Health Care Spending in Maryland:
How Does it Differ from Other States and Why?
(a primer for policymakers)

Maryland Health Care Commission

March 18, 2010

Evolution of the Spending Report

- Expenditure report - linked to the idea that MHCC would set rates of growth targets. If growth targets were exceeded, MHCC (HCACC) would take stronger action.
- 1995-Budgets never implemented – MHCC develops a spending matrix analogous to Personal Health Care Expenditures. Monitors spending to determine how fast sectors grow. From the start, problems were apparent with OOP spending (spending by uninsured)
- 1996-2006 – Reports on the level of spending and distribution of spending and annual rate of growth from the previous year in total, by payer, and sector
- 2007-2009 – Adds 5 year look back on spending levels and growth rates.
- 2009 – Recognition that MHCC had taken report as far as it could go, given current funding levels.
- Accomplishments
  - Know Maryland per capita spending and aggregate rates of growth trend to US averages. Combining and reconciling data takes a lot of work.
  - Expenditure report has given birth to numerous specialized reports: practitioner report, insurance coverage, and the spotlight series.

What we have learned

- Estimating OOP spending by the insured and spending uninsured is expensive.
  - Maryland needs the equivalent of a Maryland MEPS-HC.
  - American Community Survey developed by CPS will provide detailed info for largest Maryland counties in the future – but still know spending.
- Spending levels that MHCC reports for state programs are not comparable to what the responsible organization reports due to calendar year versus state fiscal year distinctions. Serious implications when programs are expanding or contracting.
- Private sector spending estimates reflect a blend of coverage types, delivery systems, benefit levels.
- Current framework is not optimal for answering policymakers' key questions, today ….
  - How do we compare to other states?
  - What can we and what should we change?

HEALTH CARE EXPENDITURES COMPARISON REPORT

HEALTH CARE SPENDING IN MARYLAND:

HOW DOES IT DIFFER FROM OTHER STATES AND WHY?

MHCC MARYLAND HEALTH CARE COMMISSION

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Comparisons – selected subset of states

What factors differ in Maryland from other states? Can they be changed?

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Each chapter focuses on a different category of factors thought to vary with spending .

Where does Maryland rank on spending?

What demand factors are related to spending?

What health system supply and resources are related to spending?

What characteristics of the market and policy framework are related to spending?

Beginning to put it all together– what are the strongest factors?

Bending the cost curve, questions we might pose

- Does this factor raise spending?
- Does this factor cause excessive spending?
- Does this factor raise spending growth?
- Does this factor make spending grow excessively?
- Can or should policy changes affecting this variable reduce growth of health care spending?

Source: **Is Health Spending Excessive? If So, What Can We Do About It?**,
HJ Aaron, PB Ginsburg - Health Affairs, 2009 - healthaff.highwire.org

How Much was Spent by Maryland Residents?

Per capita Personal health care spending	Total ($)		Medicare ($)	
Maryland	$5,590	/ 17th	$8,535	/3rd
National Average	5,283		7,439	
Colorado	4,717		6,590	
Delaware	6,306		7,726	
Massachusetts	6,683		8,168	
Minnesota	5,795		6,435	
New Jersey	5,807		8,512	
North Carolina	5,191		6,841	
Oregon	4,880		6,116	
Pennsylvania	5,933		7,521	
Virginia	4,822		6,373	
Wisconsin	5,670		6,198	

What do we mean by demand factors?

