HEALTH POLICY

Preferences for Patient Cost Sharing Among Medicare Beneficiaries after HMO Plan Withdrawals

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OBJECTIVE: To assess Medicare beneficiaries' willingness to cost share in order to minimize disruptions in coverage from HMO plan withdrawals.

DESIGN: Cross-sectional survey of Medicare beneficiaries from February 1999 to March 1999.

SETTING: Ten U.S. counties with the highest HMO plan withdrawal rates.

PATIENTS/PARTICIPANTS: Seven hundred one Medicare beneficiaries for response rate of 69%.

MEASUREMENTS AND MAIN RESULTS: Percentage of respondents willing to accept more out-of-pocket costs in order to continue their Medicare HMO coverage. Most respondents (67%) were willing to pay more out-of-pocket costs so that their HMO could have continued Medicare coverage. Those who were white ($P = .03$), had higher incomes ($P = .01$), and returned to traditional fee-for-service Medicare ($P = .004$) were more likely than other respondents to accept increased patient cost sharing. Most beneficiaries preferred Medicare policies requiring HMOs to sign longer-term Health Care Financing Administration (HCFA) contracts (72%) and to offer coverage to beneficiaries regardless of where they lived in a given state (87%). However, respondents' preferences for such policy options were not associated with the amount of cost sharing that respondents were willing to accept.

CONCLUSIONS: Most Medicare beneficiaries are willing to accept increased patient cost sharing in order to reduce disruptions in their HMO coverage. Policies intended to reduce HMO plan withdrawals, such as requiring health plans to sign longer-term HCFA contracts, are supported by many Medicare beneficiaries, but these policy preferences were not related to willingness to cost share. In light of an apparent willingness to pay more out-of-pocket medical costs, Medicare beneficiaries in general may accept increased cost sharing in order to retain their HMO coverage.

KEY WORDS: Medicare HMO pullouts; Medicare policy; cost sharing.

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Since the establishment of the Medicare+Choice program, HMO plan withdrawals have affected over 1.6 million beneficiaries,¹⁻⁴ and this trend is expected to continue. Many HMOs report that inadequate reimbursement is a primary reason for leaving the Medicare program,^{5,6} and that without increased government reimbursement or patient cost sharing, plans will be unable to provide enrollees with expanded benefits such as prescription drug coverage, and thus, plan withdrawals are likely to continue.^{7,8}

With the adverse effects of coverage disruptions on quality of care,^{9,10} effective policies that address factors for HMO plan withdrawals must be urgently considered, especially given the high disease burden among Medicare beneficiaries. Some believe that improving the financial status of Medicare HMOs by increasing reimbursement rates and/or patient cost sharing is necessary.¹¹ Others believe that current funding is adequate and have proposed modifying the contractual participation of HMOs in the Medicare+Choice program as a way to limit coverage disruptions.¹² For example, regulatory changes with regard to the scope of coverage areas and the minimum length of Medicare HMO contracts may reduce coverage disruptions. However, requiring a greater coverage commitment from Medicare HMOs without addressing the cost implications, some contend, may lead to increased plan withdrawals.

In light of continuing HMO plan withdrawals, we address several relevant questions. First, would Medicare beneficiaries be willing to pay more out-of-pocket costs so that they could continue their HMO coverage? Second, do beneficiaries prefer policies requiring that Medicare HMOs commit to larger coverage areas for longer periods of time? Third, do these policy preferences vary with the amount of out-of-pocket costs that beneficiaries are willing to accept?

METHODS

Non-institutionalized Medicare beneficiaries who were enrolled in an HMO that stopped offering coverage as of December 31, 1998 were eligible for this study. The under-65 Medicare HMO population was not included in this study. Using an age-stratified (≥ 65 years old) telephone list, eligibility was determined by a telephone screener of adults who resided in the 10 U.S. counties with the highest Medicare HMO withdrawal rates.^{13,14} Of the 3,281 Medicare beneficiaries who were contacted and screened for

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eligibility, 1,017 of them were enrolled in an HMO that ceased offering insurance coverage. Among those who were found to be study eligible, 701 interviews were completed for a response rate of 69%.

