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Connecticut Medicare Advantage Enrollment Has Grown Significantly

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The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Connecticut almost doubled between December 2005 and September 2007, from about 29,700 to over 56,700 persons (Table 1). The enrollment in MA and prepaid plans represents 10.5% of Connecticut Medicare beneficiaries, trailing the national enrollment rate of 20%.

Enrollment in the MA program in rural areas in Connecticut remains minimal but growing, from 169 persons to almost 2,000 persons (4% of rural Medicare beneficiaries in Connecticut) between December 2005 and September 2007, below the national average of 10.2%.

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Connecticut, 2005-2007

	Number of Enrollees		Percent of Medicare Population	
Location	Dec. 2005	Sept. 2007	Dec. 2005	Sept. 2007
All Medicare Advantage and Prepaid Plans:				
Total	29,664	56,731	5.5%	10.5%
Rural	169	1,994	0.3%	4.1%
PFFS Plans:				
Total	0	5,159	0.0%	1.0%
Rural	0	215	0.0%	0.4%

Source: RUPRI Center for Rural Health Policy Analysis, based on Centers for Medicare and Medicaid Services data, as of September 2007.

Note: PFFS = private fee-for-service.

Growth Significant in Private Fee-for-Service Plans and Health Maintenance Organization Plans

The increase in MA enrollment in Connecticut has been led by rapid growth in private fee-for-service (PFFS) plans, health maintenance organization (HMO) plans, and point of service (POS) plans. While in December 2005 there were no enrollees in PFFS plans statewide, enrollment in PFFS plans jumped to over 5,000 in September 2007 (Table 1). The number of enrollees in HMO and POS plans also grew, from about 28,600 to over 49,000.

Medicare Advantage Plans Described

MA plans are private-sector plans that contract with Medicare to provide all Medicare-related services, plus additional benefits (e.g., prescription drugs, vision care, preventive care), sometimes at an additional cost to beneficiaries. Prepaid plans are special plans created over the years by legislation and comprise mostly "cost" plans. PFFS plans, created by legislation in 1997, are private MA plans that contract with Medicare like other MA plans, but for the most part do not operate networks of providers, such as HMOs operate. Instead, PFFS plans pay providers on a fee-for-service basis after receiving payment from Medicare.

Conclusion and Implications

MA plans have spread to more areas and enrolled a higher number of beneficiaries due to a number of factors, including significant growth in payment to MA plans. PFFS plans have gained a strong foothold in rural areas because the differential between the MA Medicare payment and traditional Medicare payment is large, and because it is less difficult to set up a PFFS plan than other types of MA plans (e.g., HMOs). Thus, there are strong incentives for PFFS plans to seek rural enrollment. While it is too early to gauge the full impact of MA plans, these plans give more options to Medicare recipients and lower out-of-pocket costs. On the other hand, providers have had to make significant adjustments in timing and collection practices to deal with these new Medicare program payers. The U.S. Congress is now wrestling with how to pay for the rapid growth in MA plans, especially PFFS plans.

Contact and Further Information

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For more information on national MA enrollment figures, see policy briefs and tables posted on the RUPRI Center Web site at http://www.unmc.edu/ruprihealth.

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