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Minnesota Medicare Advantage Enrollment Has Grown Significantly

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The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Minnesota almost doubled between December 2005 and September 2007, from over 129,000 to over 218,000 persons (Table 1). The enrollment in MA plans represents about 30% of Minnesota Medicare beneficiaries, exceeding the national enrollment rate of 20%.

Growth in the MA program in Minnesota was more significant among persons living in rural areas, where rural enrollment grew almost threefold, from over 22,000 persons to almost 63,000 persons (24% of rural Medicare beneficiaries in Minnesota) between December 2005 and September 2007.

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Minnesota, 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	129,028	218,185	17.9%	30.2%
Rural	22,308	62,780	8.4%	23.6%
PFFS Plans:				
Total	20,941	60,366	2.9%	8.4%
Rural	11,828	31,392	4.4%	11.8%

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 dramatic increase in MA enrollment in Minnesota has been led by exceptionally rapid growth in private fee-for-service (PFFS) plans. While in December 2005 there were about 21,000 enrollees in PFFS plans statewide, enrollment in PFFS plans jumped to over 60,000 in September 2007 (Table 1). There has also been growth in regional preferred provider organization plans in Minnesota, which now account for over 11,000 enrollees in the state. In contrast, the number of enrollees in health maintenance organization (HMO) and point of service plans decreased by 1.4% in the same period. More than half of the PFFS enrollees in Minnesota 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

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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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