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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Differences in Health Care Prices Across Metropolitan Areas Linked to Competition and Other Factors

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December 2, 2005

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Highlights

Highlights of GAO-06-281T, a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Differences in utilization of health care services across the country have been well documented, but less has been reported on geographic variation in price. As health care spending is the product of utilization and price, information on health care prices and factors contributing to price differences provides an additional perspective on drivers of health care spending. In an August 2005 report, GAO examined claims data on enrollees of preferred provider organizations (PPO) participating in the Federal Employees Health Benefits Program (FEHBP) and found substantial price variation across metropolitan areas, after adjusting prices to account for area differences in the cost of providing services and in the types of services provided.

This statement is based on GAO's August 2005 report entitled *Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices* (GAO-05-856). It focuses on (1) factors that underlie area differences in price and (2) the contribution of price to geographic differences in spending on health care.

What GAO Found

GAO found that market characteristics were closely associated with price differences across metropolitan areas for the FEHBP PPOs we reviewed. Areas with the least competitive markets—that is, areas with a higher percentage of hospital beds concentrated in the two largest hospitals or hospital networks—had prices of hospital stays and physician services that were higher than areas with the most competitive markets. The percentage of primary care physicians' reimbursement that was paid on a capitation basis in health maintenance organizations (HMO)—a proxy for a payer's power to bargain with providers on price—was also associated with geographic price variation. We found that in areas where either market share was concentrated among few providers or HMO bargaining power was weak (as measured by lower levels of HMO capitation), hospital and physician prices paid by the PPOs in our study were higher than average. When we controlled for other factors that might be associated with geographic price variation, hospital competition and payer bargaining power remained associated with lower prices, but the effect was reduced, and much variation remained unexplained.

Price contributed to geographic differences in spending per enrollee, but less than utilization. For both hospital and physician services, price contributed to about one-third and utilization to about two-thirds of the variation in spending between metropolitan areas in the highest and lowest spending quartiles. Price was positively associated with spending, as was utilization, for both hospital and physician services. Therefore, areas with either high prices or high utilization tended to also have high spending. In the case of physician services, price and utilization were modestly but negatively associated, such that areas with high physician prices tended to have somewhat lower utilization of physician services and areas with low physician prices tended to have somewhat higher utilization of physician services.

www.gao.gov/cgi-bin/getrpt?GAO-06-281T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov.

Madam Chairman and Members of the Committee:

I am pleased to be here to discuss the findings from our August 2005 report entitled *Federal Employees Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*.[1] In this report, we examined differences in prices paid for hospital stays and physician services across selected metropolitan areas in 2001,[2] the most recent year for which data were available when the study began. Differences in utilization of health care services across the country have been well documented, but less has been reported on geographic variation in price. As health care spending is the product of utilization and price, more information on health care prices and factors contributing to price differences provides an additional perspective on drivers of health care spending.

Our study examined claims data on behalf of more than 2 million enrollees of preferred provider organizations (PPO) participating in the Federal Employees Health Benefits Program (FEHBP). The prices these PPOs negotiated with physicians and hospitals were the same for the enrollees in FEHBP as for PPO enrollees insured through other employers. Our study found that prices for FEHBP PPO hospital stays varied by more than 250 percent and prices for physician services varied by about 100 percent across metropolitan areas. We adjusted prices to account for area differences in the cost of providing services and in the types of services provided using Medicare's methods of adjusting hospital and physician payments for these area differences, with some modifications.

A detailed account of our findings and methodology is included in our August 2005 report. My remarks today will focus on (1) factors that underlie area differences in price and (2) the contribution of price to geographic differences in spending on health care. These remarks are based on the information contained in the report. The work done for the report was performed from September 2002 through July 2005 in accordance with generally accepted government auditing standards.

[1]GAO-05-856 (Washington, D.C.: Aug. 15, 2005).

[2]We excluded some of the 331 metropolitan areas in the 50 states and the District of Columbia for lack of adequate claims information or sufficient number of hospital stays to support our analyses. We had a sufficient volume of hospital stays and physician services to analyze hospital prices in 232 metropolitan areas and physician prices in 319 metropolitan areas.

In summary, market characteristics were closely associated with price differences across metropolitan areas. Areas with the least competitive markets—that is, areas with a higher percentage of hospital beds concentrated in the two largest hospitals or hospital networks—had prices of hospital stays and physician services that were higher than areas with the most competitive markets. The percentage of primary care physicians' reimbursement that was paid on a capitation basis in health maintenance organizations (HMO)—a proxy for a payer's power to bargain with providers on price[3] —was also associated with geographic price variation.[4] We found that in areas where either market share was concentrated among few providers or HMO bargaining power was weak (as measured by lower levels of HMO capitation), hospital and physician prices paid by the PPOs in our study were higher than average. When we controlled for other factors that might be associated with geographic price variation, hospital competition and payer bargaining power remained associated with lower prices, but the effect was reduced, and much variation remained unexplained.

