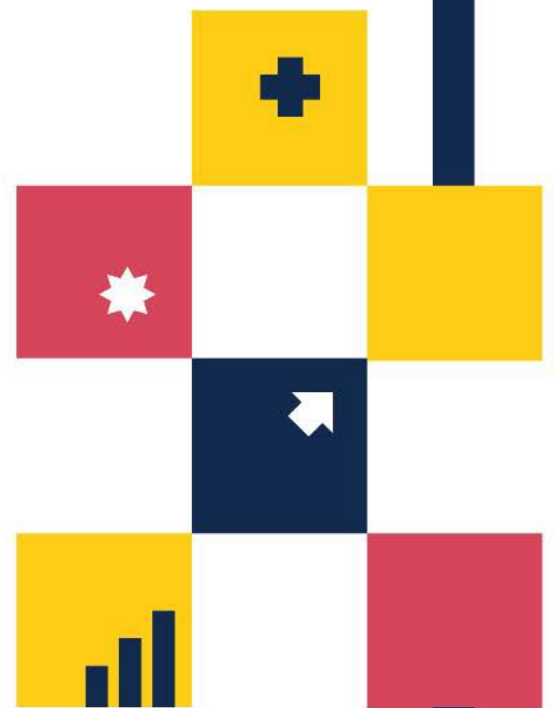


Payments for Professional Services in Maryland (In-Network services only)

2023





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Introduction:

This report investigates the disparities in payment rates for in-network professional services across various private health insurance carriers and compares these rates to the payment structures established by Medicare and Medicaid for the same services. It particularly emphasizes the variation in payment rates based on the market share of payers and geographic regions of service delivery.

The analysis relies on data extracted from the Maryland Medical Care Data Base (MCDB) spanning the years 2021 to 2023. This comprehensive database encompasses health claims and encounter data reported by private payers for residents of Maryland who are enrolled in private health insurance plans. For the purposes of this study, we utilized both the professional services and enrollment files from the MCDB.

Payment rates for professional services are calculated utilizing the payments per Relative Value Unit (RVU) associated with identical service levels. RVUs serve as a quantifiable measure reflecting the resource expenditure associated with each service, comprising three essential components: the work RVU, which denotes the effort and expertise required to deliver a service; the practice expense RVU, which accounts for the operational costs borne by a physician's practice—including expenses for equipment, facilities, non-physician staff, and necessary supplies; and the malpractice liability RVU, which reflects the costs associated with acquiring medical malpractice insurance pertinent to the service provided. In the course of this report, RVUs from the Medicare physician fee schedules (PFS) for the years 2021, 2022, and 2023 have been employed, covering over 10,000 distinct physician services.



2023 Professional Services Payment Rates: Highlights:

- Payments per RVU for all payers increased about 3.0% in 2023 compared to 2022 (\$39.58 and \$38.43 respectively). In contrast, we observed a 0.4% decrease from 2021 through 2022.
- The private payment rates for 2023 were about 109% of Medicare and about 120% of Medicaid. Compared to a year ago, private payments were about 105% and 116% of Medicare and Medicaid rates respectively.
- Private payment rates in 2023 varied by geographic region in Maryland, with the highest rates in DC Metro (\$41.33 compared to \$40.01 in the Baltimore Metro area and \$36.83 in the rest of Maryland).
- The Private to Medicare payment ratios across specialties showed variation. Surgical and radiation oncology and radiology received higher Medicare rates of 148% and 144%, respectively. General practice, cardiology, neurological surgery, and emergency medicine were paid between 131% and 139% of Medicare rates.



