

# RUPRI Center for Rural Health Policy Analysis

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## Rhode Island Medicare Advantage Enrollment Has Grown Modestly

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The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Rhode Island grew modestly (by 4%) between December 2005 and September 2007, from over 58,600 to over 61,200 persons (Table 1). However, the enrollment in MA and prepaid plans represents about 35% of Rhode Island Medicare beneficiaries, exceeding the national enrollment rate of 20%.

There are no rural enrollees in Rhode Island.

**Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Rhode Island, 2005-2007**

Location	Number of Enrollees		Percent of Medicare Population	
	Dec. 2005	Sept. 2007	Dec. 2005	Sept. 2007
<b>All Medicare Advantage and Prepaid Plans:</b>				
Total	58,647	61,222	33.0%	34.5%
<b>PFFS Plans:</b>				
Total	0	984	0.0%	0.6%

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.

### Modest Growth in Health Maintenance Organization and Point of Service Plans

Health maintenance organization (HMO) and point of service plans continued to dominate the MA market in Rhode Island, with about 96% of the enrollment. Although private fee-for-service (PFFS) plans grew in Rhode Island, enrollment was still less than 1,000 persons in September 2007 (Table 1). Almost 1,600 enrollees were in local preferred provider organization plans.

### 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>.