2017

SPENDING AND USE AMONG MARYLAND'S PRIVATELY INSURED

Maryland Health Care Commission
CENTER FOR ANALYSIS AND INFORMATION SYSTEMS

Highlights

- **Per Member Per Month (PMPM) Overall Spending (all services combined) growth rate was flat:** PMPM spending for all services combined increased by about 6% from 2016–2017.
  - **PMPM spending growth rate was flat in the privately insured market:** PMPM spending (all services combined) increased by about 6% from 2016–2017 compared to a 5% increase from 2015–2016.
  - **PMPM spending increased in the individual and small group market:**
    - For the individual market, spending grew faster in 2017 (a 16% increase in spending) than in 2016, which had about an 11% increase in PMPM spending.
    - PMPM spending in the small group market increased by about 6% in 2017 compared to no increase in spending in 2016.
- **Increases in Prescription Drug and Professional Services were the primary contributors to the 6% increase in spending for 2017:**
  - **Prescription drug spending increased by about 14% across all markets.** This increase was driven by increases in both utilization of about 8% and unit costs of about 5%.
    - The individual (32% increase) and large group (14%) markets were the primary market contributors in the 14% increase in prescription drug spending in 2017.
    - Prescription drugs accounted for about 30% of the total privately insured PMPM spending in 2017.
  - **Professional services increased by about 8% across all markets.** This increase was driven by increases in both utilization of about 5% and unit costs of about 3%.
    - The individual market (18%) was the main contributor to the 5% increase followed by small group (9%) and large group (6%).
    - Professional services were about 29% of the total privately insured PMPM spending in 2017.
- **Other Service Category PMPM Changes in 2017:**
  - **Lab/imaging continue to show a decrease in PMPM spending.** Although lab/imaging continue to show a reduction in PMPM spending in 2017, the rate of decline did not change from a year ago (4% decrease for both 2017 and 2016).
    - The 4% decrease was mainly driven by a 6% decrease in unit cost offset by a 2% increase in utilization.
  - **Inpatient Hospital Facility PMPM spending growth rate grew (10 percentage points) in 2017.** Inpatient hospital facility showed a 4% increase in PMPM spending in 2017 compared to a 6% decrease in 2016. Below is a breakdown of the 10-point swing in PMPM spending for inpatient hospital facility:
    - The large group market increased from -8% in 2016 to 2% in 2017 (a 10 percentage point swing)
    - The small group market increased from -3% in 2016 to 10% in 2017 (a 13 percentage point change)
    - The individual market increased from 5% in 2016 to 14% in 2017 (a nine percentage point swing).

      The 4% increase in inpatient hospital facility PMPM spending was mainly driven by utilization (3%).

Highlights Cont'd

- **Self-insured non-ERISA plans (State/Local Gov't and Public Schools) added in 2017:**
  - This addition only affected the large group market (a 75% increase in member months from 9,075,225 w/o self-insured non-ERISA in 2016 to 15,879,061 w/ self-insured non-ERISA in 2017). The self-insured non-ERISA added about 560,137 members per month on average to the large group market enrollment for 2017.
  - Private market distribution is now 76% (up from 62%) in the large group market, compared to 12% each in the small group and individual markets, down from 18% and 20%, respectively.

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Background

This report examines health care spending and utilization patterns for Maryland residents insured through the privately insured individual, small employer, and large employer markets.[1] The analysis relies on 2015, 2016, and 2017 data from Maryland's Medical Care Database (MCDB), which contains health insurance enrollment, health care claims, and encounter data for Maryland residents. These data are submitted quarterly to the Maryland Health Care Commission (MHCC) by private health insurance carriers. Most private health insurance carriers serving Maryland residents submit MCDB data, including CareFirst, United HealthCare, Kaiser Permanente (Kaiser), Cigna, Aetna, and Evergreen Health.[2] This report is limited to data for Maryland residents who are enrolled in fully insured and self-insured non-ERISA health plans and who are under 65 years of age.

For the first time, this report includes data on the self-insured population in Maryland as part of the large employer market findings. Specifically, these data are self-insured non-ERISA data for State/Local government, and Public Schools of Maryland insured members. In addition, the large employer market findings also include data on the Federal Employee Health Benefits Program (FEHBP) PPO plan, as well as the State of Maryland employees prescription drug data (via the Pharmacy Benefits Management).