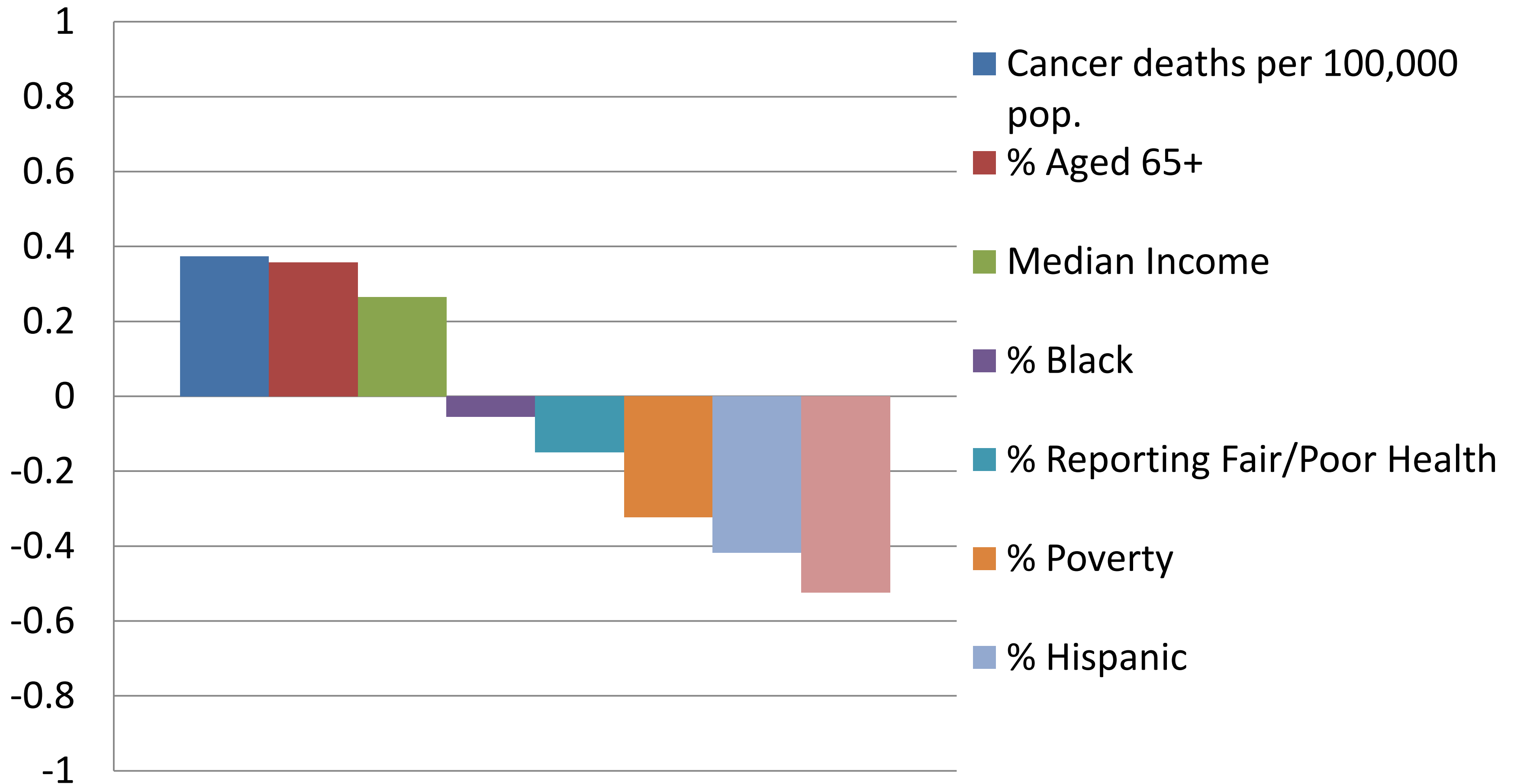
- Demographic, socioeconomic, and health characteristics of a population are associated with utilization of health services and, subsequently, health care spending patterns.

- Utilization is driven by a range of complex and interrelated factors; health status is a major determinant and is in turn influenced by health behaviors, age, income, race/ethnicity, and insurance status.

