	Plan Age (years)	Model Type	Tax Status	Total Enrollment
Advantage Care	3	Group/IPA	For-profit	21,818
Blue Plus	21	IPA	Non-profit	70,201
Blue Shield of California HMO	8	Group/IPA	Non-profit	277,815
DAKOTA CARE	10	IPA	For-profit	19,819
HealthSource Maine	10	IPA	For-profit	66,011
North Central Health Protection Plan	24	IPA	Non-profit	40,969
Physicians Health Plan - MI	14	IPA	Non-profit	190,231
Rockford Health Plans	16	Network	For-profit	44,995
Trigon Blue Cross Blue Shield	10	IPA	For-profit	21,583
United Health Care of Texas, Inc.	10	IPA	For-profit	34,103
Welborn Health Plans	9	Staff	For-profit	35,082

Data Source: InterStudy Competitive Edge, August 1996.

enrollees are also younger, and a greater percentage are IPA models. The percentages of for-profit HMOs and non-profit HMOs in the two groups are similar.

Reasons for Not Offering a Medicare Risk Product in Rural Areas

For the commercial sample, AAPCC rates emerged as the most important factor in their decisions not to offer a Medicare risk product in rural areas. Several HMOs described low AAPCC rates in rural counties as the only reason why they are not offering a Medicare risk product in the rural portions of their commercial service areas. Other HMOs cited a combination of factors, including low AAPCC rates, inability to develop a sufficient provider network, and small numbers of Medicare beneficiaries.

After AAPCC rates, a secondary concern for one HMO has been whether it could negotiate appropriate provider contracts, especially with hospitals in "single hospital towns," which have not been willing to accept per diem reimbursement for Medicare patients. However, since the $367 AAPCC floor was announced, some hospitals and physician groups that previously did not want to negotiate with the HMO have said that they might now be interested.

According to one HMO that currently offers a Medicare risk product in urban areas, three factors were important in deciding which counties to include in its Medicare service area: adequacy of AAPCC rates, the ability to develop a sufficient provider network, and the number of Medicare beneficiaries. Because it takes a fair amount of effort to conduct separate rate negotiations with providers for a Medicare risk product, this HMO decided to focus on urban areas, where AAPCC rates would allow it to develop a reasonable network and there were enough Medicare beneficiaries to "make it worth the effort."

Two HMOs have submitted Medicare risk applications for urban counties. For one of these HMOs, the number of Medicare beneficiaries was the biggest factor in choosing counties to be served, although AAPCC rates and the need for a contiguous service area were also important considerations. The other HMO had an internal division among senior management about the advisability of developing a Medicare risk product because of the start-up costs and concern that the product would draw a significant number of enrollees from the profitable supplemental products offered by the HMO's parent corporation. The HMO was unsuccessful in developing two joint ventures with organized delivery systems to offer a Medicare risk product. Consequently, it decided to develop a product using internal resources in an urban area where a provider network could be developed quickly, and AAPCC rates made the product potentially viable from a financial perspective.

Federal Medicare Risk Contract Requirements

Three HMOs in the commercial sample identified HCFA's access standards as federal requirements that are more difficult to meet in rural areas. Two more HMOs felt the access standards might be a problem, but had not yet sufficiently analyzed those standards. One HMO thought it could duplicate its commercial quality assurance and appeals processes for a Medicare risk product without difficulty, but believed that reporting data within HCFA's time frame would be more problematic.

Experience with Other Medicare Products

Of the eleven HMOs not currently serving rural Medicare risk enrollees, seven do not offer any Medicare products. One HMO has a Medicare risk product in urban areas and a health care prepayment plan (HCPP); its parent corporation offers Medicare supplemental and SELECT

products.[5] A second HMO has an urban Medicare risk product and supplemental products offered by a parent corporation. A third HMO has an HCPP, and a fourth HMO's parent corporation offers Medicare supplemental products. Two HMOs previously had Medicare risk products in rural areas, but dropped them because of financial losses.

