MHCC | MARYLAND HEALTH CARE COMMISSION

SPOTLIGHT ON MARYLAND

Explaining the Growth of Private Health Insurance Expenditures in Maryland

Table 1: Private Insurance Expenditures and Rate of Growth by Type of Service: Maryland and U.S., 2001

	Maryland			United States		
Expenditure Components	2001 Total in billions	Percent of Total Spending by Service	Rate of Growth, 2000-2001	2001 Total in billions	Percent of Total Spending by Service	Rate of Growth, 2000-2001
Total Health Expenditures	$8.19	100.0%	10.6%	$496.10	100.0%	10.5%
Hospital Services	$2.76	33.7%	10.9	$152.15	30.7%	9.2
Physician Services	$2.75	33.6%	10.0	$150.95	30.4%	9.7
Other Professional Services[1]	$0.33	4.1%	7.0	$49.62	10.0%	9.7
Prescription Drugs	$1.10	13.4%	12.3	$66.60	13.4%	17.5
Nursing Home Care	$0.02	0.3%	11.8	$7.52	1.5%	3.0
Home Health Care	$0.09	1.1%	11.1	$6.99	1.4%	-10.1
Other Services	$0.05	0.6%	12.2	$3.35	0.7%	3.1
Administration and Net Cost of Insurance	$1.09	13.4%	10.2	$58.93	11.9%	13.4

Source: Maryland State Health Expenditure Accounts; Center for Medicare and Medicaid Services, Office of the Actuary.
[1]Includes dental services.

In 2001, private health insurance accounted for 39 percent of all health care spending in Maryland, or $8.2 billion for all medical services, drugs, and equipment purchased by policyholders. In that year, private insurers' spending grew by over $780 million, or 10.6 percent above its level in 2000. The privately insured increase made up 35.2 percent of Maryland's total spending growth. The size and continued growth of privately insured spending has led the MHCC to develop this Spotlight examining the factors that drive the increase and how insurance premiums and benefits may change as a result.

Maryland's consumers can expect that continued higher spending on medical care financed by private health insurance will be reflected in increasing insurance premiums and changes in benefits. Increasing expenditures have coincided with loosening of restrictions that had been imposed by managed care. If spending increases are due to greater use of services, purchasers will seek to restrain current and future spending by increasing the share of costs borne by the consumer in the form of higher out-of-pocket costs.

The Role of Private Coverage

The 39 percent of Maryland's health expenditures due to private health insurance is a larger proportion of spending than the national average, which is 35 percent. Maryland's high proportion of private insurance spending is due to the state's high rate of coverage. In 2001, 78 percent of the state's population under age 65 had employer-sponsored health insurance, compared to 67 percent of the nonelderly population nationwide. Of Maryland's nonelderly population with coverage of any kind, 85 percent had group coverage through an employer (Fronstin, 2001a).

Maryland has a high rate of private insurance coverage for two reasons. First, employment rates are high. In 2001, unemployment in Maryland was just 4 percent, compared to 4.7 percent nationwide (BLS). Second, more Maryland residents have government jobs, which are more likely than private sector jobs to offer coverage. Public employment (federal, state, and local) accounted for 18.3 percent of total employment in Maryland compared to a nationwide average of 14.7 percent (U.S. Census Bureau). Maryland's past efforts to control overall health care costs, particularly hospital costs may have also played a role.

Sources of Privately Insured Spending Growth

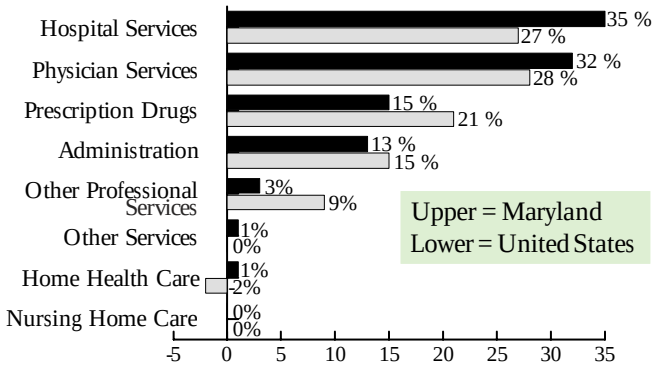
Together, spending on hospital services, physician services, prescription drugs, and administrative costs make up more than 94 percent of all private insurance health care spending in Maryland (Table 1). These sectors are also responsible for almost all growth in spending. Spending on hospital care and physician services each account for about one-third of total spending, and prescription drugs and administrative costs are each responsible for a little more than one-eighth. With the exception of prescription drugs, the growth rate in these sectors is very similar to the overall increase of 10.6 percent in private insurance expenditures. This means that their contributions to Maryland's growth in spending are generally consistent with their contributions to Maryland's level of spending statewide.

While the factors increasing Maryland's expenditures are generally in line with factors increasing national expenditures, there are some notable differences. In Maryland, spending increases are coming more from hospital and physician services and less from prescription drugs and administrative costs than in the United States overall.