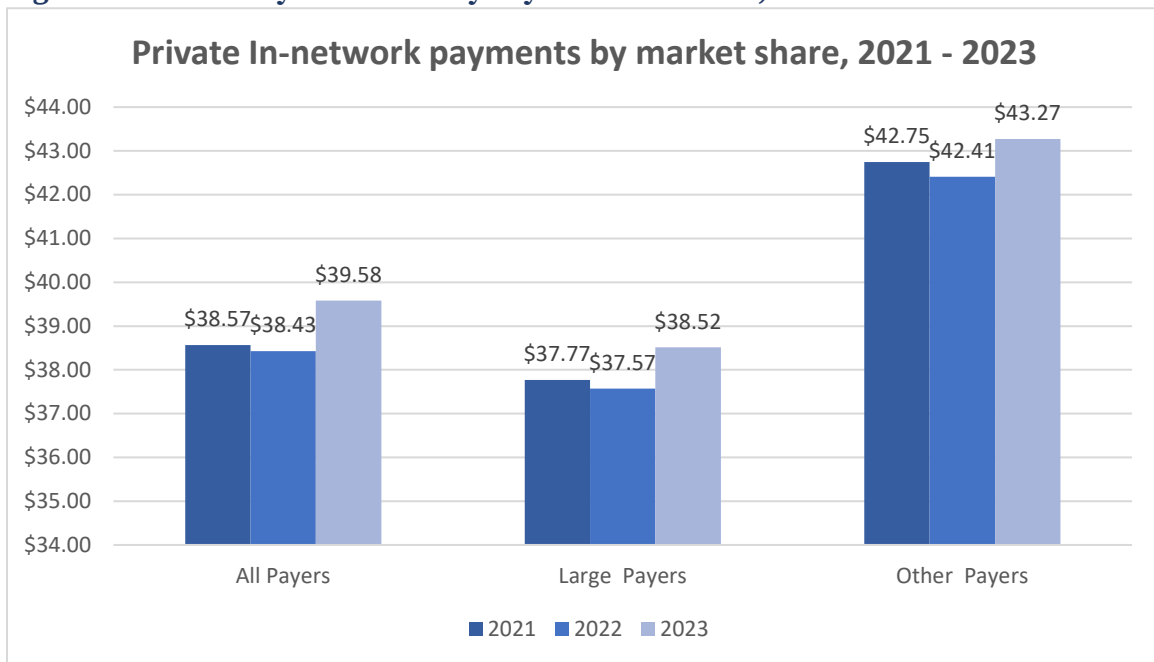
Impact of Private Payer Market Share and Region on Payment Rates

Payment rates for professional services are determined by the payment per RVU for a given group of services. RVUs measure the quantity of care rendered per service in which more difficult, resource-intensive, and therefore more expensive services have a higher number of RVUs assigned.

Payment Rates by Private Payer:

The payment rate for all private payers combined was \$39.58 in 2023 compared to \$38.43 in 2022, an increase of 3.0%. The payment changes from 2021 to 2022 was a 0.4% decrease (see Figure 1). The payment per RVU was lower among large payers for all three years. The payment rate for large payers was 88% of the rate for other payers in 2021 (\$37.77 v. \$42.75), 89% of the rate in 2022 (\$37.57 v. \$42.41) and 89% of the rate in 2023 (\$38.52 v. \$43.27). The change in the year-over-year payment rate was lower among large payers compared to other payers from 2021 to 2022 (-0.5% v. -0.8%). This was not consistent with the change from 2022 to 2023 (2.5% v. 2.0%). These differences in growth rates were not enough to cause a material difference in payment rates by market share.

Figure 1: Private Payment Rates by Payer Market Share, 2021 – 2023

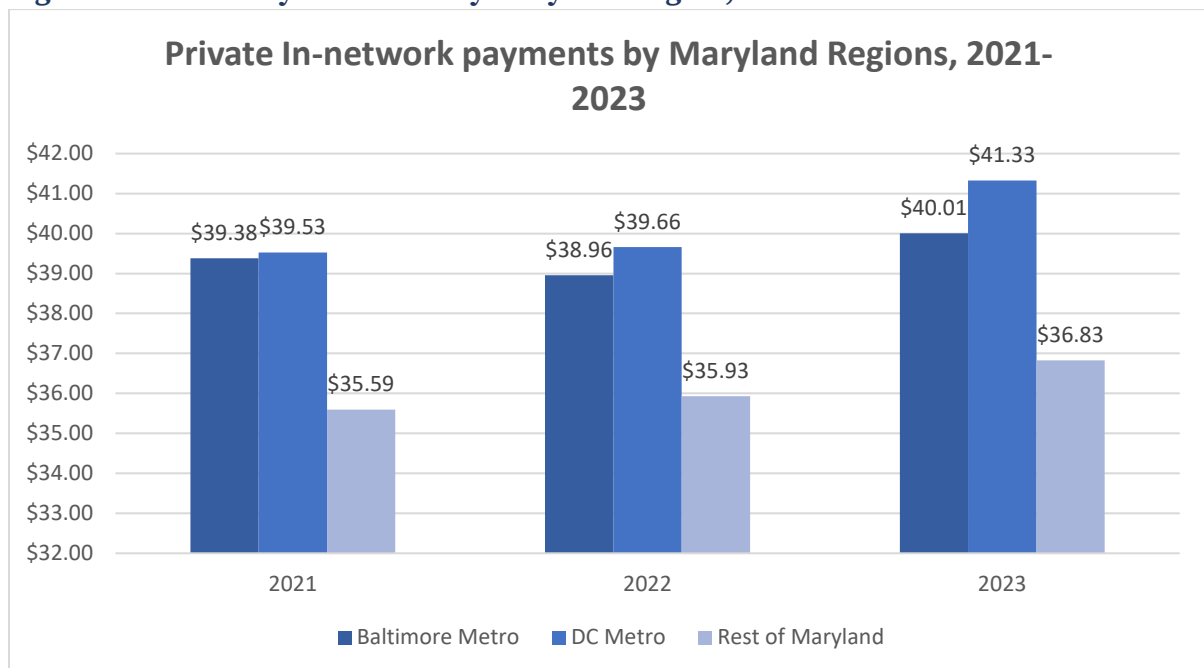


Payment Rates by Region:



Payment rates in Maryland varied by region, based on various factors including but not limited to the resource cost and payer mix (large payers vs. other payers) in each region. Participating providers in locations with higher resource costs tend to receive higher rates from payers because carriers account for differences in resource costs associated with the provider’s geographic region, much as Medicare does in the Medicare Physician Fee Schedule (MPFS). Many private payers align their fee schedules with the MPFS or with certain components of the MPFS. Medicare’s geographic practice cost indices (GPCIs) for the “DC + MD/VA SUBURBS” region is the highest compared to any other geographic area in Maryland (not shown). Private payers apply a similar approach. Providers in the “DC Metro” area received a higher average payment rate than other providers in Maryland regardless of payer market share, as shown in Figure 2, where payment rates were highest in the DC Metro area from 2021 to 2023.

Figure 2: Private Payment Rates by Maryland Region, 2021 – 2023



How Private Payment Rates Compare with Medicare and Medicaid Payments

Medicare payments for services are often used as a benchmark for private payment rates because Medicare is a large purchaser of professional services. Medicare payment rates are based on a resource-based relative value scale (RBRVS)¹. On a

¹ Medicare payment rates for specific services are derived from a systematic assessment of clinician time and expertise, practice resources including equipment and staff, and medical liability expenses using RBRVS. A standard conversion factor is applied to the



national basis, private payment rates are between 118% and 179% higher than Medicare prices, with an average of 143% over the past ten years². Much of the variation in professional payments is due to physicians' and insurers' market power, types of physicians' services used in the analysis, and payment components included in the calculation.

A 2016 survey of Medicaid physician fees shows that although Maryland's Medicaid payment rate was higher than the national average (Maryland Medicaid's fee index was 1.35 of the national Medicaid fee index), it was significantly lower than the Medicare payment rate. The ratio of the Medicaid-to-Medicare payment rate was 0.88 in Maryland in 2016.³ In other words, the Medicaid payment rate was about 12% lower than the Medicare payment rate in Maryland in 2016.

What would Medicare have paid?

As shown in Figure 3, the payment rate for services reimbursed by all private payers was comparable to what Medicare would have paid for a similar set of services, with ratios of 1.09 for 2023, 1.05 for 2022 and 1.02 for 2021. Based on the difference in payment rates between large payers and other payers, the ratio of the private payment rate to the Medicare payment rate varied slightly by payer market share. Large payer payment rates were 6% higher than Medicare in 2023, 3% higher in 2022 and the same in 2021.

The payment rate for large payers was \$38.52, \$37.57, and \$37.77, in 2023, 2021 and 2021, respectively compared with \$36.35 in 2023, \$36.46 in 2021 and \$37.86 in 2021 for Medicare. Payment per RVU among other payers was \$43.27, \$42.41, and \$42.75 in 2023, 2021, and 2021, respectively; it would have been \$36.54, \$36.33, and \$37.79 in 2023, 2021, and 2021, respectively if other payers used the Medicare fee schedule to reimburse a similar set of services (see Figure 4). Other payers paid on average about 13% higher in 2023, and 17% higher in 2022 and 18% higher in 2021 for covered services than what Medicare would have paid. The difference in what Medicare would have paid for services provided by large payers vs. other payers is due to the difference in the intensity of services provided by those payers.

resources estimated to produce a service which yields a payment rate. The rate is further adjusted by variations in the costs of inputs in local markets. The RBRVS approach allows for a fair comparison of the resources needed for any specific service. The conversion factor then sets the payment rate and geographic adjustments establish a basis for ensuring payment equity across regions.

² <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>

³ <https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump>



Figure 3: Ratio of Private-to-Medicare Payment Rate, by Payer Market Share, 2021 – 2023