Maryland Compares: Demand-Side Indicators

	MD /Rank	US	CO	DE	MA	MN	NJ	NC	OR	PA	VA	WI
Percent 65+ (%)	11.5 /41st	12.4	9.8	13.2	13.3	12.1	13.0	12.1	12.9	15.3	11.4	13.0
African American(%)	28.9 / 5th	13.0	4.1	20.1	6.0	4.4	13.5	21.7	2.0	10.4	19.9	6.1
Hispanic(%)	5.4 /27th	14.1	18.9	5.8	7.7	3.6	14.9	6.0	9.5	3.9	5.8	4.4
Median Income($)	57,019 / 3rd	41,990	50,105	49,545	53,657	51,202	57,338	40,863	42,568	43,714	51,103	46,142
Poverty (%)	9.2 /47th	12.7	10.2	9.6	9.9	8.1	8.4	13.8	12.9	11.2	9.5	10.9
Uninsured (%)	14.0 /24th	15.5	16.8	11.8	10.8	8.5	14.4	16.6	16.1	11.5	13.6	10.4
F/P Health ‘04 (%)	12.2 /42nd	14.7	12.0	14.2	12.4	11.2	15.2	18.9	16.2	15.0	12.9	12.0
Can. Death Rate (% per 100,000 p.)	190.2 /23rd	185.8	159.2	207.3	188.9	176.5	186.1	193.7	188.8	195.3	187.8	185.5

Strength of Demand-Side Association with Spending



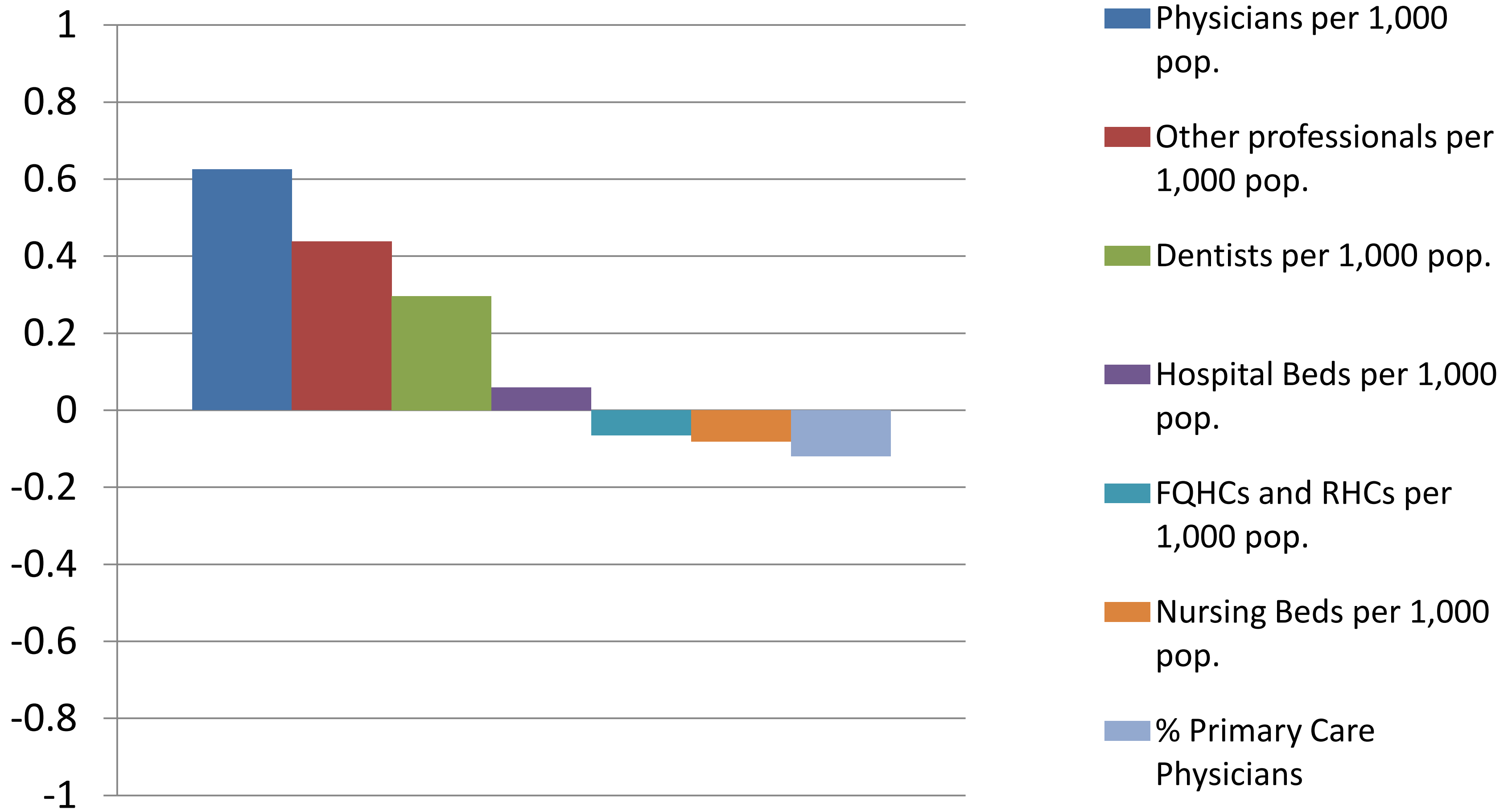
What do we mean by factors of supply?