Part 1 of this report presents enrollment, spending, utilization, and unit cost data for all privately insured health insurance markets, including comparisons among the individual, small employer, and large employer markets. Data on variation by geography, age, and service category are also included. Part 2 of this report focuses exclusively on the small employer market. Part 3 of the report provides similar data for the individual market only.

Members of Kaiser plans are only included in the individual and small employer market data discussed in Part 2 and Part 3 of this report. The only data that include Kaiser members are the overall enrollment data at the end of a year, and the median expenditure risk score results.

This report is one in a series of reports that fulfills the annual reporting requirements for certain types of information from the MCDB, as required under Maryland law.[3] Measures used in this analysis are defined in the Methods section of Appendix B at the end of this report.

[1] Data on self-insured plans and publicly funded insurance products are included in this report.

[2] On July 31, 2017, Evergreen Health, Inc. ("Evergreen" or the "Company") was ordered into Rehabilitation and the Risk and Regulatory Consulting, LLC was appointed as Receiver for Evergreen. On September 1, 2017, the Circuit Court for Baltimore City, Maryland ordered the Company into Liquidation. All policies were terminated on September 30, 2017, unless otherwise expired or terminated prior to that date.

[3] Annotated Code of Maryland, Health-General, §19-133.

PART 1:
The Privately Insured Market in Maryland

This part of the report presents enrollment, spending, risk, utilization, and unit cost data for all privately insured health insurance markets for years 2015, 2016, and 2017. The individual, small employer, and large employer markets are compared throughout. Data on variation by service category are also included.

Enrollment, Spending, and Risk Across Maryland's Privately Insured Markets: 2015, 2016, and 2017

This section provides information on enrollment in privately insured health insurance in Maryland, as well as spending and risk (as measured through member health status). This information is essential in understanding trends over time in health care costs and insurance participation, as well as how the individual market, small employer market, and large employer market differ. This section also provides information on consumer out-of-pocket (OOP) costs across markets and variation in spending across different types of services.

Exhibit 1 and Exhibit 2 illustrate the following:

- Enrollment in privately insured health plans decreased in 2017. The largest percentage decrease occurred in the individual market (17%) compared to about a 5% decline and a 1% decline in the large employer and small employer markets, respectively.
- Overall, Per Member Per Month (PMPM) spending (all services combined) increased by about 6% in 2017. Spending increased in all three privately insured health insurance markets in Maryland in 2017, continuing the upward trend in annual spending. In 2017, the individual market also saw the most significant increase in all services combined PMPM spending (about 16%), compared to the large employer (5%) and small employer (6%) markets.
- The prescription drug service category showed the highest increase of 14% in PMPM spending among all service categories for 2017. This 14% increase was mainly driven by a 13.6% increase in brand-name prescription drug spending in 2017. Generic drugs had about a 4% increase for the same period. The individual market depicted the most substantial increase in drug spending of about 32% across all markets in 2017. This 32% increase was driven by both increases in utilization (14%) and unit cost (16%). See the individual market section for more results on prescription drugs for this market. The large group market had about a 13% increase, which was mainly driven by approximately a 13.5% increase (down from 17% in 2016) in brand-name drug spending while small group showed a more modest increase of about 5%. See Exhibits A7 – A17 in Appendix A.
- In 2017, OOP spending (all services combined) increased in the small employer market (6%), but remained flat in the large employer and individual markets. Similar to 2015 and 2016, OOP spending was highest in the individual market in 2017, at $117, compared to $89 for the small employer market and $51 for the large employer market.
- Labs/imaging was the only service category to show a decrease (4%) in PMPM spending across all markets in 2017. This decline in PMPM spending was primarily driven by a 6% decrease in unit costs, offset by a 2% increase in utilization.

- Maryland's privately insured population illness burden worsened over time from 2015 through 2017 as the median expenditure risk scores for these years increased (0.28 for 2015, 0.32 for 2016, and 0.35 for 2017) for all markets combined. The median expenditure risk score for the large employer market (0.36) was about the same as for the individual market (0.35) for 2017. The small employer market members had a slightly lower illness burden (risk score: 0.25).