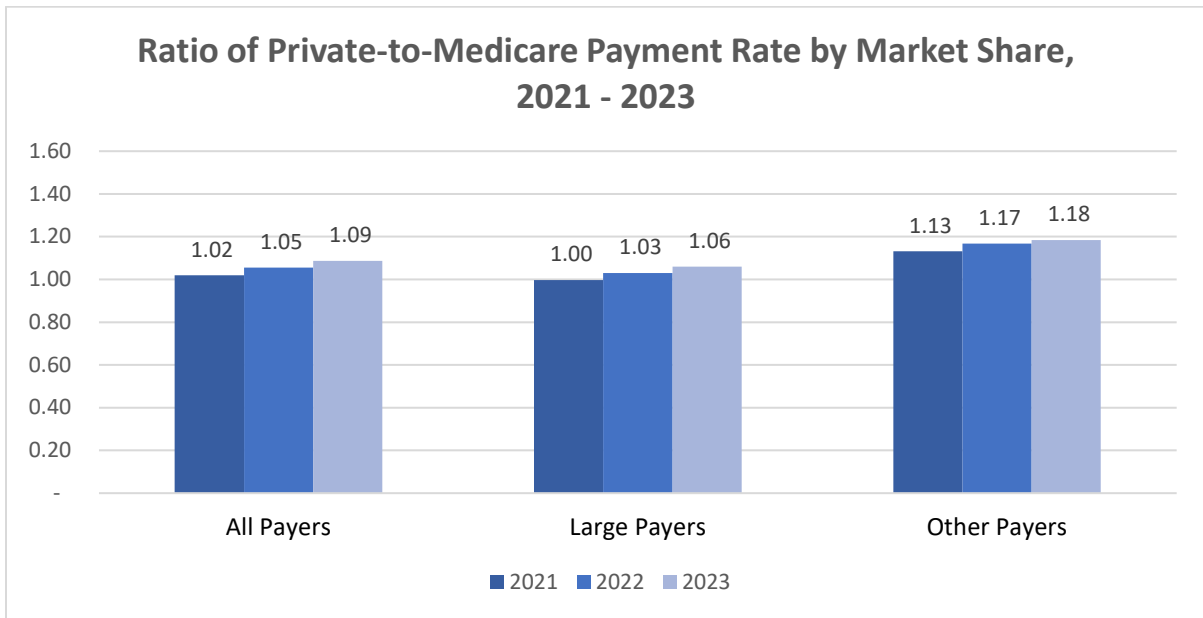


Figure 4: Private vs. Medicare Payment Rates, by Payer Market Share, 2021 – 2023

Market Share	2023		2022		2021	
	Private	Medicare	Private	Medicare	Private	Medicare
All Payers	\$39.58	\$36.39	\$38.43	\$36.43	\$38.57	\$37.85
Large Payers	\$38.52	\$36.35	\$37.57	\$36.46	\$37.77	\$37.86
Other Payers	\$43.27	\$36.54	\$42.41	\$36.33	\$42.75	\$37.79

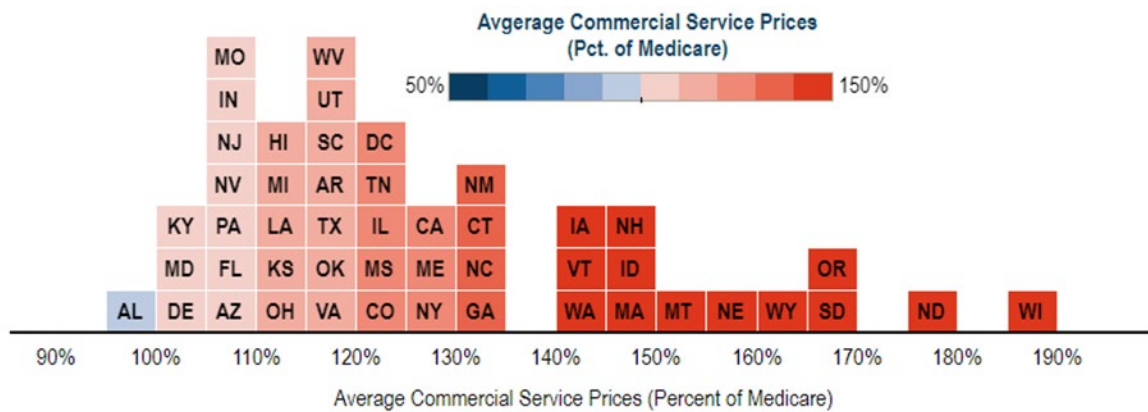


How Private Professional Payment Rates in Maryland Compare Nationally

To understand how Maryland physician payment rates compare with other states, we compared our methodology with a similar methodology adopted by the health care cost institute (HCCI) to calculate payment rates. HCCI used claims data to compare the negotiated rates paid by commercial payers for physician services to the Medicare payments for the same services in different areas of the country. Using a sample of nearly 210 million claims for employer-sponsored insurance individuals in 2017, they measured the average commercial prices paid for the 500 most provided services in physician settings across 271 metro areas and across 48 states and Washington, DC. They found that private physician payment rates were, on average, 122% of Medicare rates nationally in 2017.

As shown in Figure 5, the average private rates varied dramatically across the states, from below Medicare rates in Alabama (98%) to nearly twice Medicare rates in Wisconsin (188%). Maryland showed an average private rate of 104%.

Figure 5: Average Nationwide Private Physician Payment Rates, 2017⁴



Milliman released a White Paper in November 2023 examining commercial reimbursement rates. The study reveals consistent variation among states, echoing findings from the HCCI study. Wisconsin boasts the highest reimbursement rates, while Alabama and Maryland rank lowest in reimbursement rates among the states analyzed⁵.

