



## Geographic Variation in Health Care Spending: What Do We Know, and Why Does It Matter?

## FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

**Mark Miller, PhD**

*Executive Director*

Medicare Payment Advisory Commission

**Stephen Zuckerman, PhD**

*Senior Fellow*

The Urban Institute

**Gerard Anderson, PhD**

*Professor and Director*

Center for Hospital Finance and Management

Bloomberg School of Public Health

Johns Hopkins University

FRIDAY, MAY 21, 2010

9:00AM–9:30AM—Breakfast

9:30AM–11:15AM—Discussion

### LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor

*(Across from the Dirksen  
Senate Office Building)*

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*The Dartmouth Atlas of Health Care*<sup>1</sup> displays Medicare spending in 306 sub-state areas called hospital referral regions. The *Atlas's* color-coded maps designate the level of Medicare per capita spending, which in 2007 ranged from a low of \$5,221 to a high of \$17,274. Areas in the Deep South and the north Atlantic region appear in the darkest color, indicating the highest spending. Northwestern and north central areas appear in the lightest shades, with other variations across the map. This regional variation has supported the belief that Medicare spending could be reduced by 29 percent, with no diminution in quality of care, if spending in all areas resembled that in low spending areas of the country.<sup>2</sup> While this claim has piqued the interest of policymakers, it has also worried providers and others who fear indiscriminate reductions in Medicare payments or services.

The causes of the striking differences in Medicare spending are complex and difficult to tease out. How much can be attributed to prices paid for health care services; the illness burdens of populations; social determinants of health like education, poverty, and race; or provider responses to the financial incentives in fee-for-service medicine? Researchers affiliated with *The Dartmouth Atlas* have created an extensive body of work designed to identify the causes of the variation and measure their contributions to health care spending. Their analyses identify health status as the most important determinant of health spending, but variations in health status explain only a small portion of geographic spending differences.<sup>3</sup> Several studies have concluded that larger supplies of health care providers in an area, namely hospitals and physician specialists, are associated with higher health care utilization for Medicare beneficiaries.<sup>4</sup> Other research, focusing on the relationship between utilization and quality, has found little or no relationship between higher spending and improved quality.<sup>5</sup>

Recent work by the Medicare Payment Advisory Commission (MedPAC) demonstrated that the health care service utilization of Medicare beneficiaries is quite variable across areas after accounting for price and health status differences.<sup>6</sup> MedPAC also compared episodes of care for select conditions across several metropolitan statistical areas (MSAs), which revealed that some areas exhibit low-cost treatment patterns for a particular condition. Low episode-of-care costs do not necessarily translate into low per capita spending in an area, however, because of differences in propensity to treat: beneficiaries with mild symptoms may receive treatments in some areas, resulting in more episodes of care and higher per capita spending.<sup>7</sup> Stephen Zuckerman and colleagues have furthered the understanding of

beneficiary health in explaining geographic differences in Medicare spending by using an expanded set of health measures, including existing and new conditions.

Even as the research continues, the policy proposals to reduce the “excess” spending illustrated by *The Dartmouth Atlas* circulate. The Congressional Budget Office (CBO), in its *Budget Options* report, identified four ways to reduce future Medicare spending by capitalizing on the regional variations work.<sup>8</sup> One option is to lower Medicare physician fees in areas with unusually high spending. Another is to reduce Medicare hospital payments for specific elective procedures in areas with high use of those services. A third option is across-the-board payment reductions in high spending areas. The final option is to adjust Medicare cost sharing and supplemental coverage so that Medicare beneficiaries in high spending areas would have incentives to reduce their use of services. CBO cautions that any of these options could disrupt access to care, that they do not necessarily target inappropriate services, and that any of them could affect provider behavior in unintended ways.

This Forum session will explore geographic variation and potential policy responses by focusing on what is known and what is not known about the reasons for the variations and may identify issues for further discussion. Even though the dramatic differences in spending across the country have been used as evidence that the level or growth in spending could be lowered without hurting quality of care, most of the variation remains unexplained. Further, limitations in measuring health status and quality should qualify conclusions about the effects of reducing the variation. Vagaries of local health care markets, combined with pending changes in coverage associated with health care reform, complicate analyses of geographic variations, and, at the same time, raise the importance of understanding this policy issue.

## KEY QUESTIONS

- What kinds of insights into health care spending can be gained through the examination of geographic differences? How do local health care market conditions affect spending? How do state Medicaid policies and availability of health care resources affect spending?
- What do we know about geographic variation in health care spending for populations other than Medicare? What is the relationship between Medicare spending and spending on other populations?

- How well can differences in health status be measured and accounted for in this research? Is quality of care adequately measured in these analyses?
- What data are needed to fully understand geographic variations in health care spending? What additional information is needed to develop policies to reduce spending in high spending areas?
- How can federal policy decisions affect the practice of medicine? How can low spending practice styles be transferred to other areas?

### SPEAKERS

**Mark Miller, PhD**, executive director of the Medicare Payment Advisory Commission (MedPAC), will describe MedPAC's analyses of geographic variations, per capita versus per episode spending patterns, and the relationship between Medicare and private payer spending. **Stephen Zuckerman, PhD**, senior fellow at the Urban Institute, will present his latest findings on the contribution of beneficiary health status to geographic variations in spending. **Gerard Anderson, PhD**, professor and director, Center for Hospital Finance and Management, Johns Hopkins Bloomberg School of Public Health, will comment on the state of the research on geographic variations and what it means for developing methods to control spending growth.

### ENDNOTES

1. See the *Dartmouth Atlas* Web site at [www.dartmouthatlas.org](http://www.dartmouthatlas.org).
2. John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002): pp. w96–w114; available with subscription at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=wennberg&andexactfulltext=and&searchid=1&FIRSTINDEX=30&resourcetype=HWCIT>.
3. Jason M. Sutherland, Elliott S. Fisher, Jonathan S. Skinner, "Getting Past Denial—The High Cost of Health Care in the United States," *New England Journal of Medicine*, 361, no. 13 (September 24, 2009): pp. 1227–1230; available with subscription at <http://content.nejm.org/cgi/reprint/361/13/1227.pdf>.
4. Elliott S. Fisher *et al.*, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, 138, no. 4 (February 18, 2003): pp. 273–287; available at <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&hid=105&sid=54987550-bee6-4868-98f2-0d56d51bb3fe%40sessionmgr112>.

5. Laura Yasaitis *et al.*, "Hospital Quality and Intensity of Spending: Is There an Association?" *Health Affairs*, Web Exclusive (May 21, 2009): pp. w566–w572; available with subscription at <http://content.healthaffairs.org/cgi/reprint/28/4/w566?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=yasaitis&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>.
6. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Measuring Regional Variation in Service Use*, December 2009; available at [www.medpac.gov/documents/Dec09\\_RegionalVariation\\_report.pdf](http://www.medpac.gov/documents/Dec09_RegionalVariation_report.pdf).
7. MedPAC, *Report to the Congress: Increasing the Value of Medicare*, June 2006; available at [www.medpac.gov/documents/Jun06\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun06_EntireReport.pdf).
8. Congressional Budget Office, *Budget Options, Volume 1: Health Care*, December 2008; available at [www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf](http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf).