Rural Neglect

Medicare HMOs Ignore Rural Communities

A REPORT BY

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INTRODUCTION

Today about 16 percent of Medicare's 39 million beneficiaries belong to Health Maintainence Organizations (HMOs) through the Medicare+Choice Program.[1] The share of the Medicare population enrolled in managed care has grown steadily since the early 1990s and is likely to continue growing. This growth, coupled with a belief that managed care can help contain health care costs, has encouraged policymakers to make managed care a cornerstone of Medicare reform proposals. The two leading Medicare reform proposals now under consideration—one identified with Medicare Commission co-chairs Senator John Breaux and Representative William Thomas and the other developed by President Clinton—both include provisions designed to encourage beneficiaries to switch to HMOs. The Breaux-Thomas proposal, in fact, depends on the existence of competing HMOs and makes the traditional Medicare program compete with those HMOs.

What effect would Medicare reform proposals that rely on HMOs have on beneficiaries who live in rural communities? To gauge the ability of Medicare managed care plans to serve rural beneficiaries, Families USA analyzed the presence of Medicare+Choice plans in rural counties in 1999.[2] Using HMO contract information from the Health Care Financing Administration (HCFA), we calculated the percentage of rural beneficiaries nationally and in each state who have access to no HMOs, access to just one HMO, and access to two or more HMOs.

Our analysis found that, for most of the 9.2 million Medicare beneficiaries who live in rural areas, the growing reliance on Medicare HMOs is, at best, irrelevant: there is no Medicare HMO serving the county in which they live. Those rural beneficiaries who do have access to a Medicare HMO generally cannot realize the benefits of competition among plans: the majority have only one HMO available to them. The results show that, when it comes to health care for rural Americans, HMOs are not the answer.[3]

KEY FINDINGS

- Nationally, three out of four rural Medicare beneficiaries (73 percent) live in a county that is not served by any Medicare HMO. Only one rural beneficiary in four (27 percent) lives in a county that is served by one or more HMOs.
- Just one rural Medicare beneficiary out of ten (10 percent) lives in a county that is served by two or more HMOs.
- There are no HMOs available to rural Medicare beneficiaries in 13 states. Those states are: Alaska, Idaho, Iowa, Kansas, Kentucky, Mississippi, Nebraska, North Dakota, South Carolina, South Dakota, Utah, Vermont, and Wyoming.
- In another 14 states, some rural Medicare beneficiaries have access to an HMO, but they have access only to one HMO that has no competitors. Those states are: Alabama, Colorado, Delaware, Florida, Indiana, Maine, Maryland, Michigan, Missouri, Montana, Nevada, New Hampshire, Virginia, and West Virginia. In 12 of these states, the majority of rural beneficiaries lack access to any Medicare HMO.
- In 22 states, some rural Medicare beneficiaries have a choice of two or more HMOs. However, in only five states do the majority of rural beneficiaries have such a choice; those states are: Connecticut, Hawaii, Massachusetts, Pennsylvania, and Rhode Island.
- Next year, it is likely that even fewer rural Medicare beneficiaries will have access to HMOs. Based on data about current availability of HMOs and managed care organizations' announced intentions to withdraw from certain areas, it is estimated that only 23 percent of rural beneficiaries (2.1 million) will have access to an HMO in the year 2000.

WHAT THE NUMBERS SHOW: HMOs ARE NOT AN OPTION FOR RURAL MEDICARE BENEFICIARIES

In 1993, about 100 HMOs participated in Medicare. By August of 1999, the number had more than tripled, to 310 Medicare HMOs. To serve Medicare beneficiaries and receive reimbursement from the Medicare program, these HMOs