In 2001, inpatient and outpatient hospital services accounted for 33.7 percent of total privately insured spending in Maryland, compared to 30.7 percent nationwide. Privately insured hospital spending in Maryland grew faster than the national average in 2001 (10.9 percent vs. 9.2 percent).

Increasing expenditures for hospital services in Maryland accounted for 35 percent of the growth in privately insured spending (Figure 1). By comparison, hospital charges were responsible for 27 percent of national spending growth. Furthermore, increases in Maryland's hospital spending were largely associated with outpatient services. Private outpatient spending grew by 18.5 percent from 2000 to 2001; inpatient spending grew by only 7 percent. Thus, even though outpatient spending makes up less than one-third of all hospital spending in Maryland, it was responsible for about half of the overall increase in hospital spending.

Growth in Expenditures for Different Types of Service as a Percent of Total Spending Growth: Private Insurers in Maryland and U.S., 2000-2001



Source: Maryland State Health Expenditure Accounts; US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary

The difference between inpatient and outpatient spending increases is due primarily to the cost of care provided in the two settings. Data from Maryland's Health Services Cost Review Commission (HSCRC) indicate that the number of inpatient stays and of ambulatory surgeries financed by all sources have each increased at approximately 4 percent per year. However, the cost per inpatient stay increased in 2001 by 5.4 percent, while the cost per ambulatory surgery increased at a 12 percent rate (HSCRC).

The proportion of Maryland's private insurance health spending due to physician services (33.6 percent) also exceeds the U.S. average (30.4 percent). Maryland's privately insured spending on physician services grew at approximately the national average rate in 2001 (10 percent vs. 9.7 percent). Thus, increased spending for physician services accounted for another 32 percent of Maryland's privately insured spending growth in 2001, compared to 28 percent of national spending growth.

Evidence on the reasons for increases in physician fees comes from the Maryland Medical Care Data Base (MCDB), which includes claims records of all insurers who collect more than $1 million dollars in health care premiums in the state of Maryland during a calendar year. From claims data, it is possible to measure the growth in services and users of services for both HMO and non-HMO plans to learn what part of growth is due to increases in health care services and what part to increasing prices.

For non-HMO plans, an more extensive analysis of detailed claim information pegged the increase at 16 percent. Of that growth, 8 percent was due to increases in the number of users, 5 percent was attributed to the jump in the number of services per user and 3 percent was due to intensity gains. The study found that on average price had no impact on expenditure growth.

For HMO plans, expenditures rose 5 percent. An analysis limited to HMO fee-for-service claim data showed that spending grew by 3 percent. Driving that increase was a 9 percent gain in intensity per service. The study found that the number of services per user was unchanged, but the number of users dropped by 1 percent cent and reported prices were lower by 5 percent, due mainly to changes in prices reported by one large payer. This study showed that the 9 percent drop in HMO enrollment played a role in slowing spending growth, although the number of patients obtaining care through HMOs is not falling as rapidly.

In 2001, expenditures for prescription drugs continued their rapid increase in Maryland and in the rest of the United States. In both Maryland and the United States overall, spending on prescription drugs represented 13.4 percent of total private spending. However, Maryland's rate of increase was lower than the national rate. Thus, increased spending for prescription drugs accounted for 15 percent of total privately insured spending growth in Maryland, compared to 21 percent nationally.

The fourth-largest source of private spending in Maryland and the nation is administration and the net cost of private insurance. The component includes marketing, claims adjudication, reserve requirements, general administrative

costs, and profit. In 2001, spending on insurance administration accounted for 13.4 percent of total private expenditures in the state and 11.9 percent nationally.

Growth in this area was slightly less in Maryland compared to the nation (10.2 percent vs. 13.4 percent). Thus, increases in administrative costs made up 13 percent of Maryland's growth and 15 percent of U.S. growth.

Changes in Private Insurance Premiums and Benefit Design

Rapid increases in spending covered by private health insurance encourage health plans and employers to explore strategies for limiting their financial risks. In the mid 1990s, many analysts hoped that HMOs and managed care would provide effective cost containment, but their success has been limited and these organizational arrangements met with significant resistance on the part of employees and other potential enrollees. As a result, in recent years there has been a national movement of privately insured individuals out of HMOs into other types of health plans.

The national retreat from managed care over the last several years has also occurred in Maryland. In 2000, 39.4 percent of Maryland's privately insured population was enrolled in a health maintenance organization. In 2001, the proportion of privately insured Marylanders enrolled in HMOs dropped to 34.4 percent. National estimates suggest that this decrease in enrollment represents a partial, rather than a full retreat from managed care. Between 2000 and 2001, the proportion of workers enrolled in traditional indemnity plans remained constant, while the decrease in HMO enrollment was mostly offset by the increase in preferred-provider organization (PPO) enrollment (Kaiser/HRET).