This study was funded by the American Medical Association. Survey sample and design were reviewed and approved by a university-based institutional review board. The telephone survey of eligible beneficiaries was conducted during February and March of 1999. The survey included questions that assessed beneficiaries' willingness to accept increased patient cost sharing. Respondents were asked: Would you have been willing to pay more out-of-pocket costs so that (name of HMO) could have continued Medicare coverage in your area? Respondents also were asked about their preferences for potential policy changes: 1) Do you think that Medicare HMOs should have to sign longer than 1-year contracts?; and 2) Do you think that Medicare HMOs should have to offer coverage to all Medicare recipients in a given state, no matter where in the state they live? Information on beneficiaries' age, gender, race, education level, income, and health status was collected during the telephone interview.

Data were analyzed using SPSS (Version 9.0; SPSS Inc., Chicago, Ill). χ^2 analyses were conducted to assess potential association between respondent characteristics and the additional amount of out-of-pocket costs that beneficiaries were willing to accept. To assess variation in cost-sharing preferences among beneficiaries, logistic regression analysis was conducted that included respondents' age, gender, race, income, education, health status,

and current insurance status as independent variables. Since policy options such as requiring HMOs to sign longer contracts have potential cost implications, we also estimated a logistic regression model that assessed the relationship between policy preferences and the degree of cost sharing that beneficiaries were willing to accept.

RESULTS

Among those surveyed, 50 percent re-enrolled in another Medicare HMO after their original HMO dropped their coverage (Table 1). Beneficiaries who enrolled in another HMO had completed more years of education and had higher annual incomes than those who returned to traditional fee-for-service Medicare ($P < .05$).

Most respondents (67%) were willing to pay more out-of-pocket costs so that their HMO could have continued Medicare coverage. In χ^2 analyses (Table 2), respondents' willingness to pay differed on the basis of race ($P < .01$), annual income ($P < .03$), education level ($P < .04$), and current insurance status ($P < .02$). In multivariate analysis, white patients (odds ratio [OR] 2.17; 95% confidence interval [95% CI], 1.07 to 4.41) and those with annual incomes greater than \$20,000 (OR 1.20; 95% CI, 1.04 to 1.40) were more likely than other patients to accept increased cost sharing (Table 3). Compared to other patients, beneficiaries who returned to traditional fee-for-service Medicare were more willing to pay more out-of-pocket costs in order to have continued their previous HMO coverage (OR 1.73; 95% CI, 1.19 to 2.52).

Table 1. Respondent Characteristics by Current Insurance Type

Characteristics	Insurance Coverage as of January 1, 1999	
	Enrolled in Another Medicare HMO N = 352 (50%)	Returned to Traditional Medicare N = 349 (50%)
Mean age, y (SD)	71.6 (4.5)	71.6 (4.3)
Female, n (%)	193 (54.8)	184 (52.7)
White, n (%)	333 (94.6)	322 (92.3)
Education, n (%)*		
Some high school or less	50 (14.3)	74 (21.3)
High school graduate	124 (35.4)	139 (39.9)
Some college	89 (25.4)	68 (19.5)
Associate degree, trade, or technical school	16 (4.6)	21 (6.0)
4-year college graduate	44 (12.6)	33 (9.5)
Post-graduate	27 (7.7)	13 (3.7)
Annual income, n (%)*		
Less than \$15,000	73 (24.4)	101 (33.3)
\$15,000–\$19,999	44 (14.7)	54 (17.8)
\$20,000–\$29,999	74 (24.7)	77 (25.4)
\$30,000–\$39,999	51 (17.1)	37 (12.2)
Over \$40,000	57 (19.1)	34 (11.2)
Overall rating of health, n (%)		
Excellent	40 (11.5)	42 (12.0)
Very good	140 (40.2)	126 (36.1)
Good	106 (30.5)	102 (29.2)
Fair	45 (12.9)	59 (16.9)
Poor	17 (4.9)	20 (5.7)

* $P < .05$.