Table 1

Rural Beneficiaries and Access to Medicare HMOs, 1999, by State

	All Rural Beneficiaries	No Access		Access to Only One HMO		Access to Two or More HMOs	
State	Number	Number	Percent of Rural Beneficiaries	Number	Percent of Rural Beneficiaries	Number	Percent of Rural Beneficiaries
Alabama	238,948	225,012	94%	13,936	6%	0	0%
Alaska	22,712	22,712	100%	0	0%	0	0%
Arizona	103,236	0	0%	70,568	68%	32,668	32%
Arkansas	269,446	223,561	83%	23,538	9%	22,347	8%
California	168,168	112,894	67%	52,265	31%	3,009	2%
Colorado	103,049	84,986	82%	18,063	18%	0	0%
Connecticut	43,582	0	0%	15,601	36%	27,981	64%
Delaware	29,686	0	0%	29,686	100%	0	0%
Florida	218,483	140,772	64%	77,711	36%	0	0%
Georgia	353,615	290,705	82%	47,961	14%	14,949	4%
Hawaii	42,993	74	0%	8,045	19%	34,874	81%
Idaho	113,940	113,940	100%	0	0%	0	0%
Illinois	345,934	251,109	73%	80,186	23%	14,639	4%
Indiana	258,489	252,777	98%	5,712	2%	0	0%
Iowa	300,450	300,450	100%	0	0%	0	0%
Kansas	203,587	203,587	100%	0	0%	0	0%
Kentucky	345,162	345,162	100%	0	0%	0	0%
Louisiana	168,657	48,861	29%	70,242	42%	49,554	29%
Maine	129,675	78,537	61%	51,138	39%	0	0%
Maryland	58,972	0	0%	58,972	100%	0	0%
Massachusetts	14,877	3,435	23%	0	0%	11,442	77%
Michigan	294,171	277,047	94%	17,124	6%	0	0%
Minnesota	258,999	247,744	96%	6,794	3%	4,461	2%
Mississippi	302,093	302,093	100%	0	0%	0	0%
Missouri	319,347	302,283	95%	17,064	5%	0	0%
Montana	102,678	98,548	96%	4,130	3%	0	0%
Nebraska	150,025	150,025	100%	0	0%	0	0%
Nevada	31,779	25,228	79%	6,551	21%	0	0%
New Hampshire	74,351	44,516	60%	29,835	40%	0	0%
New Mexico	103,771	77,840	75%	19,079	18%	6,852	7%
New York	235,363	117,129	50%	63,269	27%	54,965	23%
North Carolina	449,616	386,842	86%	4,868	1%	57,906	13%
North Dakota	69,082	69,082	100%	0	0%	0	0%
Ohio	340,991	93,899	28%	149,156	44%	97,936	29%
Oklahoma	236,916	96,476	41%	83,503	35%	56,937	24%
Oregon	170,996	65,654	38%	80,547	47%	24,795	15%
Pennsylvania	344,802	82,063	24%	82,553	24%	180,186	52%
Rhode Island	13,416	0	0%	0	0%	13,416	100%
South Carolina	184,421	184,421	100%	0	0%	0	0%
South Dakota	85,847	85,847	100%	0	0%	0	0%
Tennessee	325,853	196,471	60%	100,427	31%	28,955	9%
Texas	511,387	262,228	51%	163,287	32%	85,872	17%
Utah	56,408	56,408	100%	0	0%	0	0%
Vermont	64,711	64,711	100%	0	0%	0	0%
Virginia	264,985	248,238	94%	16,747	6%	0	0%
Washington	160,700	57,327	36%	36,147	22%	67,226	42%
West Virginia	198,618	151,263	76%	47,355	24%	0	0%
Wisconsin	291,951	263,234	90%	16,502	6%	12,215	4%
Wyoming	43,525	43,525	100%	0	0%	0	0%
USA	9,220,463	6,748,716	73%	1,568,562	17%	903,185	10%

Sources:
1) The number of rural Medicare beneficiaries was taken from the Health Care Financing Administration's (HCFA) enrollment file (www.hcfa.gov/medicare/stats/enroll98.htm).
2) The number of HMOs in rural counties was determined using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp).
3) Rural counties were identified using data from the U.S. Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt).

Note: Percentages may not add up to 100 due to rounding.

must meet government requirements for benefits, provider availability, marketing, and consumer protections, and apply for and sign a contract with the Health Care Financing Administration (HCFA). A Medicare HMO's geographic service area can be one county or more; in some cases, HCFA allows plans to serve a portion of a county. This analysis assumes all beneficiaries in a county have access to any HMO in the county, even if the HMO's designated service area is only a portion of the county. Therefore, this analysis may overstate rural beneficiaries' access to HMOs.

About a fourth of all Medicare beneficiaries—some 9.2 million people—live in a rural county. Nearly three out of four of those rural beneficiaries (6.7 million) currently live in a county that is not served by any Medicare HMO. Roughly one in six rural beneficiaries (1.6 million) has access to only one HMO. A single HMO, by definition, cannot give beneficiaries the benefits of competition—better service and lower prices. Even fewer rural beneficiaries have a choice of more than one HMO. Just one rural beneficiary in ten (0.9 million) has a choice of two or more Medicare managed care plans.