⁴ <https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices>

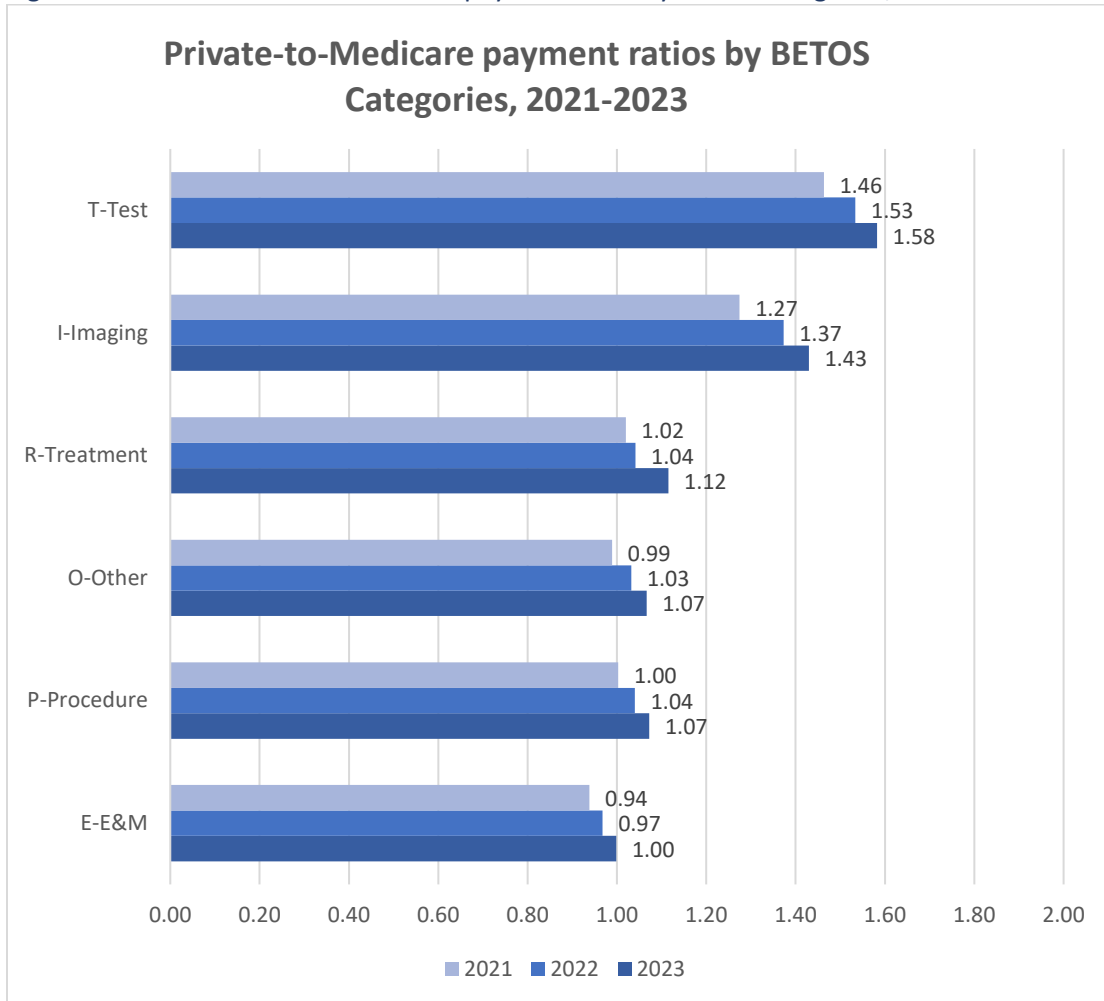
⁵ <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-payment-rates-medicare-fee-for-service>



Private vs. Medicare Payment Rates, by BETOS Category

As shown in Figure 6, the private payment rates in 2023 for Imaging, and Tests were 143%, and 158% higher, respectively than what Medicare would have paid for these service categories based on the Berenson-Eggers Type of Service (BETOS) 2023 classification system. In contrast, private payment rates were of the same as Medicare for Evaluation and Management services and 107% and 112% of Medicare for both Procedures and Treatments categories based on the BETOS 2023 classification system.

Figure 6: Ratio of Private-to-Medicare payment rates by BETOS categories, 2021 -2023



What would Medicaid have paid?

As shown in Figure 7, the payment rate for services reimbursed by all private payers combined was 20% higher in 2023 and 16% higher in 2022, and 27% higher in 2021 than



what Medicaid would have paid for a similar set of services. Both large payers and other payers paid substantially higher than Medicaid across all three years.