EXHIBIT 1. Enrollment, Spending, and Risk Scores in Maryland's Privately Insured Markets

	2015				2016				2017			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
MEMBERS[a]												
Total members as of December 31 (000 omitted)	1,794	1,314	231	249	1,812	1,353	226	233	1,706	1,288	224	194
MEMBER MONTHS												
Total member months (000 omitted)	21,509	15,815	2,651	3,043	21,780	16,126	2,741	2,913	20,823	15,879	2,579	2,365
SPENDING												
PMPM spending, all services combined	$396	$396	$372	$417	$415	$414	$371	$464	$442	$436	$393	$537
PMPM OOP, all services combined	$61	$48	$90	$106	$64	$51	$84	$117	$63	$51	$89	$117
PMPM OOP, Medical Only	$48	$36	$70	$88	$50	$38	$65	$100	$49	$38	$70	$99
PMPM OOP, Prescription Drugs	$13	$11	$21	$18	$14	$13	$19	$17	$15	$13	$19	$19
PMPM SPENDING BY SERVICE CATEGORY												
Inpatient Hospital Facility	$65	$65	$59	$71	$62	$60	$57	$74	$64	$61	$63	$84
Outpatient Hospital Facility	$74	$73	$66	$85	$78	$75	$65	$102	$77	$75	$68	$104
Outpatient Non-Hospital Facility	$9	$9	$8	$11	$9	$9	$9	$10	$9	$9	$9	$13
Professional Services	$115	$116	$109	$113	$120	$121	$108	$124	$129	$128	$118	$146
Labs/Imaging	$33	$32	$33	$39	$32	$31	$31	$37	$31	$30	$29	$36
SubTotal (Medical Only)	**$296**	**$295**	**$275**	**$318**	**$300**	**$296**	**$270**	**$347**	**$310**	**$303**	**$287**	**$383**
Prescription Drugs[1]	$100	$101	$97	$99	$116	$118	$101	$116	$132	$133	$106	$154
RISK SCORE												
90th Percentile	3.03	3.11	2.62	2.88	3.25	3.32	2.84	3.26	3.38	3.40	2.94	3.64
Median expenditure risk score	0.28	0.31	0.20	0.20	0.32	0.34	0.21	0.27	0.35	0.36	0.25	0.35
10th Percentile	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04

(1) Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).

Notes:

- Some calculations in the above exhibit might not be exact due to rounding.
- The large employer market now includes State/Local government and Public Schools of Maryland insured members.
- Expenditure Risk Score differences are measured as absolute differences from 2015 to 2016 and 2016 to 2017.
- Results exclude Kaiser HMO plans.

EXHIBIT 2. Percentage Changes in Enrollment, Spending, and Risk Scores in Maryland's Privately Insured Markets

	Market (2016 0ver 2015)				Market (2017 0ver 2016)			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
MEMBERS								
Total members as of December 31	1%	3%	-2%	-7%	-6%	-5%	-1%	-17%
MEMBER MONTHS								
Total member months	1%	2%	3%	-4%	-4%	-2%	-6%	-19%
SPENDING								
PMPM spending, all services combined	5%	5%	0%	11%	6%	5%	6%	16%
PMPM OOP, all services combined	5%	6%	-7%	10%	-2%	0%	6%	0%
PMPM OOP, Medical Only	4%	6%	-7%	14%	-2%	0%	8%	-1%
PMPM OOP, Prescription Drugs	8%	18%	-10%	-6%	7%	0%	0%	12%
PMPM SPENDING BY SERVICE CATEGORY								
Inpatient Hospital Facility	-6%	-8%	-3%	5%	4%	2%	10%	14%
Outpatient Hospital Facility	5%	3%	-1%	20%	0%	0%	4%	2%
Outpatient Non-Hospital Facility	-2%	-2%	4%	-4%	6%	3%	6%	27%
Professional Services	5%	5%	0%	10%	8%	6%	9%	18%
Labs/Imaging	-4%	-3%	-8%	-4%	-4%	-3%	-5%	-4%
SubTotal (Medical Only)	**1%**	**0%**	**-2%**	**9%**	**4%**	**2%**	**6%**	**10%**
Prescription Drugs[1]	16%	17%	4%	17%	14%	13%	5%	32%
RISK SCORE	**DIFFERENCES (2015 TO 2016)**				**DIFFERENCES (2016 TO 2017)**			
90th Percentile	n/a	0.22	0.22	0.38	n/a	0.08	0.10	0.38
Median expenditure risk score	n/a	0.03	0.01	0.07	n/a	0.02	0.04	0.08
10th Percentile	n/a	0.00	0.00	0.00	n/a	0.00	0.00	0.00