- The supply of health care services encompasses a broad range of personnel, facilities, and equipment.
- Personnel includes physicians, non-physician health care professionals, mid-level technicians , and so on.
- Facilities include general short-stay hospitals, psychiatric hospitals, skilled-nursing facilities, and long-term-care facilities, among others, usually measured by the number of beds.
- Supply is affected by consumer preferences and health status, provider choices about different practice settings, local practice norms that may promote varying approaches to treatment or uses of technology, and policy interventions that limit or facilitate changes in supply.
- Particular aspects of the way health care is supplied in an area can result in a higher level of spending and can spur excessive growth.

Maryland Compares: Supply-Side Indicators

	MD /Rank	US	CO	DE	MA	MN	NJ	NC	OR	PA	VA	WI
Physician per 1,000 p. ’04	4.28 / 3rd	3.08	3.00	3.01	4.88	3.15	3.70	2.79	3.10	3.73	2.94	2.86
PCP* share of total (%)	35.9 / 48th	43.4	45.7	42.0	33.5	52.7	39.2	44.1	45.7	40.4	44.9	50.0
Dentists per 1,000 p. ‘04	0.71 / n.a.	0.57	0.62	0.42	0.80	0.61	0.76	0.42	0.57	0.64	0.54	0.56
Oth. HCP ‘00**	10.7 / n.a	7.9	7.4	11.7	12.6	7.8	10.7	7.4	6.1	11.1	8.2	3.1
FQHC/RHC per 1,000 p. ‘04	.005 /49th	.022	.019	.008	.008	.028	.006	.021	.028	.014	.016	.019
Hosp. Beds per 1,000 p. ’04	2.21 /39th	2.77	1.95	2.32	2.36	3.17	2.53	2.88	1.91	3.12	2.48	2.64
SNF/NF Beds per 1,000 p. ’05	5.2 /33rd	5.9	4.3	5.5	7.9	7.1	5.9	5.0	3.5	7.2	4.2	7.0

Strength of Supply-Side Association with Spending



Why do we consider market and policy factors?

- The market environment is shaped by the demand and supply factors and by policy and regulatory forces that collectively affect health care spending in a variety of direct and indirect ways.

- The market and interventions by policymakers can constrain or expand the level of resources available to providers or consumers, or the mix of services available.