Indications are that the dearth of HMOs serving rural beneficiaries will not improve next year and, instead, will probably worsen (see Table 2). Each July 1, Medicare HMOs must notify HCFA of their plans to continue in the program the following year. Plans may either withdraw entirely or drop counties from their

Table 2
Estimated Change In Access to Rural HMOs, 1999-2000, Nationally

	1999		2000	
	Number of Rural Beneficiaries	Percent of Rural Beneficiaries	Number of Rural Beneficiaries	Percent of Rural Beneficiaries
No HMOs	6,748,716	73%	7,073,625	77%
Only One HMO	1,568,562	17%	1,388,871	15%
Two or More HMOs	903,185	10%	757,967	8%

Sources:
1) The number of rural beneficiaries was taken from the Health Care Financing Administration's (HCFA) 1998 enrollment file (www.hcfa.gov/medicare/stats/enroll98.htm).
2) The number of HMOs in rural counties was determined using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp) and HCFA's list of plan withdrawals for the year 2000, "Medicare Managed Care Non-Renewals: List of Plans."
3) Rural counties were identified using data from the Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt).

Note: Figures for the year 2000 include all plans operating in rural counties contained in HCFA's Medicare Compare database minus those that have announced withdrawals in 2000. The 2000 figures do not account for any new contracts that HCFA might approve for rural areas before 2000. As of August 1999, HCFA reported having 23 applications for new contracts or service area expansions. It was not known how many of these, if any, were to serve rural counties.

geographic service areas. New plans may apply for contracts at any time during the year. A significant number of managed care plans (99) dropped out of the Medicare program or decreased their service areas for 1999, and the same number of HMOs have decided to withdraw or reduce their service areas for the year 2000. These withdrawals and reductions in service areas have a concentrated effect on rural counties because many of the plans eliminating service or decreasing service areas are in rural counties and because rural counties have few HMOs to begin with.

Next year, based on the non-renewal data submitted to HCFA, it is likely that only one rural beneficiary in seven (1.4 million) will have access to one HMO, and fewer than one in twelve rural beneficiaries (0.8 million) will have a choice of two or more HMOs (see Table 3 in the Appendix). In 10 states, the plan withdrawals for the year 2000 will increase the number of rural beneficiaries without access to a Medicare HMO by 10 percent or more. Those states are: Arizona, California, Connecticut, Louisiana, Maryland, New Hampshire, New York, Ohio, Oregon, and Washington.

WHY HMOs DO NOT SERVE RURAL AREAS

Even with little competition and recent legislation to raise Medicare reimbursement rates for rural areas, HMOs have chosen not to do business there. HMOs—at least as they are currently structured—may be an inherently unsuitable system of health delivery for rural areas. There are a number of reasons for this:

The number of potential HMO enrollees in rural areas is small and is spread over a broad area. Limited enrollment restricts the potential for profits yet increases the risk of financial loss from a few high-cost illnesses. Moreover, a small population spread out over a large area prohibits economies of scale. Operating expenses such as marketing to potential enrollees, negotiating with providers, setting up information systems among providers, meeting quality assurance regulations, and other fixed costs can be spread only among a limited pool of enrollees.

HMOs have difficulty recruiting rural providers. Rural areas contain relatively fewer physicians, hospitals, and other providers than urban and suburban areas.

This situation strengthens the market power and negotiating position of providers in rural communities. Generally, rural providers—like any other scarce commodity—are in demand; they do not need the promise of additional patients that drives urban physicians to contract with HMOs. Rural physicians are less likely than their urban counterparts to limit their fees to Medicare-approved rates, and those practicing in federally designated health professional shortage areas receive bonus Medicare payments.[7] These physicians are not likely to benefit from the level of payment obtainable from managed care plans compared to the payment available from the combination of Medicare and beneficiary out-of-pocket payments.

REIMBURSEMENT RATES ARE NOT A MAJOR DETERRENT TO HMO PARTICIPATION IN MEDICARE

Research has shown that Medicare HMOs are overpaid by the government. This overpayment occurs for a number of reasons.