The two HMOs with urban Medicare risk enrollees began their risk contracts in 1994 and mid-1996. Enrollment in both risk products has been lower than anticipated, which the HMOs attribute to market saturation and the small size of their provider networks. One of these HMOs was forced to close HCCP enrollment when it began the risk contract, because HCFA would not allow the HMO to have both. The HMO feels it could do a better job serving rural areas if it were allowed to keep the HCPP product, which incorporates primary care physician designation and care management. The Medicare SELECT product offered by the HMO's parent corporation has a significant number of enrollees in rural areas, and has exceeded enrollment projections annually.

The second HMO with an HCPP product decided to stop selling it after HCFA placed HCPP contracts under state regulation. The state regulated the HCPP product as a Medigap policy, and would not allow the HMO to require enrollees to stay within the contracted network for care. The HMO felt that this change interfered with its ability to manage care, and decided a year ago to apply for a Medicare cost contract instead of continuing with the HCPP product.

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[5] HCPPs only cover Medicare Part B services; reimbursement is on a reasonable cost basis. Medicare SELECT products are Medigap products that usually offer lower premium costs in exchange for obtaining services from a PPO or other restricted network; reimbursement is on a fee-for-service basis.

Future Plans Regarding Medicare Risk Products in Rural Areas

One of the two HMOs with urban Medicare risk enrollees plans to serve rural enrollees in the future, and the other plans to serve them if its rural AAPCC rates increase. Three HMOs in the commercial sample are considering Medicare risk contracts, but have not decided whether to submit applications or which counties would be in their service areas. Six HMOs have no plans to serve rural Medicare risk enrollees in the near future. Two of these HMOs have submitted Medicare risk applications for urban service areas, and another is preparing such an application. One HMO has applied for a Medicare cost contract; a second is considering a Medicare cost or SELECT product, and a third is considering a traditional Medicare supplemental product.

An HMO with an urban Medicare risk product plans to expand its service area slowly outward in three phases, reaching rural areas by the year 2000. This HMO described its motivation to serve rural areas both in terms of its mission as a non-profit organization and as part of its overall business strategy. Expansion of its Medicare risk service area statewide will help the HMO compete for large employer retiree groups, including state employees. The other HMO with an urban Medicare risk product indicated that its future plans to offer the product in rural areas will depend on AAPCC rates. This HMO stated, "If reimbursement is increased, we are ready to expand risk contracting. We have the infrastructure and provider relationships to offer a Medicare risk product in rural areas. With a very different capitation rate, we would have the motivation to offer it."

An HMO affiliated with a plan in a neighboring state that has a Medicare risk contract is considering a Medicare risk contract application either as a service area expansion for the affiliated plan or as a separate application that builds on the affiliate's experience. If the HMO does apply, it anticipates that the Medicare service area will include some rural counties, but will initially be smaller

than its commercial service area. The counties selected will depend on the HMO's ability to negotiate contracts with hospitals. Another HMO considering a Medicare risk product has been motivated by new leadership. This HMO is employing financial modeling to determine the feasibility of offering the Medicare risk product in the rural counties in its commercial service area.

Three HMOs recently conducted feasibility studies for Medicare risk products. One of these HMOs is considering a Medicare risk contract. The HMO explained, "We are a not-for-profit HMO and don't need to make money for stockholders, but we don't want to offer a Medicare risk product at the expense of our commercial products." The HMO expressed concern about having a critical mass of potential enrollees, low AAPCC rates, and the number of seniors that leave the area for the winter. Currently, no other HMOs offer a Medicare risk product in the service area, but the HMO believes that its two major competitors are considering doing so, and feels that it would be beneficial to "be the first on the block" to offer the product.

The feasibility studies conducted by the other two HMOs had very negative results, and they decided not to apply for Medicare risk contracts. One HMO described the outcome of its study as "dismal." The study only analyzed urban counties because the HMO's rural AAPCC rates were so low that it was "not even a question of feasibility in the rural counties." However, the study still projected a $7.6 million loss for a Medicare risk product.

