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Vermont Medicare Advantage Enrollment Has Grown Modestly

by Timothy McBride, Yolonda Lahren, and Steven Meyer

Enrollment in Medicare Advantage (MA) and prepaid plans in Vermont reached roughly 1,500 persons in September 2007 (Table 1). This enrollment represents 1.5% of Vermont Medicare beneficiaries, trailing the national enrollment rate of 20%.

Most of the MA enrollees in Vermont were in rural areas, accounting for almost 90% of enrollees in September 2007 (more than 1,300 enrollees out of almost 1,500).

Table 1. Enrollment in Medicare Advantage and Prepaid Plans in Vermont, 2005-2007

Location	Number of Enrollees Sept. 2007	Percent of Medicare Population Sept. 2007
All Medicare Advantage and Prepaid Plans:		
Total	1,496	1.5%
Rural	1,313	1.8%
PFFS Plans:		
Total	1,496	1.5%
Rural	1,313	1.8%

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.

All Vermont MA Enrollees Are in Private Fee-for-Service Plans

All of the enrollment in MA plans in Vermont was in private fee-for-service (PFFS) plans in September 2007, and most of the PFFS enrollees were in rural areas (Table 1).

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

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.

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