For services reimbursed by large payers, the payment per RVU was about 17% (2023) and 14% and 25% (2022 and 2021) higher than if the services were reimbursed under the Medicaid fee schedule. Large payers paid \$37.61, \$37.71, and \$39.40 in 2023, 2021, and 2021 respectively, compared with \$33.23 in 2023, \$30.33 in 2021 and \$33.24 in 2021 if Medicaid reimbursed the services (see Figure 8).

The difference in payment rates between other payers and Medicaid was greater than that between large payers and Medicaid. In the years 2021 to 2023, payments per RVU were \$42.75, \$42.41, and \$43.27, respectively for services reimbursed by other payers, compared with \$30.33, \$33.15, and \$33.21, respectively for the years 2021 through 2023 if Medicaid reimbursed the services (see Figure 8).

Figure 7: Ratio of Private-to-Medicaid Payment Rate, by Payer Market Share, 2021 – 2023

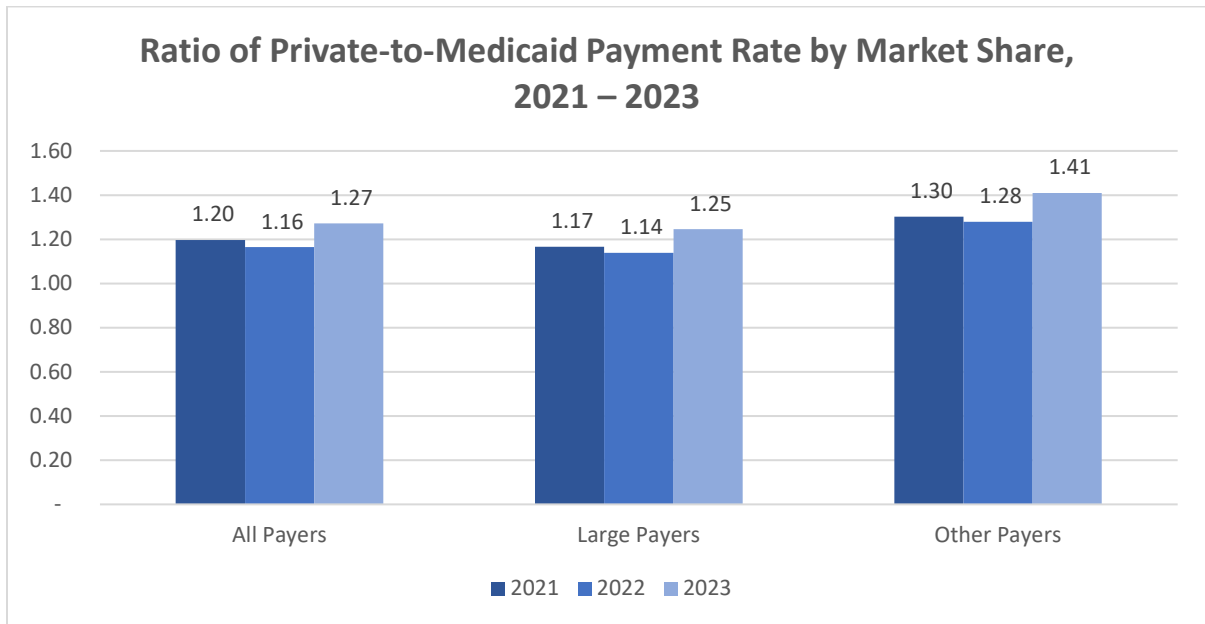


Figure 8: Private vs. Medicaid Payment Rates, by Payer Market Share, 2021 – 2023

Market Share	2023		2022		2021	
	Private	Medicaid	Private	Medicaid	Private	Medicaid
All Payers	\$39.58	\$33.08	\$38.43	\$33.01	\$38.57	\$30.33
Large Payers	\$38.52	\$33.04	\$37.57	\$32.98	\$37.77	\$30.33
Other Payers	\$43.27	\$33.21	\$42.41	\$33.15	\$42.75	\$30.33

Private vs. Medicare Payment Rates, by Provider Specialty

The Private to Medicare payment ratios across specialties showed variation. Radiology and Cardiology specialties received higher Medicare rates of 148% and 144%, respectively. General practice, cardiology, neurological surgery, and emergency medicine were paid between 131% and 139% of Medicare rates. Anesthesia and orthopedics received 126% and 122%, respectively. Obgyn, urology, general surgery, internal medicine, cardiovascular surgery, pediatrics, and family medicine received rates ranging from 110% to 118%. Psychiatry rates were equal to Medicare prices. On the other hand, nurse practitioners, ophthalmology, dermatology, and gastroenterology were paid less than Medicare rates.