First, Medicare HMOs were found to serve beneficiaries who were healthier and less costly to care for than those who remained in fee-for-service Medicare. Since the reimbursement rate paid by the government to HMOs is computed based on the cost of caring for Medicare's fee-for-service patients, HMO subscribers cost the government more money than if they remained in fee-for-service. The General Accounting Office, the Medicare Payment Advisory Commission, the Congressional Budget Office, and other researchers have concluded that Medicare HMOs make more than a reasonable profit, given the relatively low costs incurred by the Medicare managed care patient population.[4]

Second, Medicare fee-for-service costs include a payment to hospitals to cover the cost of training new physicians in residency programs. HMOs, however, tend to use hospitals that have small or no residency programs. Again, because the HMO payment rate is based on fee-for-service costs, including the graduate medical education payment, the result is overpayment of HMOs.[5]

Despite these findings, Congress increased payment rates for Medicare HMOs in rural areas as part of the Balanced Budget Act of 1997 (BBA). The BBA instituted a minimum payment of $367 in 1998, a significant increase over $221, the lowest 1997 payment. This increase, however, has not stimulated HMO participation in rural counties. Contrary to industry claims, research shows that payment rates are not the determining factor for HMO decisions about where to do business. Rather, reimbursement is just one of several business factors that contribute to plans' decisions about whether to participate in Medicare. Other factors include relative market position, market penetration, ability to form provider networks and negotiate discounts, and length of service in a county.[6] The General Accounting Office, for example, found that nearly all counties with high payment rates (greater than $694) experienced HMO exits in 1999, while only a third of counties with low payment rates (below about $380) experienced exits. A number of the conditions the GAO found to foster plan participation in Medicare are simply not present in rural areas.

Rural beneficiaries are somewhat less healthy than urban beneficiaries, and HMOs may perceive rural beneficiaries as expensive to cover. Medicare's current

risk adjusters do not fully compensate for the higher cost of care for sicker patients.

HMOs cannot make much money by reducing utilization because it is already low in rural areas. Even though rural beneficiaries are in somewhat poorer health, they use fewer services than their urban counterparts. The rural elderly visit physicians less frequently than the urban elderly, and Medicare expenditures per enrollee for physician services are lower for the rural elderly than the urban elderly, even after accounting for lower costs in rural areas.[8] Because utilization in rural areas is already low, and HMOs make money by reducing utilization, there is little incentive for HMOs to do business in rural areas.

Rural physicians could form HMOs but may be averse to doing so for fear of violating antitrust or fraud and abuse laws against self-referral. The dearth of physicians in rural areas means a provider network is likely to control most if not all of any given service area, which raises anti-trust concerns. Furthermore, rural physicians tend to perform laboratory and other ancillary services in their own offices because independent ancillary services are relatively scarce. This is an explicit exception to Medicare restrictions against referring patients to ancillary services in which a physician has a financial interest. Physicians may perceive that providing these ancillary services outside their individual offices but as part of a network that they own will invite prosecution for violation of self-referral restrictions.

WHAT THIS MEANS FOR RURAL BENEFICIARIES

Rural areas are disproportionately elderly and disproportionately poor, so changes in Medicare are likely to have significant impacts on rural people and rural communities. In 1997, 18 percent of the residents in rural counties were age 65 and older compared to 15 percent in metropolitan counties.[9] In 1997, 15.9 percent of the population in non-metropolitan areas—compared to 12.6 percent of those in metropolitan areas—had incomes below poverty.[10]

Rural beneficiaries may be harmed by Medicare reform that depends on competing HMOs. If HMOs are not willing to serve rural areas, then rural beneficiaries must rely on traditional Medicare. But Medicare reform has the

potential to dramatically alter the traditional program and affect its ability to serve rural beneficiaries. The Breaux-Thomas proposal, in particular, could seriously disadvantage rural beneficiaries by weakening traditional Medicare. This proposal requires traditional Medicare to compete against private plans and allows private plans to vary benefits. Such a reform places the traditional Medicare program at risk and is likely to result in higher costs for rural beneficiaries. The reason for this is because the Breaux-Thomas proposal changes the way costs are spread among beneficiaries.

For more than three decades, the premium for the traditional Medicare program has been based on the costs of serving *all* Medicare beneficiaries, healthy and sick, no matter whether they got their care from an HMO or in the traditional fee-for-service program. The Breaux-Thomas proposal, however, separates the healthy from the sick and charges each accordingly.

Under the Breaux-Thomas Medicare reform proposal, private plans will be able to "cherry pick" by varying benefits and using benefit design to attract healthier enrollees. In urban and suburban areas, where beneficiaries have a choice of plans, many of the healthier may opt for these private plans. As the healthier beneficiaries leave, traditional Medicare will be left with the sickest—and costliest—beneficiaries, driving up the cost of the premium. As the premium for traditional Medicare increases, more urban and suburban beneficiaries will flee to the cheaper plans, further increasing the costs and premiums of traditional Medicare. In effect, rural beneficiaries, healthy and sick alike, will be penalized for the flight of healthy urban and suburban beneficiaries.