(1) Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).

Unit Costs by Market and Service Category for Privately Insured Health Plans: 2015, 2016, and 2017

Unit Cost is one component of the PMPM spending calculation (along with utilization, which is addressed in the next section). Since the unit cost measure has two components (the price for a given service and the intensity of that service), a change in the unit cost measure allows us to observe if the change was driven by price or intensity (mix of services). In other words, a change in either price or intensity will cause a change in the unit cost and subsequently, a change in the overall PMPM spending. Results for these two components of unit cost will be shown in the next report.

In general, unit costs are derived by dividing the amount that the insurer allows in payment for a claim (including the consumer's OOP share of the cost) by the units of measure appropriate for that claim. The units of measure differ by service category (for example, hospital discharge days for inpatient claims; visits for most outpatient claims; and 30-day scripts for prescription drugs).

Exhibit 3 and Exhibit 4 illustrate the following:

- Unit costs increased for most service categories in 2017, except for outpatient non-hospital facility services and labs/imaging. Across all three markets in 2017, the decrease in unit costs is less (down by about 1%) for outpatient non-hospital facility services compared to 2016 (down by about 28%). Please note that outpatient non-hospital facility services account for about 2% of total PMPM spending.
- Unit costs for labs/imaging decreased across all three markets (down by about 6%, all markets combined) in 2017.
- Unit costs increased across all three markets for professional services and prescription drugs, with the individual market showing the most significant jump for prescription drugs (17%).
- Unit costs for inpatient hospital facility services increased for small employers and in the individual market but remained flat in the large employer market, compared to 2016.

EXHIBIT 3. Unit Cost by Service Category in Maryland's Privately Insured Markets

	2015				2016				2017			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
SERVICE CATEGORY												
Inpatient Hospital Facility (Cost per IP Day)	$3,085	$2,895	$3,842	$4,101	$2,940	$2,695	$3,743	$3,940	$2,965	$2,694	$3,919	$4,204
Outpatient Hospital Facility (Cost per Visit)	$1,313	$1,242	$1,504	$1,714	$1,150	$1,094	$1,276	$1,357	$1,168	$1,123	$1,336	$1,304
Outpatient Non-Hospital Facility (Cost per Visit)	$1,020	$1,064	$895	$893	$687	$707	$683	$610	$682	$701	$675	$610
Professional Services (Cost per Visit)	$183	$181	$190	$190	$186	$184	$190	$199	$191	$188	$195	$206
Labs/Imaging (Cost per Visit)	$133	$130	$140	$153	$130	$127	$131	$146	$123	$121	$123	$132
Prescription Drugs (Cost per Script)[1]	$96	$97	$92	$92	$102	$103	$95	$98	$107	$107	$99	$115

(1) Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).

Notes:

- Results exclude Kaiser HMO plans.
- Some calculations in the above exhibit might not be exact due to rounding.
- The large employer market now includes State/Local government and Public Schools of Maryland insured members.

EXHIBIT 4. Annual Percentage Change in Unit Cost by Service Category in Maryland's Privately Insured Markets

	% Change (2016 over 2015)				% Change (2017 over 2016)			
	Total	Large Employers	Small Employers	Individual	Total	Large Employers	Small Employers	Individual
SERVICE CATEGORY								
Inpatient Hospital Facility (Cost per IP Day)	-5%	-6%	-3%	-4%	1%	0%	5%	7%
Outpatient Hospital Facility (Cost per Visit)	-13%	-12%	-15%	-21%	2%	3%	5%	-4%
Outpatient Non-Hospital Facility (Cost per Visit)	-28%	-27%	-24%	-32%	-1%	-1%	-1%	0%
Professional Services (Cost per Visit)	3%	3%	0%	5%	3%	2%	3%	4%
Labs/Imaging (Cost per Visit)	-3%	-2%	-7%	-5%	-6%	-4%	-6%	-10%
Prescription Drugs (Cost per Script)[1]	7%	7%	3%	7%	5%	4%	4%	16%

(1) Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).