Potential Impact of Changes in Medicare Risk Program

The majority of HMOs in the commercial sample strongly identified establishment of a more equitable AAPCC reimbursement system as the most important change needed to encourage HMOs to serve rural Medicare beneficiaries under risk contracts. Several HMOs described the AAPCC

system as "unfair" and "inequitable," and said they could not understand why the rates in their areas are so much lower than those in other parts of the country.

One HMO suggested that HCFA allow HMOs to experiment with different mixes of provider types and services to see how best to serve rural areas. This HMO observed that some rural areas do not have the range of providers and services that are available in urban areas, while needs for other services (e.g., home health care) may be greater in rural areas. The HMO also suggested that HCFA conduct focus groups with rural providers and Medicare beneficiaries to help figure out how to best meet the needs in rural areas.

One HMO felt that HCFA might interest health plans in serving rural areas by sponsoring more demonstration programs and by developing joint ventures with HMOs to serve rural areas that involve a cap on the HMO's potential risk. The HMO also suggested that flexibility in guidelines regarding provider ratios and specialty care would help remove barriers to serving rural areas. Another HMO concluded that allowing PSOs to serve Medicare beneficiaries would have a negative impact on its willingness to serve rural Medicare beneficiaries.

Reduction of Geographic Variation in AAPCC Rates

The vast majority of HMOs in the commercial sample responded positively to changes that would reduce geographic variation in AAPCC rates. Nine HMOs anticipated that these changes would have a positive impact on their willingness to serve rural Medicare enrollees under a risk contract. One HMO thought the changes would be positive for low AAPCC areas, but would not be a major factor in its decisions about rural areas because rural AAPCC rates in its commercial service area are already above the $367 floor. This HMO suggested that competition will be the major force leading HMOs to expand into rural areas, and that plans may end up subsidizing Medicare

risk products in rural areas to obtain market share if competition in urban areas increases. One HMO had concerns about the potential negative impact of AAPCC changes on its urban rates.

Several HMOs indicated that a minimum AAPCC rate of $367 would be an increase over current rates in some or all of the rural counties in their commercial service areas. A few HMOs were not sure whether a $367 rate would be a sufficient incentive to offer a Medicare risk product in rural areas, but they described it as "getting close" to the amount needed. One HMO felt that blending of national and local rates may be especially helpful in counties that have had low utilization rates for preventive services due to limited access. However, the HMO was concerned that HMO costs in these areas may be higher than traditional indemnity insurance because of appropriate increases in utilization, and felt that AAPCC rates should cover those costs.

Risk Adjustment of AAPCC Rates

Many of the commercial sample HMOs expressed support for the concept of risk adjustment, but some were concerned about the methodology that would be used. Five HMOs felt that risk adjustment would not affect their willingness to serve rural areas under a Medicare risk contract.

Modification of 50/50 Rule

The 50/50 rule has not been a problem for the four HMOs that have Medicaid enrollees, or for the other seven HMOs in the commercial sample. Two HMOs thought the rule might be problematic under certain circumstances, and one HMO noted that the rule would have given it an advantage in seeking a Medicare risk contract, because it is one of the few HMOs with commercial HMO enrollees in its state.

CONCLUSIONS

The results of this study underscore the importance of AAPCC rates as a factor in HMOs' decisions to offer Medicare risk products in rural areas, but also identify other factors that influence these decisions, including the HMO's experience with commercial HMO products in rural areas, whether the HMO has an established rural provider network (or believes it can successfully develop one), employer demand for retiree coverage, the presence of sufficiently large senior populations, the HMO's corporate mission, contiguous service area requirements, and competition from other HMOs.

The study also shows that AAPCC rates and provider network considerations are important factors in decisions made by a number of HMOs to exclude rural counties in their commercial service areas from their Medicare risk contract service areas. Among the HMOs serving rural commercial enrollees but not serving rural Medicare beneficiaries under risk contracts, low AAPCC rates again emerge as a primary reason, along with the ability to develop a sufficient provider network and the limited number of Medicare beneficiaries in some rural areas.