Rural beneficiaries are especially vulnerable to the disruptions caused by HMOs that leave markets. When a health plan withdraws from Medicare, beneficiaries lose the benefits and providers upon which they have relied, and they experience financial burdens from high out-of-pocket costs and high Medigap premiums. Rural beneficiaries are unlikely to have any remaining managed care alternatives to join. Therefore, they need a reliable and affordable traditional program to fall back on.

CONCLUSION

As this report has shown, Medicare HMOs have ignored rural communities. Few HMOs currently serve rural communities, and the number appears to be declining, not increasing. As a result, rural beneficiaries' well-being depends on their access to a strong, affordable traditional Medicare program. Medicare reform should be carefully structured to preserve the traditional program and maintain its affordability. Otherwise, rural beneficiaries—who tend to be older, sicker, and poorer—could suffer great harm.

ENDNOTES

[1] The term "HMO" in this report refers to managed plans under the Medicare+Choice program. Nearly all of these managed care plans are HMO models, although, technically, a few are Provider Sponsored Organizations (PSOs).

[2] In this report, rural counties are those that are not part of a metropolitan statistical area as determined by the Office of Management and Budget and the Census Bureau. New Jersey is the only state that has no rural counties.

[3] The findings in this report are based on plan data contained in HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp). Cost-based plans were excluded because they allow beneficiaries to use traditional Medicare at any time.

[4] Physician Payment Advisory Commission, *Annual Report to Congress*, 1997. The Physician Payment Advisory Commission (now the Medicare Payment Advisory Commission) estimated that HMOs cost the government $2 billion annually in overpayment.

[5] The Balanced Budget Act of 1997 will gradually phase out the payment to HMOs for graduate medical education.

[6] U.S. General Accounting Office, *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues*, GAO/HEHS-99-91 (Washington, DC: U.S. General Accounting Office, April 1999).

[7] Serrato, Carl, Randall Brown, and Jeanette Bergeron, "Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?" *Health Care Financing Review,* Fall 1995, Vol. 17, No. 1.

[8] Ibid.

[9] Rural Poverty Research Institute, Rural Policy Context, *Age Characteristics in Rural America* (www.rupri.org/policyres/context/age.html).

[10] U.S. Census Bureau, *Policy in the United States: 1997,* P60-201, Table A (Washington, DC: Census Bureau, September 1998).

APPENDICES

METHODOLOGY

This report analyzed rural Medicare beneficiaries' access to HMOs nationally and by state.

In this report, "rural" counties are those that are not part of a metropolitan statistical area (MSA) as determined by the Office of Management and Budget and the U.S. Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt). The number of Medicare beneficiaries in each rural county was obtained from the Health Care Financing Administration's Medicare State and County Enrollment File (www.hcfa.gov/medicare/stats/enroll98.htm).

The HMOs available in each rural county were identified using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp). This database includes each HMO contract and the counties served under each contract. All HMOs serving any rural county were included in the analysis. Cost-based plans were excluded because they allow beneficiaries to move freely between the HMO and traditional Medicare.

These data sources were then combined to determine the number and percentage of rural beneficiaries nationally and in each state who have access to no HMOs, to only one HMO, or to two or more HMOs.

HCFA occasionally approves service area expansions or new contracts during the year, and the analysis does not account for any plans that might have been made available since August of 1999. Any recent changes in plan availability in rural areas would not significantly affect the overall numbers in the analysis.

The estimates for the year 2000 were derived by subtracting the plans that have informed HCFA of their intention to withdraw from Medicare and/or to reduce their service areas.

Table 3

Rural Beneficiaries and Access to Medicare HMOs Estimated for 2000, By State

	All Rural Beneficiaries	No Access to HMOs		Access to Only One HMO		Access to Two or More HMOs	
State	Number (1999)	Number	Percent of Rural Beneficiaries	Number	Percent of Rural Beneficiaries	Number	Percent of Beneficiaries
Alabama	238,948	225,012	94%	13,936	6%	0	0%
Alaska	22,712	22,712	100%	0	0%	0	0%
Arizona	103,236	21,589	21%	53,455	52%	28,192	27%
Arkansas	269,446	223,561	83%	23,538	9%	22,347	8%
California	168,168	131,384	78%	36,784	22%	0	0%
Colorado	103,049	84,986	82%	18,063	18%	0	0%
Connecticut	43,582	15,601	36%	0	0%	27,981	64%
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Kansas	203,587	203,587	100%	0	0%	0	0%
Kentucky	345,162	345,162	100%	0	0%	0	0%
Louisiana	168,657	111,656	66%	17,768	11%	39,233	23%
Maine	129,675	78,537	61%	51,138	39%	0	0%
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Oklahoma	236,916	102,053	43%	118,998	50%	15,865	7%
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Rhode Island	13,416	0	0%	13,416	100%	0	0%
South Carolina	184,421	184,421	100%	0	0%	0	0%
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Virginia	264,985	248,238	94%	16,747	6%	0	0%
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2) The number of HMOs in rural counties was determined using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp).
3) Rural counties were identified using data from the Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt).