Table 2. Out-of-pocket Costs that Beneficiaries Are Willing to Pay More to Remain in a Medicare HMO by Respondent Characteristics

	Monthly Out-of-pocket Costs				P Value
	\$0	\$1 to \$25	\$26 to \$50	>\$50	
Age, n (%)					
<70 years old	78 (37)	40 (19)	66 (31)	27 (13)	.09
≥70 years old	131 (36)	95 (26)	84 (23)	52 (14)	
Sex, n (%)					
Male	98 (36)	56 (20)	77 (28)	43 (16)	.22
Female	111 (37)	79 (26)	73 (24)	36 (12)	
Race, n (%)					
White	189 (35)	127 (24)	146 (27)	78 (14)	.01
Non-white	20 (61)	8 (24)	4 (12)	1 (3)	
Education, n (%)					
Less than college	174 (39)	106 (24)	110 (25)	55 (12)	.04
College graduate	34 (27)	29 (23)	40 (33)	23 (18)	
Annual income, n (%)					
<\$20,000	93 (40)	59 (25)	53 (23)	27 (12)	.03
≥\$20,000	80 (30)	61 (23)	84 (31)	44 (16)	
Self-reported health status, n (%)					
Excellent or very good	92 (35)	68 (24)	84 (30)	39 (14)	.14
Good, fair, or poor	116 (41)	66 (23)	64 (22)	40 (14)	
Insurance status, n (%)					
Medicare HMO	140 (41)	68 (20)	88 (26)	47 (14)	.02
Traditional Medicare	68 (30)	67 (29)	62 (27)	32 (14)	

With respect to policy preferences, most respondents wanted HMOs to sign longer-term Health Care Financing Administration (HCFA) contracts (72%), and provide coverage options to all markets in a given state regardless of where a Medicare beneficiary may reside (87%). After controlling for respondent characteristics, there was no difference in policy preferences based on the amount of patient cost sharing that beneficiaries were willing to accept.

DISCUSSION

Over two thirds of our study respondents would accept increased cost sharing in order to continue their Medicare HMO coverage. Those who were white, had higher incomes, and returned to traditional fee-for-service Medicare were more willing to pay higher out-of-pocket expenses. With

regard to policy options that may reduce HMO coverage disruptions, most respondents preferred that Medicare HMOs sign longer-term HCFA contracts. In addition, a large majority of respondents believed that Medicare HMOs should make coverage available to all who are eligible, and not just those living in select areas of a given state. However, preferences for these policy options were not associated with willingness for patient cost sharing.

On the basis our study, many beneficiaries appear willing to accept higher out-of-pocket costs in order to maintain their HMO coverage. When an HMO drops coverage in a service area, continuity of care and access to medical services may be adversely affected, especially if patients are forced to switch physicians, have no other HMO options, or are excluded from obtaining Medigap insurance to pay for benefits such as prescription coverage.⁹ Given their disproportionately high disease burden, Medicare beneficiaries are particularly vulnerable to disruptions in care and coverage,^{15,16} and as we found, paying higher out-of-pocket costs to ensure the viability of the Medicare+Choice program seems to be an acceptable option among many beneficiaries.

However, as we found in our study, certain segments of the Medicare population, such as those who were nonwhite and had lower annual incomes, may be less willing to accept more out-of-pocket costs. Studies have shown that lower-income Medicare beneficiaries spend a higher percentage of their income out of pocket for health care,¹⁷ and as such, they may be less able to accept increased cost sharing. Therefore, efforts that lead to increased patient cost sharing may disproportionately affect nonwhite and lower-income beneficiaries by limiting their insurance options.

