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Medicare Variation Revisited: Is Something Wrong with McAllen, Texas, or Is Something Wrong with Medicare?

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Health policy analysts have long known that Medicare spends much more per patient in some parts of the country than in others, even after accounting for regional differences in prices and other health measures. Many assume that Medicare spending and utilization patterns are representative of the health care system as a whole, even though Medicare accounts for less than one-quarter of total U.S. health care.[1] Many assume regional variation is due to "practice patterns" or "physician culture"—and that the lower levels of spending are necessarily proper, with higher spending indicative of wasteful care by doctors and unreasonable demands by patients.

Recent research has demonstrated otherwise. Regional variation in Medicare spending is *not* correlated with variation in non-Medicare spending, and variation in non-Medicare spending *is* associated with measures of disease burden and health status. The data indicate that something is deeply wrong not with the doctors or the patients but with Medicare's payment system, service mix, and incentives.

McAllen and El Paso. A research group at Dartmouth devoted to analyzing the geographic patterns in Medicare[2] has found large differences between per-patient Medicare spending and utilization in different geographical areas. The group did not find enough regional variation in observed measures of patient health status, disease incidence, or outcomes of care to fully explain the variation in health care utilization by the Medicare population.

Atul Gawande brought the phenomenon of geographic variation to greater public attention with an article in *The New Yorker* describing McAllen and El Paso, two regions in Texas that have superficially similar demographics but vastly different levels of per-patient Medicare spending. Dr. Gawande, who interviewed doctors and hospital administrators in McAllen (but not in El Paso), attributed the difference to "the culture of money," which led doctors to recommend more intensive procedures to more patients than necessary.[3]

The Dartmouth group attributes the variation to regional differences in physician "practice patterns"—essentially, regional variations in physician culture that lead to more unnecessary care in some locations.[4] This is not inconsistent with Dr. Gawande's conclusion; the "culture of money" and how it is pursued could conceivably be one factor that varies from place to place.

Underlying these explanations is an assumption that physician behavior is to blame. Researchers use Medicare data not because they are interested in Medicare as such but because Medicare datasets are easily available. This approach might be reasonable

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if, as many assume, there were no systematic differences between how physicians treat Medicare patients and how they treat other patients.

However, is that assumption valid, making Medicare data a valid sample for analyzing treatment of all patients? Or is this a case of "looking where the light is better"? If patterns look different for non-Medicare patients, the problem might not be with doctors in certain areas but with the Medicare program itself.

Non-Medicare Spending Patterns. A recent article in *Health Affairs* suggests that the difference between McAllen and El Paso highlighted by Dr. Gawande might really be a feature of Medicare, not of local physician culture. The authors obtained data on treatment of patients in both locations covered by Medicare *and also* data on patients in both locations covered by a private, non-profit insurance company—Blue Cross and Blue Shield of Texas (BCBS-TX).[5]

They found that while Medicare indeed spends almost twice as much more per patient overall in McAllen than in El Paso, BCBS-TX spends about the same in both places. In fact, BCBS-TX's per-patient spending was actually slightly lower in McAllen. These findings persisted for spending on specific types of services and several specific diseases. This is inconsistent with the assumptions that health policy wonks have been making for years—that Medicare and private health spending have similar patterns, and the source of variation must therefore be physician or patient culture.

This is also consistent with results of other researchers looking at the question on a nationwide basis:

- Andrew Rettenmaier and former Medicare trustee Thomas Saving found that state-by-state variation in per-patient Medicare spending was not strongly correlated with total per-capita health care spending.[6] This finding further undermines the idea that Medicare spending is a good proxy for total health care spending.
- Rong Yi found that regional variation in spending on privately insured patients was closely correlated with measures of disease burden.[7] This finding casts doubt on the claim that the only source of spending variation is physician culture. It could actually be that the diseases are not evenly distributed across the population in different regions and a significant portion of the variation is the result of regions with more diseases receiving more health care.
- Richard Cooper has called into question the notion that the higher levels of health care spending is unrelated to quality or health status and is therefore wasteful. Cooper found that states with higher levels of per-capita non-Medicare spending tend to rank higher in measures of quality—suggesting that additional spending actually produces some worthwhile benefit.