Note: Percentages may not add up to 100 due to rounding.

Table 4

Change In Access to Rural HMOs 1999-2000, by State

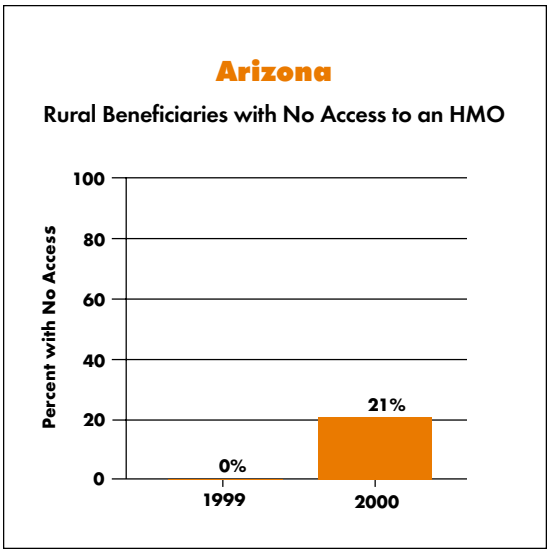
	Percent of Rural Beneficiaries With Access to . . .					
	No Access to HMOs		Access to Only One HMO		Access to Two or More HMOs	
State	1999	2000	1999	2000	1999	2000
Alabama	94%	94%	6%	6%	0%	0%
Alaska	100%	100%	0%	0%	0%	0%
Arizona	0%	21%	68%	52%	32%	27%
Arkansas	83%	83%	9%	9%	8%	8%
California	67%	78%	31%	22%	2%	0%
Colorado	82%	82%	18%	18%	0%	0%
Connecticut	0%	36%	36%	0%	64%	64%
Delaware	0%	0%	100%	100%	0%	0%
Florida	64%	69%	36%	31%	0%	0%
Georgia	82%	83%	14%	17%	4%	0%
Hawaii	0%	0%	19%	19%	81%	81%
Idaho	100%	100%	0%	0%	0%	0%
Illinois	73%	73%	23%	23%	4%	4%
Indiana	98%	98%	2%	2%	0%	0%
Iowa	100%	100%	0%	0%	0%	0%
Kansas	100%	100%	0%	0%	0%	0%
Kentucky	100%	100%	0%	0%	0%	0%
Louisiana	29%	66%	42%	11%	29%	23%
Maine	61%	61%	39%	39%	0%	0%
Maryland	0%	100%	100%	0%	0%	0%
Massachusetts	23%	23%	0%	0%	77%	77%
Michigan	94%	94%	6%	6%	0%	0%
Minnesota	96%	96%	3%	3%	2%	2%
Mississippi	100%	100%	0%	0%	0%	0%
Missouri	95%	95%	5%	5%	0%	0%
Montana	96%	96%	3%	4%	0%	0%
Nebraska	100%	100%	0%	0%	0%	0%
Nevada	79%	79%	21%	21%	0%	0%
New Hampshire	60%	100%	40%	0%	0%	0%
New Mexico	75%	75%	18%	18%	7%	7%
New York	50%	56%	27%	21%	23%	23%
North Carolina	86%	86%	1%	1%	13%	13%
North Dakota	100%	100%	0%	0%	0%	0%
Ohio	28%	36%	44%	39%	29%	25%
Oklahoma	41%	43%	35%	50%	24%	7%
Oregon	38%	50%	47%	35%	15%	15%
Pennsylvania	24%	24%	24%	24%	52%	52%
Rhode Island	0%	0%	0%	100%	100%	0%
South Carolina	100%	100%	0%	0%	0%	0%
South Dakota	100%	100%	0%	0%	0%	0%
Tennessee	60%	60%	31%	33%	9%	6%
Texas	51%	53%	32%	32%	17%	15%
Utah	100%	100%	0%	0%	0%	0%
Vermont	100%	100%	0%	0%	0%	0%
Virginia	94%	94%	6%	6%	0%	0%
Washington	36%	50%	22%	18%	42%	33%
West Virginia	76%	79%	24%	21%	0%	0%
Wisconsin	90%	90%	6%	10%	4%	0%
Wyoming	100%	100%	0%	0%	0%	0%
USA	73%	77%	17%	15%	10%	8%