Figure 9: Private to Medicare Payment Ratios By Provider Specialty, 2023

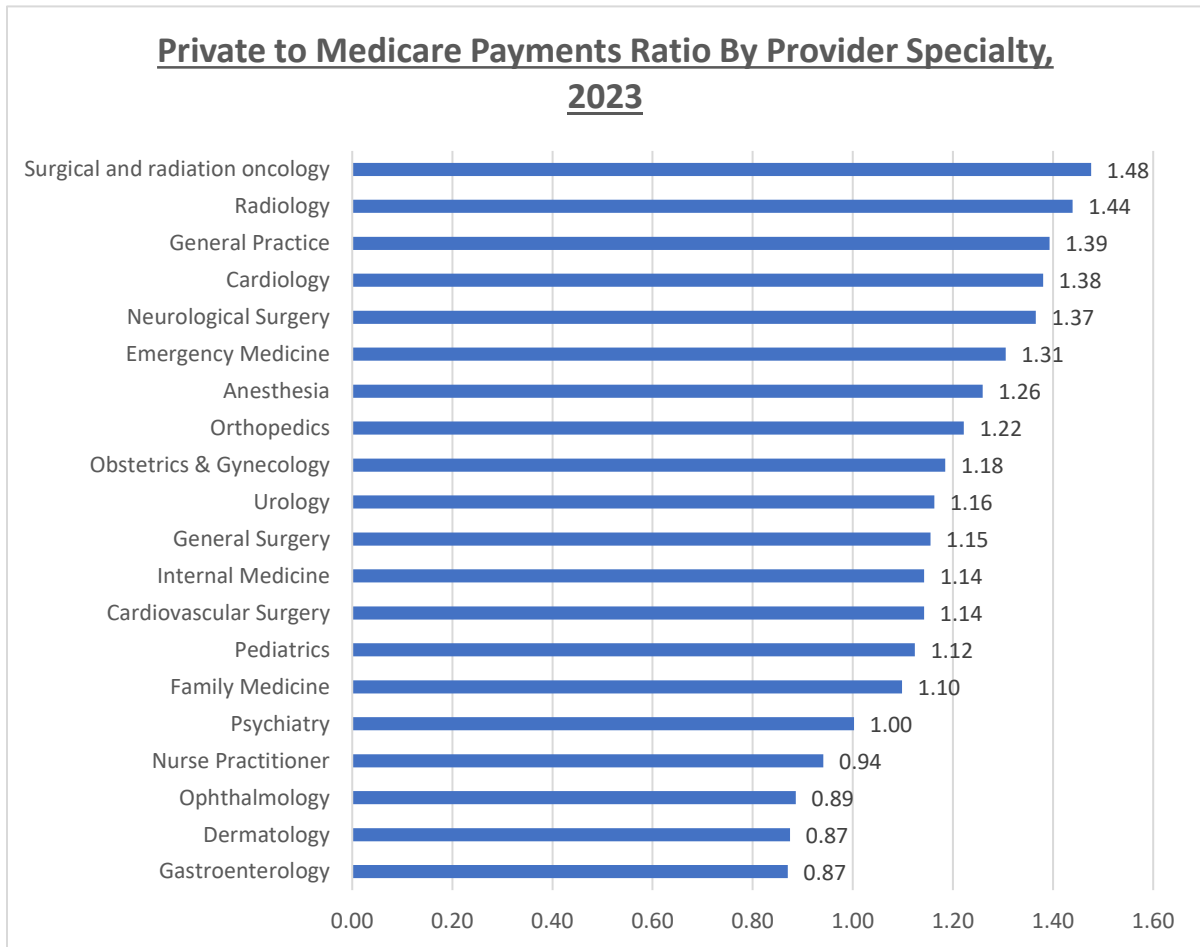


Figure 10: Anesthesia, 2023

Appendix

Data Sources.

The analyses for this report used 2021 to 2023 payment and service data from the Maryland Medical Care Data Base (MCDDB) professional services files for all coverage types except Medicare and Medicare Advantage. The data includes fully insured and self-insured plans.

Relative Value Units (RVUs) of Care.

Relative value units (RVUs) are nonmonetary, relative units that measure the value of health care and relative differences in resources consumed when providing different



procedures and services. The Centers for Medicare and Medicaid Services (CMS) assign relative values or weights to medical procedures primarily for the reimbursement of services performed. More complex, resource-intensive (and typically more expensive) services have a higher number of RVUs and measure the level of resources used to produce a particular service.

Payment Rate.

The average payment per RVU measures the payment rate in a standardized manner controlling for the complexity of a given service. A synthetic fee for large payers and other private payers was developed separately using the allowed amount by CPT code from the MCDB professional services files. e private fees by CPT code for in-network services only.

Medicare Payment Rate.