1. For 2008, the figure was 23 percent. Medicare Payment Advisory Commission, "Healthcare Spending and the Medicare Program," June 2010, p. 5, at *http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf* (December 15, 2010).
2. The project is known as the "Dartmouth Atlas" and is lead by Elliott S. Fisher, David C. Goodman, and founder John E. Wennberg. See *http://www.dartmouthatlas.org* (December 15, 2010).
3. Atul Gawnde, "The Cost Conundrum: What a Texas Town Can Teach Us About Health Care," *The New Yorker*, June 1, 2009, at *http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande* (December 15, 2010).
4. They also raise the possibility that regional cultural differences might affect patients' propensity to seek care.
5. Luisa Franzini, Osama I. Mikhail, and Jonathan S. Skinner, "McAllen and El Paso Revisited: Medicare Variations Not Always Reflected in the Under-Sixty-Five Population," *Health Affairs*, Vol. 29 (December 2010), pp. 2302–2309, at *http://content.healthaffairs.org/content/29/12/2302.full* (December 15, 2010).
6. Andrew J. Rettenmaier and Thomas R. Saving, "Perspectives on the Geographic Variation in Health Care Spending," Private Enterprise Research Center, June 2009 (revised May 2010), at *http://www.aei.org/docLib/Rettenmaier%20and%20Saving%20-%20Perspectives%20on%20Geographic%20Variation%20in%20Health%20Spending.pdf* (December 15, 2010).
7. Rong Yi, "Understanding Geographic Variations in Health Care Expenditure of the Privately Insured Population," presentation at the annual meeting of the American Society of Health Economists, June 4, 2006, abstract at *http://www.allacademic.com/meta/p93322_index.html* (December 15, 2010).

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Furthermore, Cooper found that the effect is reversed for Medicare spending: States with higher levels of per-beneficiary Medicare spending tend to rank *lower* on measures of quality.[8]

- Addressing the issue of comparability directly, Tomas Philipson and colleagues found that geographic variation in health care utilization is substantially larger for patients in government programs compared to those insured in the private sector.[9] Privately insured patients experience less variation in treatment levels, suggesting that Medicare's regional variation might be the result of Medicare's payment rules.

Why Should Medicare Be Different? According to Philipson and colleagues, economic theory suggests that private insurers are less able than government to control prices paid for health care services but have stronger incentives to restrain utilization while keeping patients (their customers) satisfied. Franzini and colleagues point out that BCBS-TX, like most large private insurers, implements disease management programs for patients with chronic diseases—programs that both improve patient health and reduce hospital visits, emergencies, and other sources of excess cost. Medicare does not provide or reimburse for disease management services; these services are available to Medicare patients only if they enroll in private sector Medicare Advantage plans that provide them.[10]

Furthermore, private insurers have substantial incentives to detect fraudulent bills. Undetected, fraud not only hits their bottom line but would force them to raise premiums and lose business to competitors that can better prevent fraud. Medicare has little incentive to prevent fraud and devotes only a small amount of resources to that end. Indeed, regions with the highest per-patient spending are often those with the highest levels of known fraud.

The Problem Is Medicare, Not McAllen. The evidence indicates that large variation in Medicare spending is indicative not of how health care is delivered throughout the entire system but rather that something is deeply wrong with Medicare. Not with doctors and not with patients—but with Medicare's payment system, service mix, and incentives.

The solution, then, is not to blame doctors in places like McAllen but to reform Medicare from a system that sets arbitrary payments with no regard to the value of services to patients[11] to one that helps seniors and the disabled afford the same high-quality, cost-conscious care available to patients insured in the private sector.[12]

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8. Richard A. Cooper, "States with More Health Care Spending Have Better-Quality Health Care: Lessons About Medicare," *Health Affairs* web exclusive, December 4, 2008, at *http://content.healthaffairs.org/content/28/1/w91.full.pdf* (December 15, 2010). This article touched off a debate in the pages of *Health Affairs*, in which researchers associated with the Dartmouth Atlas and others claimed that Cooper had not actually contradicted their results due to (for example) differences in the mix of specialists and generalists across states and whether that mix can account for the difference in quality. However, this also drives differences in spending. The underlying finding that higher levels of per-capita gross non-Medicare spending are associated with higher measures of quality stands, though it will take much more research to fully understand the nature of the association and interaction with other factors. Furthermore, the finding that Medicare spending follows a pattern different from the rest of the health care sector stands unrefuted.
9. Tomas J. Philipson *et al.*, "Geographic Variation in Health Care: The Role of Private Markets," *Brookings Papers on Economic Activity* (Spring 2010).
10. Research using Medicare spending and utilization data generally do not include data on patients in the Medicare Advantage program.
11. For an explanation of Medicare's price-setting mechanism, see Robert A. Book, "Illusions of Cost Control in Public Health Care Plans," Heritage Foundation *Backgrounder* No. 2301, July 24, 2009, p. 21–22, at *http://www.heritage.org/Research/Reports/2009/07/Illusions-of-Cost-Control-in-Public-Health-Care-Plans.*
12. For an explanation of how this could work, see Robert E. Moffit and James C. Capretta, "How to Fix Medicare: A New Vision for a Better Program," Heritage Foundation *Backgrounder* No. 2500, December 13, 2010, at *http://www.heritage.org/Research/Reports/2010/12/How-to-Fix-Medicare-A-New-Vision-for-a-Better-Program.*