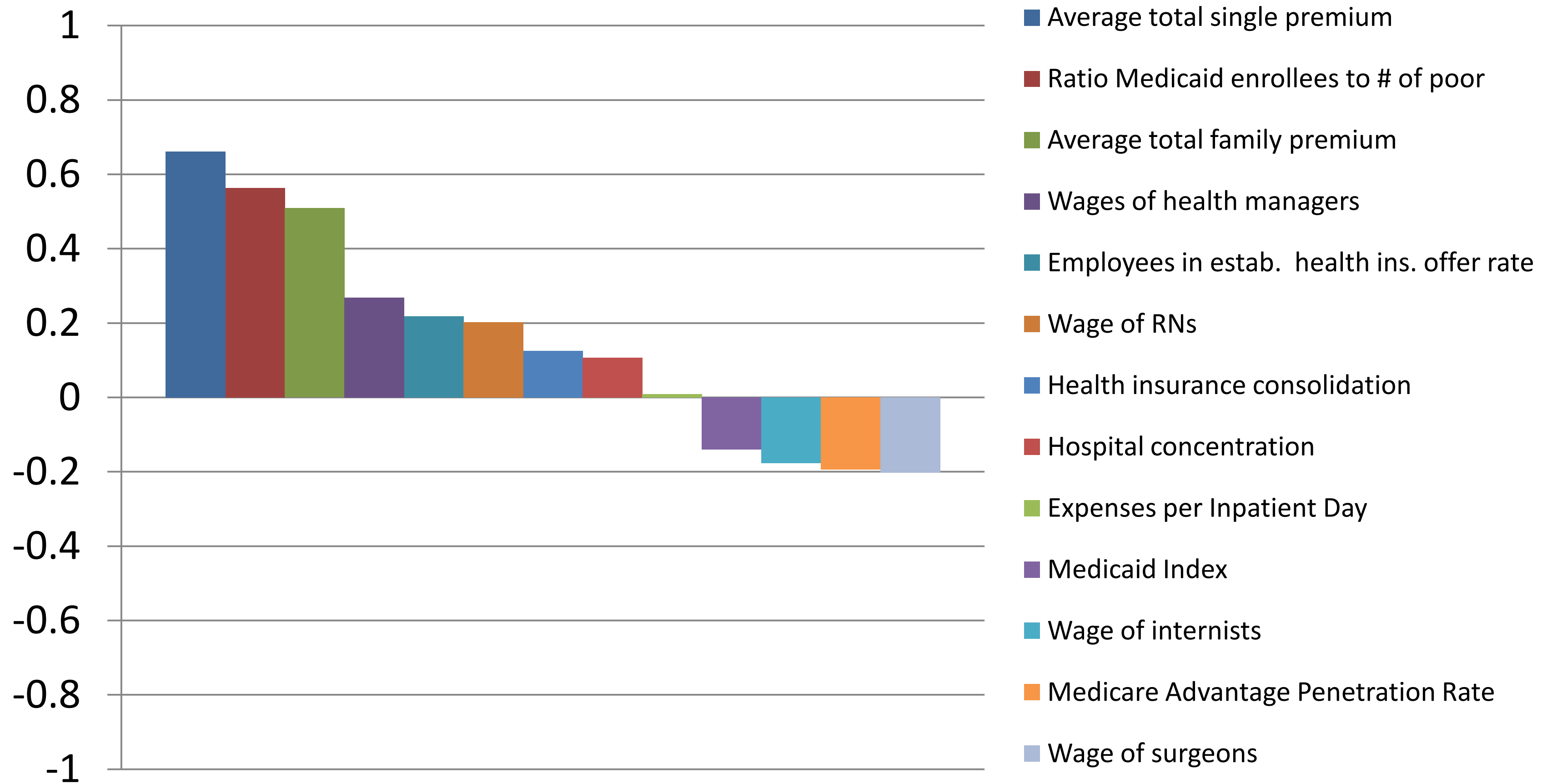
Maryland Compares: Policy/Market Indicators