RVUs assigned in Medicare's physician payment system are added to valid services in the MCDB by CPT/HCPCS codes. The Medicare conversion factor is applied to the total RVUs to produce the total payment for the service. Service-level payment and RVUs are aggregated across payer market share or provider region. The aggregated payments which are adjusted for geography are divided by the aggregate number of unadjusted RVUs to calculate an average payment per RVU. The calculated payment per RVU reflects the average amount a provider would have received for services collected in the MCDB had Medicare been the payer. This calculated payment per RVU is the Medicare payment.



Medicaid Payment Rate.

The fee schedule provided by the Maryland Medical Assistance Program (Medicaid) lists the amount Medicaid would pay for a service. The 2021 Medicaid fee schedule is merged to the MCDB from respective years (2018 to 2021) by CPT/HCPCS codes. Service-level Medicaid payments and Medicare RVUs are aggregated at various levels (payer share and provider region), and the average payment per RVU is calculated by dividing aggregated geographically adjusted payments by unadjusted aggregated RVUs. This average payment per RVU is the Medicaid payment.

Benchmarking with Medicare and Medicaid Payment Rate.

To examine relative payment rates, we calculated the ratio of the average payment rate among private payers in the MCDB to what Medicare or Medicaid would have paid (Medicare payment rate and Medicaid payment rate, respectively) for the service mix included in the MCDB.

Maryland Regions.

- **Baltimore Metro:** Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County
- **DC Metro:** Montgomery County and Prince George's County
- **Other Maryland:** Western Maryland, Eastern Shore/Southern Maryland
 - Western Maryland: Garrett County, Allegany County, Washington County, Carroll County, and Frederick County
 - Eastern Shore/Southern Maryland: St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County, and Worcester County

Payer Market Share.

Large Payers: CareFirst, United Healthcare

Other Payers: All other private payers that are not CareFirst or United Healthcare

Note: This report excludes Kaiser.



Figure A1: Data Distribution - Large Payers v. Other Payers

	Distribution		
	No. of Services	No. of RVUs	Total Spending
Largest Payers	81%	81%	79%
Other Payers	19%	19%	21%
Total	100%	100%	100%

Limitations:

- The results in this report are for in-network services only.
- All services are rendered in Maryland only.
- The private population is limited to under age 65
- The private synthetic fees are based on the allowed amount reported by private payers. However, some of these amounts are estimated by some private payers.
- The Medicaid fees are MCO imputed fee-for-service equivalents provided by Medicaid.
- Data excludes self-insured ERISA plans for 2015 and beyond due to the *Gobeille v. Liberty Mutual Ins. Co.* SCOTUS ruling for 2015 and beyond.
- Federal Employee Health Benefit (FEHB) Program data were excluded from this year’s report because of the reporting restriction imposed by the Office of Personnel Management (OPM) on payers who have a contract with the Office to stop reporting all FEHB data to APCDs.

Figure A2: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims v. Medicare, 2004 and 2003⁶

Table A 2-1: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims versus Medicare, 2004

CLASSIFICATION	NON-HMO PLAN				HMO PLAN			
	Pymt Per RVU Using Medicare Rate	% of Pymt	Pymt Per RVU	% Diff from Medicare	Pymt Per RVU Using Medicare Rate	% of Pymt	Pymt Per RVU	% Diff from Medicare
Total	\$38.82	100%	\$39.82	2.6%	\$38.95	100%	\$37.76	-3.0%

⁶ https://mhcc.maryland.gov/mhcc/pages/plr/plr_healthmd/plr_healthmd_Utilization.aspx



Table A 3-1: Payment Rates for Private Non-HMO and HMO Fee-for-Service Claims versus Medicare, 2003

CLASSIFICATION	NON-HMO PLANS				HMO PLANS			
	Pymt per RVU Using Medicare Rates	% of Pymts	Pymt per RVU	% Diff from Medicare	Pymt per RVU Using Medicare Rates	% of Pymts	Pymt per RVU	% Diff from Medicare
Total	\$38.19	100%	\$38.90	1.8%	\$38.39	100%	\$37.36	-2.7%

Private payments in Maryland have been lower than the national average since MHCC began benchmarking private payer payments almost twenty years ago. In 2004, private payment rates in Maryland for professional services were very close, on average, to the Medicare rate.

Fee-for-service (FFS) payments for HMO plans were 3% below the Medicare rate, while payments from non-HMO plans average 3% above Medicare. Also, for 2003, the average HMO-FFS payment rate was approximately 3% less than the Medicare rate and about 2% more than Medicare for non-HMO-FFS payment rates⁷.

Acknowledgments

This report on payments for professional services in Maryland was conducted by the Center for Analysis and Information Systems staff of the Maryland Health Care Commission. The staff involved in this report's development was Shankar Mesta. Questions about the report should be directed to Shankar Mesta (shankar.mesta@maryland.gov).

The Maryland Health Care Commission is an independent regulatory commission administratively located within the Maryland Department of Health.

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