RUPRI Center for
Rural Health Policy Analysis

November 2007 www.unmc.edu/ruprihealth

Illinois Medicare Advantage Enrollment Has Grown Significantly

by Timothy McBride, Yolonda Lahren, and Steven Meyer

The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Illinois grew by about 50% between December 2005 and September 2007, from almost 94,300 to over 141,500 persons (Table 1). However, the enrollment in MA and prepaid plans represents about 8% of Illinois Medicare beneficiaries, trailing the national enrollment rate of 20%.

Growth in the MA program in Illinois was more significant among persons living in rural areas, where enrollment more than doubled, from about 9,400 persons to over 21,300 persons (6.6% of rural Medicare beneficiaries in Illinois) between December 2005 and September 2007.

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Illinois, 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	94,279	141,572	5.4%	8.1%
Rural	9,425	21,330	2.9%	6.6%
PFFS Plans:				
Total	9,188	43,513	0.5%	2.5%
Rural	2,233	13,541	0.7%	4.2%

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 Most Significant in Private Fee-for-Service Plans

The increase in MA enrollment in Illinois has been led by rapid growth in private fee-for-service (PFFS) plans. While in December of 2005 there were only about 9,200 enrollees in PFFS plans statewide, enrollment in PFFS plans jumped to about 43,500 in September of 2007 (Table 1). In contrast, enrollment in health maintenance organization (HMO) and point of service plans in Illinois grew only about 12% in the same period. About 30% of the PFFS enrollees in Illinois were in rural areas.

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

For further information, please contact Timothy D. McBride, Ph.D., RUPRI Center for Rural Health Policy Analysis, (314) 977-4094 or mcbridet@slu.edu.

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.

Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (Grant #1U1C RH03718)