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In The Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Variations in County-Level Costs Between Traditional Medicare and Medicare Advantage Have Implications for Premium Support

Synopsis

In comparing spending for beneficiaries enrolled in traditional Medicare with spending for those in private Medicare Advantage plans, researchers found that costs for Medicare Advantage are higher in about half of U.S. counties—corresponding to areas of the country where traditional Medicare costs are low. The relative costliness of Medicare Advantage varies by geographic area and by the type of plan. Policymakers should consider these findings when assessing the potential impact of proposals to redesign Medicare as a "premium support" program.

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The Issue

Amid concerns over increasing Medicare costs, some members of Congress, including the House Budget Committee, have proposed converting the popular social insurance program into a premium support program, under which beneficiaries would receive a set amount to purchase health coverage on their own. Beneficiaries would receive a fixed payment from the government to enroll in a private Medicare Advantage plan or in traditional fee-for-service Medicare. The government's contribution would be set at the local level, based on average health care costs in a particular area. People enrolled in a plan with costs above the defined contribution would pay the extra amount in the form of higher premiums—in theory, creating an incentive for them to select the most cost-effective coverage available. Writing in *Health Affairs,* Commonwealth Fund–supported researchers at the George Washington University explored the relative costliness of traditional Medicare and private Medicare Advantage plans, as well as the implications for a premium support approach to Medicare reform. Analyzing county-level data from 2012, they compared the cost of providing Medicare benefits in traditional fee-for-service Medicare with the cost of providing those same benefits through Medicare Advantage HMO plans, local or regional preferred provider organizations (PPOs), or private fee-for-service plans.

Key Findings

- Overall, average Medicare Advantage plan costs were higher than traditional Medicare costs in counties where traditional Medicare costs were low. Average Medicare Advantage plan costs were lower in counties with high traditional Medicare costs.

Average Annual Medicare Advantage Plan and Traditional Medicare Costs per Beneficiary, Nationally and in Rural and Urban Counties, 2012

	Average traditional Medicare costs per beneficiary ($)	Average Medicare Advantage plan costs per beneficiary ($)	Medicare Advantage plan costs as percent of traditional Medicare
National sample	9,413	9,370	99.5
Rural counties	8,607	9,915	115.2
Urban counties	9,452	9,344	98.9

Source: Adapted from B. Biles, G. Casillas, and S. Guterman, "Variations in County-Level Costs Between Traditional Medicare and Medicare Advantage Have Implications for Premium Support," *Health Affairs*, Jan. 2015 34(1):56–63.

- Average costs for providing benefits to Medicare Advantage plan enrollees ranged from 28 percent below traditional Medicare costs (in counties with the highest traditional Medicare costs) to 26 percent above traditional Medicare costs (in counties with the lowest traditional Medicare costs).
- Within the same county, average annual Medicare Advantage HMO plan costs were 7 percent below those for traditional Medicare. Average annual costs in local PPO plans were 18 percent more than traditional Medicare costs within the same county, while regional PPO plan and private fee-for-service plan costs were both 12 percent more.
- When the researchers divided U.S. counties into 10 groups based on average per-beneficiary costs in traditional Medicare, they found that Medicare Advantage HMOs had lower costs than traditional Medicare in the six groups with the highest traditional Medicare costs. Private fee-for-service plans had lower costs in just the two highest traditional Medicare cost groups. Local and regional PPOs had lower costs than traditional Medicare only in the single highest-cost county group.
- In rural counties nationwide, it cost Medicare Advantage plans 15 percent more to provide a package of Medicare benefits than it would have cost to provide those same benefits under traditional fee-for-service Medicare. In urban counties, average annual Medicare Advantage plan costs were 1 percent below traditional Medicare costs.

The Big Picture

A premium support system would raise costs for Medicare Advantage plan enrollees in rural areas, where average plan costs exceed those of traditional Medicare, and raise costs for beneficiaries with traditional Medicare in urban areas, where costs for that coverage are high. The study results also raise questions about the potential for a premium support system to slow the growth in Medicare spending. "After 30 years of federal and private support," the authors note, "the most tightly organized Medicare Advantage HMOs have achieved significant cost savings relative to costs in traditional Medicare in only a limited number of urban counties."

> "[T]he traditional Medicare program is not as universally inefficient and expensive relative to private plans as is often suggested."

About the Study

Researchers analyzed 2012 data provided by the Centers for Medicare and Medicaid Services to compare the costs of providing the same defined Medicare benefits in four types of Medicare Advantage plans and traditional Medicare in 2,933 counties throughout the country. The study excluded Medicare Advantage employer plans and Special Needs Plans.

The Bottom Line

Transforming Medicare into a premium support program would affect beneficiaries differently depending on where they live. More detailed analysis is needed to understand the full impact of such a proposal on Medicare costs and beneficiaries nationwide.

B. Biles, G. Casillas, and S. Guterman, "Variations in County-Level Costs Between Traditional Medicare and Medicare Advantage Have Implications for Premium Support," *Health Affairs*, Jan. 2015 34(1):56–63.

This summary was prepared by Ellen Bayer.