Price contributed to geographic differences in spending per enrollee, but less than utilization. For both hospital and physician services, price contributed to about one-third and utilization to about two-thirds of the variation in spending between metropolitan areas in the highest and lowest spending quartiles. Price was positively associated with spending, as was utilization, for both hospital and physician services. Therefore, areas with either high prices or high utilization tended to also have high spending.

Background

In public programs, such as Medicare, prices are administratively set, whereas in the private sector, prices are generally negotiated between providers and health insurers, or payers. Payers may negotiate discounted rates with providers, for example, in exchange for an anticipated share of patient volume. Some payers, especially HMOs, may negotiate capitation arrangements with providers, under which the fixed payment per patient puts providers at risk of losing financially if the costs of treating a patient

[3]We use the term providers to refer to hospitals, physicians, and other providers of health care services unless otherwise specified.

[4]Capitation is a payment method used by managed care organizations where physicians are paid a fixed, predetermined payment for caring for an enrollee for a specified period of time, regardless of the number or type of services ultimately provided

exceed the payment. In contrast to this arrangement, which fixes the provider's payment regardless of the number of services provided, the traditional fee-for-service arrangement affords providers the opportunity to increase payments by increasing the volume of services provided. Payers that can negotiate a capitated rather than fee-for-service payment arrangement with providers likely have more negotiating power relative to providers, which in turn can affect prices. In our study, we measured payer negotiating power in a metropolitan area as the percentage of compensation that was capitated for primary care physicians.

The extent of competition among providers in an area may also affect prices. In general, economic theory holds that areas with more competition among providers are likely to have lower prices. Consolidation of providers, such as hospital mergers, reduces the number of competitors in the market, giving the consolidated competitors a larger market share. Recent trends of provider consolidation suggest that some markets are becoming less competitive.

Competition, Payer Bargaining Power, Associated with Area Price Differences

We found that in metropolitan areas where market share was concentrated among few providers or HMO bargaining power was weak (as measured by lower levels of HMO capitation), hospital and physician prices paid by the PPOs (in FEHBP) were higher than average. Many of the metropolitan areas in our study had few providers in competition; about one in four areas had only one or two hospitals or hospital networks serving the entire market. In these areas, prices for hospital stays and physician services—after adjusting for differences in these areas' cost of doing business and mix of services—were substantially higher than prices in the most competitive metropolitan areas. For example, in Rapid City, South Dakota, one of the least competitive markets in our study, hospital and physician prices were higher than average by 25 percent and 10 percent, respectively. In contrast, the hospital and physician prices in Pittsburgh, one of the most competitive markets in our study, were lower than average by 14 percent and 16 percent, respectively.[5]

FEHBP PPO hospital and physician prices were also higher, on average, in metropolitan areas with low levels of HMO capitation, suggesting little power on the part of payers to negotiate with providers on price. Across

[5]Rapid City, South Dakota was in the quartile with the least competition, and Pittsburgh, Pennsylvania was in the quartile with the most competition.

all metropolitan areas in our study, the average percentage of primary care physicians' compensation that was capitated was about 8 percent. More than a third of the areas in our study had almost no HMO capitation; in these areas, less than 1 percent, on average, of the payments to primary care physicians were paid on a capitated basis. In the quartile of metropolitan areas with the highest levels of HMO capitation, the average proportion of primary care physicians' compensation that was capitated was 23 percent.

Price Contributed to Geographic Differences in Spending, but Less than Utilization

Our study showed that prices contributed substantially to geographic differences in spending for hospital and physician care, but to a lesser extent than utilization. When we compared price differences and utilization differences in the metropolitan areas with the highest and lowest quartile of spending per enrollee, we found that the price of hospital stays contributed to about one-third of area differences in spending on hospital care while utilization—that is, the number of hospital stays—contributed to the remaining two-thirds. We found a similar relationship between the price of physician services and an area's spending on physician care—namely, one-third of spending differences was attributable to price differences and two-thirds was attributable to service use differences. We also found positive associations between price and spending and between utilization and spending. That is, areas with higher prices or higher utilization also tended to have higher spending. In the case of physician services, price and utilization were modestly but negatively associated, such that areas with high physician prices tended to have somewhat lower utilization of physician services and areas with low physician prices tended to have somewhat higher utilization of physician services.

Concluding Observations

In conclusion, our study results underscore the importance of examining an area's market structure—including interactions between payers and providers—to fully understand private sector spending differences from one area to another. We found that, in addition to utilization of services, prices played a significant role in an area's total health care spending. Therefore, it is important for participants and policy makers in geographic markets to understand the effect of prices as well as utilization on health care spending to make informed decisions about the actions needed to moderate spending in their local area.

Madame Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Subcommittee Members may have.

Contacts and Acknowledgments

For further information regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov. Christine Brudevold, Assistant Director; Hannah Fein; and Michael Kendix contributed to this statement.

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