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Kansas Medicare Advantage Enrollment Has Grown Significantly

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The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Kansas almost doubled between December 2005 and September 2007, from over 15,600 to almost 30,200 persons (Table 1). The enrollment in MA and prepaid plans represents about 7% of Kansas Medicare beneficiaries, trailing the national enrollment rate of 20%.

Growth in the MA program in Kansas was more significant among persons living in rural areas, where enrollment grew fivefold, from about 800 persons to almost 4,400 persons (2.4% of rural Medicare beneficiaries in Kansas) between December 2005 and September 2007.

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Kansas, 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	15,655	30,137	3.8%	7.3%
Rural	809	4,358	0.4%	2.4%
PFFS Plans:				
Total	283	12,420	0.1%	3.0%
Rural	94	3,755	0.1%	2.1%

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 Kansas has been led by rapid growth in private fee-for-service (PFFS) plans. While in December of 2005 there were only about 280 enrollees in PFFS plans statewide, enrollment in PFFS plans jumped to over 12,000 in September 2007 (Table 1). More than a quarter of the PFFS enrollees in Kansas 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 health maintenance organizations (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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