Table 3. Multiple Logistic Regression Model for Predicting Increased Patient Cost Sharing

Variables	Willing to Accept More Out-of-pocket Costs Odds Ratio (95% CI)	P Value
Age, y	1.00 (0.96 to 1.05)	.84
Female	1.08 (0.74 to 1.57)	.71
White	2.17 (1.07 to 4.41)	.03
College graduate	1.49 (0.84 to 2.64)	.17
Annual income ≥\$20,000	1.20 (1.04 to 1.40)	.01
Improved self-reported health status	0.92 (0.77 to 1.10)	.37
FFS Medicare versus Medicare HMO	1.73 (1.19 to 2.52)	.004

FFS, fee-for-service.

In addition to paying higher premiums for Medicare HMOs, many beneficiaries support nonfinancing options that may reduce coverage disruptions. Some policies designed to protect beneficiaries were originally enacted as part of the Medicare+Choice program. For example, Medicare beneficiaries are free to return to the fee-for-service program even between open enrollment periods, and must be extended Medigap insurance if their HMO terminates coverage. However, under the current program, HMOs sign only single-year contracts and are able to select markets on a county-by-county basis. Thus, current regulations permit HMOs to operate in profitable markets, while leaving other areas that are less profitable, and this may explain why beneficiaries residing in rural areas have been disproportionately affected by HMO pullouts.^{18,19} Therefore, policies such as requiring HMOs to sign longer-term HCFA contracts have been proposed by legislators and policymakers, and these policies would seem to have substantial support among Medicare beneficiaries.

If policy options such as longer-term HCFA contracts are adopted, some are concerned that it may have the unintended consequence of decreasing the attractiveness of the Medicare+Choice program, and thus, increase HMO plan withdrawals. Policies that require longer-term arrangements covering wide areas may constitute an undue regulatory burden for HMOs, a factor that has been cited as a key factor behind HMO plan withdrawals.⁸ In addition, the practicality of setting up expansive, state-wide networks, especially in areas where markets vary dramatically by region, has been called into question. Since the majority of HMOs withdrawing or reducing their coverage area are for-profit plans,²⁰ requiring health plans to expand coverage periods and areas without addressing financing issues could accelerate HMO plan withdrawals.^{4,21} Although the cost implications of policy changes need to be addressed, Medicare HMOs have to realize that they are part of a health insurance program that continues to be viewed by the public as a social contract between the government and beneficiaries.

Our study had several limitations. First, we surveyed noninstitutionalized Medicare beneficiaries living in the 10 U.S. counties with the highest HMO withdrawal rates and who were predominantly white, and thus our results may not generalize to the overall Medicare HMO population. However, these counties represented diverse HMO markets in 5 states and both rural and urban settings. Second, the telephone screener identified a significantly higher than expected percentage of respondents who were affected by a Medicare HMO plan withdrawal, and therefore, the higher eligibility rate in our sample raises potential response bias concerns. Third, our sample had a lower HMO re-enrollment rate compared to a re-enrollment rate of 66% nationwide. Since these 10 sampled counties had lower adjusted average per capita cost reimbursement rates compared to the national Medicare average, those HMOs remaining in the market may not have been able to offer benefits such as prescription drugs, which was what

initially drew beneficiaries into such health plans. Fourth, patients' hypothetical willingness to pay, and not their actual behavior, was assessed. However, studies have shown that hypothetical willingness has valid predictive value.^{22,23} Finally, respondents may not have recognized the explicit cost implications of their preferences for policy options meant to reduce Medicare HMO plan withdrawals, and thus, additional inquiry on this matter is important, especially since these policy options are considered by legislators and policymakers.

In establishing the Medicare+Choice program, Congress envisioned a plan that would expand health insurance options for beneficiaries while controlling government expenditures.^{6,24,25} As market-based reforms are introduced, Medicare faces the challenge of constraining health care costs while providing more options and benefits for beneficiaries. Resolving these sometimes-competing demands may rest, in part, on the willingness of beneficiaries to cost share. At the same time, Medicare HMOs must consider the consequences of coverage disruptions when participating in an insurance program that the public views as a social contract. Therefore, new policies including increased financing that may reduce disruptions in health care coverage require serious consideration if Medicare HMO plan withdrawals continue.

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