In many ways, the results of this study resemble those of the earlier Mathematica study (Serrato and Brown, 1992; Serrato et al.,1995). Both studies identified low AAPCC rates, small Medicare populations, and difficulty developing provider networks in some rural areas as reasons why HMOs choose not to offer Medicare risk products in rural areas. Corporate mission was a motivation for a few HMOs to serve rural Medicare beneficiaries in both studies. Both studies also found similar reasons why many HMOs have rural Medicare risk service areas that are smaller than their commercial service areas. Some of the HMOs in the current study had concerns about potential adverse selection in rural areas similar to those of the HMOs in the Mathematica study, while others did not perceive adverse selection to be a problem. Changes in HMO markets since 1990 may account

for the emergence in the current study of employer demand for retiree coverage, competition from other HMOs, and contiguous service area requirements as additional reasons why some HMOs are serving rural Medicare risk enrollees.

The results of our study suggest that the changes in the AAPCC payment methodology passed as part of the Balanced Budget Act of 1997 are most likely to affect the willingness of two groups of HMOs to serve rural Medicare risk enrollees. HMOs that have excluded rural counties in their commercial service areas from their Medicare risk contract service areas primarily because of low AAPCC rates comprise the first group. The second group includes HMOs that serve rural commercial populations, but do not offer a rural Medicare risk product because of low AAPCC rates in those rural counties. Some HMOs are serving rural Medicare risk enrollees unintentionally or only at the HMOs' urban facilities; these HMOs appear unlikely to increase the number of rural enrollees they serve as a result of the AAPCC changes.

Increases in rural AAPCC rates will not directly affect other factors cited by some HMOs as disincentives to Medicare risk product development in rural areas (e.g., small numbers of rural Medicare beneficiaries or the unwillingness of rural providers to contract with the HMO on a capitated basis). However, the AAPCC changes may indirectly reduce some of these barriers. For example, to the extent that increased AAPCC rates allow HMOs to offer rural physicians, hospitals, and other providers more favorable reimbursement, the AAPCC changes may encourage previously reluctant rural providers to participate in HMO provider networks. Alternatively, some of these rural providers may be motivated by increased AAPCC rates and the potential regulatory flexibility of federal PSO standards to develop PSOs, either in competition with HMOs or as joint ventures with HMOs or insurance companies.

Although the majority of Medicare risk enrollees are individuals, this study indicates that large employers seeking HMO coverage for retirees now play a growing role in encouraging HMOs to offer Medicare risk products in some rural areas. The study also suggests that competition in a few Medicare risk markets is motivating some HMOs to expand their Medicare risk service areas to include rural counties. In another sign of potential near-term growth in the rural Medicare risk contract market, several HMOs described a proposed strategy of initially developing their Medicare risk product in urban areas where AAPCC rates are higher and contracting with providers is easier, and then expanding to rural areas.

At the same time, however, a number of HMOs reported financial losses on their rural Medicare risk products, and nearly all of the HMOs currently serving rural Medicare risk enrollees indicated that their financial experience in rural areas has been less positive than in urban areas. The for-profit HMOs interviewed have clear expectations that their Medicare risk products will be profitable or will not be continued. A number of the non-profit HMOs suggested that they did not expect to make money on a rural Medicare risk product, however, they acknowledged the need to break even over the long term.

Most rural Medicare beneficiaries currently have traditional supplemental policies. Some indemnity insurers with substantial numbers of rural Medicare beneficiaries in supplemental products, for example, Blue Cross Blue Shield Associations, operate affiliated HMOs and are encouraging their rural commercial populations to move to managed care. The future of Medicare risk contracting in rural areas may depend in part on whether these organizations decide to offer Medicare risk products through affiliated HMOs, and the degree to which they encourage their Medicare supplemental subscribers to move to managed care.

The success of Medicare risk contracting in rural areas also will depend on whether increased AAPCC rates allow HMOs to offer rural enrollees the type of Medicare risk products that have competed successfully with Medicare supplemental products in higher AAPCC urban markets, i.e., products with zero premiums or low premiums compared to supplemental products, as well as additional benefits such as prescription coverage.

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