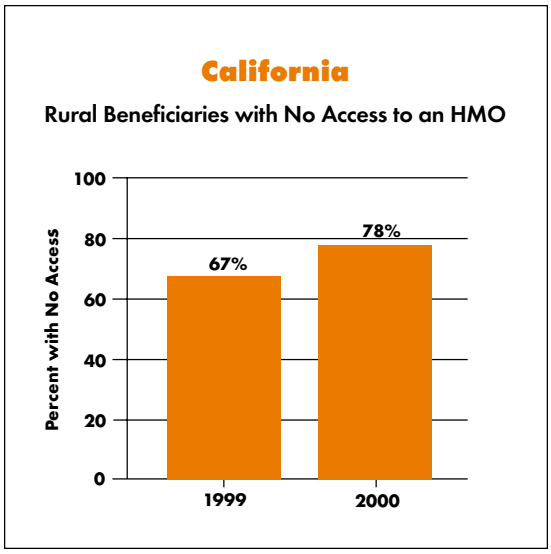
Sources:
1) The number of rural Medicare beneficiaries was taken from the Health Care Financing Administration's (HCFA) enrollment file (www.hcfa.gov/medicare/stats/enroll98.htm).
2) The number of HMOs in rural counties was determined using HCFA's Medicare Compare database (www.medicare.gov/comparison/default.asp) and the HCFA document, "Medicare Managed Care Non-Renewals: List of Plans.
3) Rural counties were identified using data from the U.S. Census Bureau (www.census.gov/datamap/fipslist/AllSt.txt).

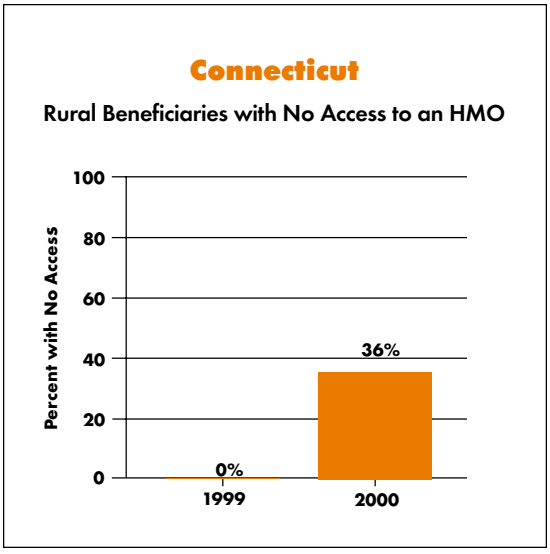
Note: Figures for the year 2000 include all plans operating in rural counties in HCFA's Medicare Compare database minus those that have announced withdrawals in 2000. As of August 1999, HCFA reported having 23 applications for new contracts or service area expansions. It was not known how many of these, if any, were to serve rural counties.

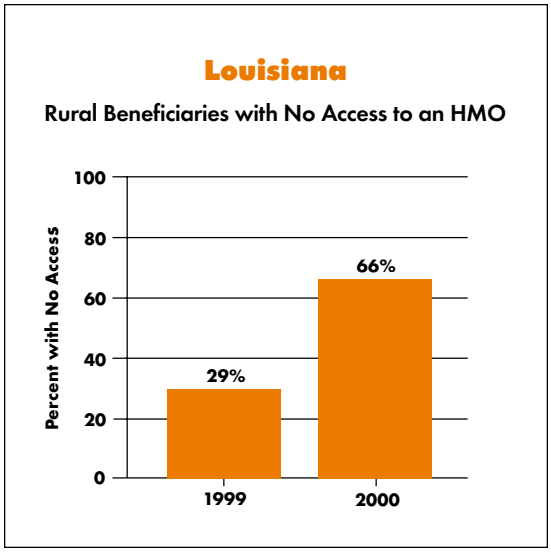
Charts

Increase in Rural Beneficiaries with No Access to an HMO: 1999-2000, Selected States*





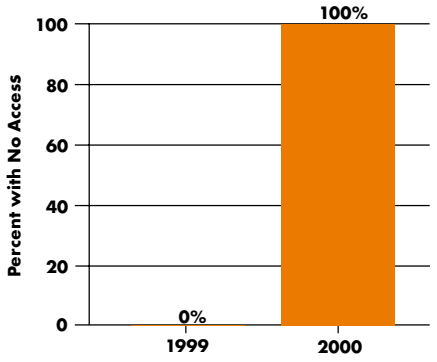




* States in which the number of rural beneficiaries who have no access to a Medicare HMO will increase by 10 percent or more from 1999 to 2000.

