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Pennsylvania Leading Nation in Rural Medicare Advantage Enrollment

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The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Pennsylvania grew rapidly between December 2005 and September 2007, from over 545,000 to over 712,000 persons, a growth rate of 31% (Table 1). The enrollment in MA and prepaid plans represents about 33% of Pennsylvania Medicare beneficiaries, exceeding the national enrollment rate of 20%.

Pennsylvania continued to lead the nation in rural MA enrollment, with almost 77,000 rural enrollees in MA and prepaid plans. Growth in the MA program in Pennsylvania was more significant among persons living in rural areas, where enrollment grew more than 50%, from over 51,000 persons to almost 77,000 persons (20% of rural Medicare beneficiaries in Pennsylvania) between December 2005 and September 2007.

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Pennsylvania, 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	545,344	712,333	24.9%	32.5%
Rural	51,008	76,816	13.3%	20.0%
PFFS Plans:				
Total	3,837	48,982	0.2%	2.2%
Rural	994	12,857	0.3%	3.4%

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 Most Significant in Private Fee-for-Service Plans

Private fee-for-service (PFFS) plans experienced the fastest growth in Pennsylvania from 2005 to 2007, growing from over 3,800 enrollees statewide to almost 49,000 (Table 1). Growth was also rapid in local preferred provider organization plans, with enrollment doubling over the same period, and in health maintenance organization (HMO) and point of service plans, which saw 17% growth. About one-quarter of the PFFS enrollees in Pennsylvania 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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