	MD /Rank	US	CO	DE	MA	MN	NJ	NC	OR	PA	VA	WI
Premium, single coverage ($)	3,721 / 23rd	3,705	3,684	3,830	4,141	3,809	3,882	3,551	3,706	3,671	3,865	3,927
Ratio, Medicaid enrollees to # of poor, '04	1.00 /37th	1.11	0.88	1.76	1.48	1.43	1.08	0.97	0.79	1.31	0.89	1.10
Premium, family coverage ($)	9,855 / 29th	10,006	10,228	10,589	10,559	10,307	11,425	10,241	9,906	9,987	10,230	10,416
Offer rate, '04 employees in private sector health ins. (%)	89.9 / 8th	86.7	85.8	91.1	92.4	88.3	90.6	84.7	80.2	92.6	90.6	86.6
Ins. Market concentra. '05	High /30th	n.a.	Med	High	High	High	Med	High	High	Med	High	Med
Pop. In counties w. high hosp. concentra. (%)	72 / n.a.	n.a.	86	100	56	77	84	100	100	71	98	83
Hosp. expense per IP day, '04 ($)	1,720 / 7th	1,450	1,699	1,563	1,723	1,203	1,691	1,226	1,977	1,394	1,352	1,380

Maryland Compares: Policy/Market Indicators (Cont'd)

	MD /Rank	US	CO	DE	MA	MN	NJ	NC	OR	PA	VA	WI
Mean hourly wages, nurse '04 ($)	31.61 / 2nd	26.35	26.45	27.63	30.83	28.36	29.71	24.26	28.07	25.80	25.64	25.82
Medicare Advantage as % of all Medicare	4.4 /32nd	14.0	26.8	0.8	16.1	18.1	8.1	7.0	32.7	25.2	2.6	9.9
Ratio of Medicaid to Medicare fees, '03	0.8 / 25th	0.69	0.74	1.01	0.80	0.79	0.35	0.97	0.86	0.52	0.87	0.77

Strength of Policy/Market Association with Spending



Putting it together

- Population characteristics, supply of health care services, public policy interventions, and market conditions—likely affect health care spending and how that spending varies across states.
- Interrelationships among factors makes its difficult to explain how each factor affects health care spending directly.

Factors Significantly Associated with Spending

Demand/Supply/Market & Policy Factors	MD's rank in 2008	Positive statistically significant relationship	Can policy changes affecting this factor reduce growth of health care spending
Percentage of population reporting fair/poor health	42	+	?
Short-term beds per capita	39	+	?
Physicians per capita	3	+	?
SNF beds per capita	33	+	?
Medicaid enrollment generosity	37	+	?
Hospital cost per day	7	+	?
Mean insurance premiums	23	+	?

These seven factors are significantly associated with state-level per capita spending and collectively explain 86% of the variation in spending when other factors of all three types are controlled in the equation. Maryland's(ranked 17th) performance is largely consistent with some of these findings, but there are exceptions on physician supply and mean insurance premiums.

Conclusions

- Recent initiatives suggest that Maryland may be heading in the right direction as part of a broad effort to better target spending
  - Health Services Cost Review Commission's Hospital Quality-Based Reimbursement Initiative and the
  - Maryland Health Care Commission's Quality Measures Performance Evaluation Guide and Quality Measures Data Center.
  - These efforts are initiatives and have yet to show results.
- Focus of much of action that the Commission is supporting will lead to better integration of care
  - Loose integration in the patient centered medical home initiative
  - Tighter integration through the clinically integrated organizations
  - Worry with greater integration is that improvements in quality occur with no parallel reductions in real price.

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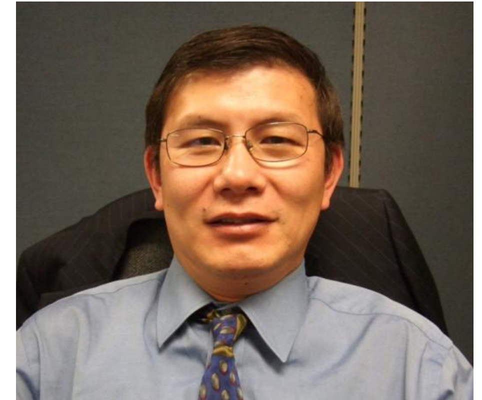

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