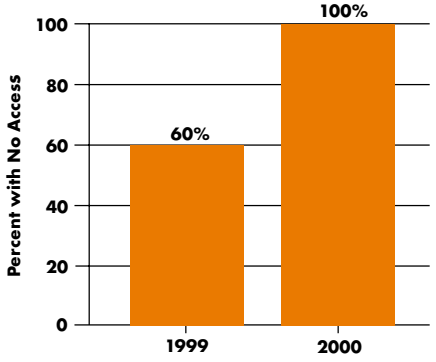
Maryland

Rural Beneficiaries with No Access to an HMO



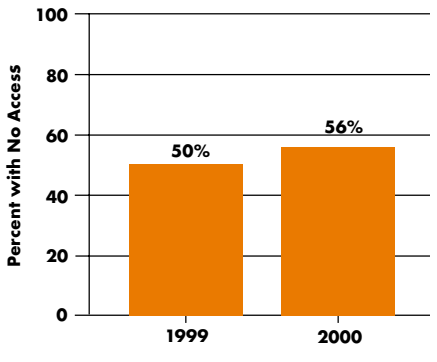
New Hampshire

Rural Beneficiaries with No Access to an HMO



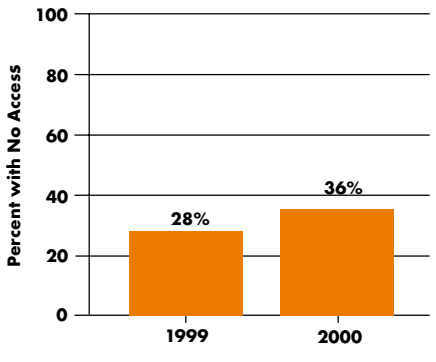
New York

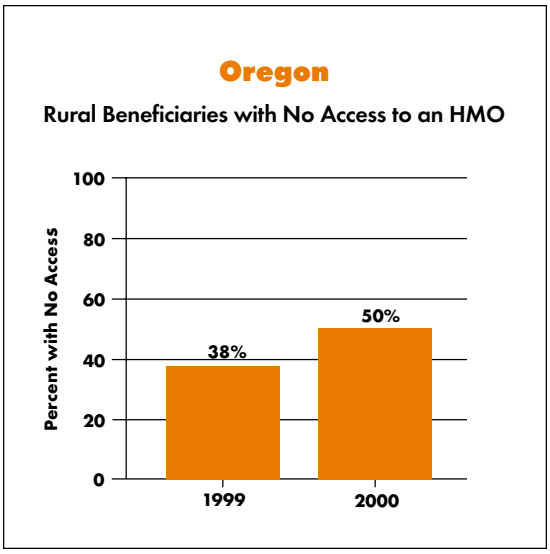
Rural Beneficiaries with No Access to an HMO

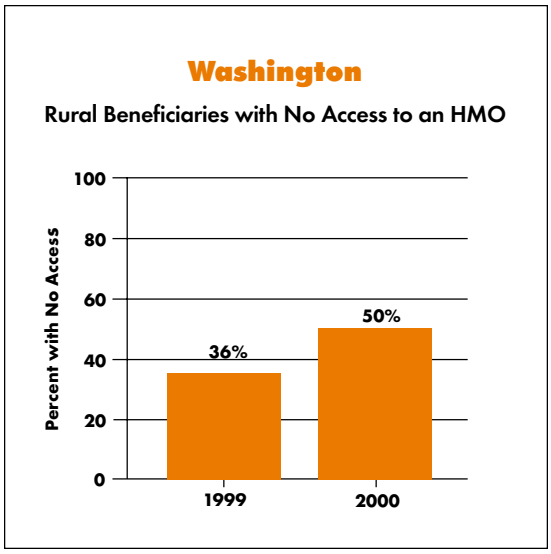


Ohio

Rural Beneficiaries with No Access to an HMO




Oregon
Rural Beneficiaries with No Access to an HMO
Percent with No Access
100
80
60
40
20
0
38%
50%
1999
2000


Washington
Rural Beneficiaries with No Access to an HMO
Percent with No Access
100
80
60
40
20
0
36%
50%
1999
2000

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