As enrollment in more restrictive forms of managed care dwindles, employers are left with fewer and more conventional options for containing the cost of health benefits. These options include increased cost sharing (such as plan deductibles, coinsurance, and copayments) and higher employee contributions for premiums.

Nationally, the average annual deductible in fee-for-service plans that allow enrollees to choose their providers, but offer incentives to use "preferred providers" under contract to the plan, increased from $187 in 2000 to $201 in 2001. This increase in deductibles affected plans that allow enrollees systematically to use out-of-network providers: PPO out-of-network options, versus in-network PPO plans or plans in which enrollees can choose their provider at the point of service (POS).

However, even workers who remain enrolled in HMO plans face higher cost sharing. Nationally, 24 percent of workers enrolled in HMOs faced copayments of at least $15 per doctor visit in 2001, compared to 19 percent in 2000; those with co-payments of $10 or less decreased to 66 percent in 2001, compared to 74 percent in 2000 (Kaiser/HRET).

In Maryland, growth in out-of-pocket expenditures, the portion of health care costs directly borne by consumers, was 12 percent in 2001. This rate of growth exceeded the rate of growth in expenditures financed by private insurance, and likely reflects increases in cost sharing.

National survey data indicate that these increases in cost sharing for services covered by the plan generally allowed employers to hold the line on the premium contributions they required of employees. In 2001, the average employee contribution for single coverage was $30, an increase of just $2 from the previous year. Nevertheless, on a national survey conducted in 2001, many (almost half) of all firms indicated that they were likely to increase employees' share of premiums soon (Kaiser/HRET).

Combining high plan deductibles with a form of medical spending account, some employers now cap their financial risks by offering defined-contribution health plans. These plans, which largely insulate employers from higher health care costs, typically entail an unusually high deductible (e.g., $3,000), and a "notional" employer contribution to a spending account. Because employees receive this contribution only as they claim it for qualified expenditures (and forfeit rights to draw the amount if they leave the employer or otherwise discontinue participation in the plan), these notional accounts may roll over from year to year without tax consequences, unlike flexible spending account balances. However, despite employer interest in defined-contribution benefits, survey results indicate that few believe that employees will be receptive to them (Fronstin, 2001b). Failure to gain acceptance among employees, and employees' satisfaction with their current health care benefits may limit the use of defined-contribution plans as a means to contain employer health care costs well below marketers' projections for these plans (PWC 2000; KPMG 1999). In Maryland, employers are taking a wait and see approach to these products. MHCC has not received any reports of employers offering the product through the first quarter of 2003.

The Cost of Health Insurance in Maryland vs. the United States and Neighboring States

While the level of and rate of increase in privately insured expenditures in Maryland are similar to national norms, insurance premiums in Maryland are somewhat higher. Averaging together premium data for the years 1999 and 2000, premiums for single coverage in Maryland averaged $2,562 (Table 2). The U.S. average premium was 97.2 percent of that rate. Premiums in the neighboring states of Pennsylvania and Virginia were respectively 94.7 percent and 93.3 percent of Maryland's. This pattern also applies to small firms (fewer than 50 employees), although the difference between Maryland and other states is slightly more pronounced.

Table 2: Average Premiums for Single Coverage in Employer-Sponsored Plans: Maryland, the U.S., and Selected States, 1999 and 2000

	All Firms	Small Firms
Maryland	$2,562	$2,747
U.S.	97.2%	96.5%
Selected neighboring states as a percent of Maryland:		
Pennsylvania	94.7%	94.4%
Virginia	93.3%	86.6%

Source: Agency for Healthcare Research and Quality, http://www.meps.ahrq.gov/MEPSDATA/ic/1999/Tables_II/IC99_299IIC.pdf and http://www.meps.ahrq.gov/MEPSDATA/ic/2000/Tables_II/IC00_200IIC.pdf

Because Maryland has developed a special health insurance program for small businesses that includes a standard benefit package, changes in small-business insurance premiums are a useful method of tracking the impact of spending increases on premiums paid by employers. The Comprehensive Standard Health Benefit Plan (CSHBP) is offered to businesses with fewer than 50 employees. From 2000 to 2001, the average premium per covered life in this plan increased by 10 percent, from $2,177 to $2,405, in line with Maryland's overall privately insured spending increases. The increase in premiums represented an increase in costs for each type of health plan and also a switch from HMO to higher-cost PPO coverage. From 2000 to 2001, the proportion of PPO CSHBP policies increased from 37 percent to 42 percent. This cost experience compares favorably to national results. Nationally, small-business (firms with fewer than 200 employees) premiums increased by 12.5 percent from 2000 to 2001 (Kaiser/HRET).

The results tell a consistent story in Maryland and the rest of the nation. Apparently driven by consumer demand, restraints on spending have weakened, resulting in increased use of medical services and higher spending. Premium increases have matched or exceeded spending increases. As premiums and out-of-pocket costs rise, and labor markets loosen, spending increases should begin to slacken.

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