Notes:

- Results exclude Kaiser HMO plans.
- Some calculations in the above exhibit might not be exact due to rounding.
- The large employer market now includes State/Local government and Public Schools of Maryland insured members.

Utilization of Services by Service Category in Maryland's Privately Insured Markets: 2017 v. 2016

Utilization of services is one component of the PMPM spending calculation (along with unit cost, discussed in the previous section). Information on utilization allows us to see the role of consumer demand for services in overall spending for the service. Utilization data can be helpful to providers to plan for future service offerings, as well as to carriers who pay for health services and to policymakers who want to make sure that patients receive necessary care, but not unnecessary care. In this report, utilization is presented as the number of units per 1,000 covered members per year for claims that were incurred during a given year, providing a standardized, comparable measure. Examples of units are the number of discharge days for inpatient hospital facility services; number of visits for outpatient hospital facility and professional services; and number of scripts for prescription drugs.

Exhibit 5 and Exhibit 6 illustrate the following:

- Across markets, the individual market experienced the highest increases in utilization of inpatient and outpatient hospital facility services as well as outpatient non-hospital facility services (about 2% of total PMPM spending).
- Similarly, the individual market also experienced the highest increase in utilization of professional services, labs/imaging, and prescription drugs.
- Both the small and large employer markets saw modest declines in the utilization of outpatient hospital facility services.

EXHIBIT 5. Annual Percentage Changes in Utilization of Inpatient and Outpatient Facility Services by Market, 2016 – 2017

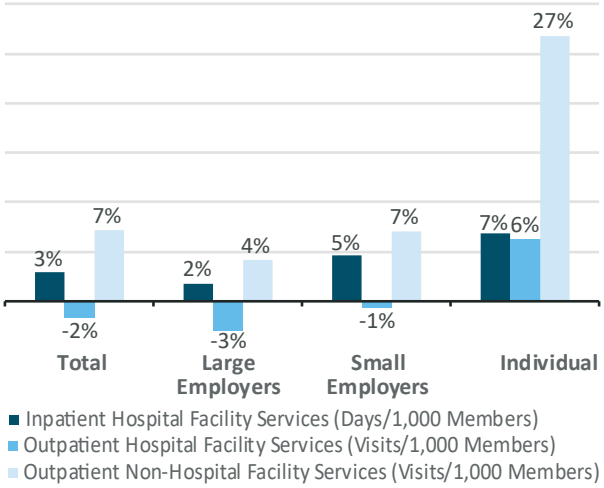
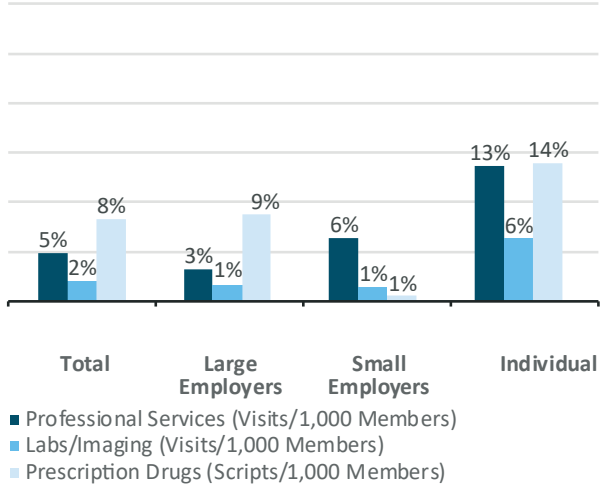


EXHIBIT 6. Annual Percentage Changes in Utilization of Professional Services, Labs/Imaging, and Prescription Drugs by Market, 2016 – 2017



Notes:

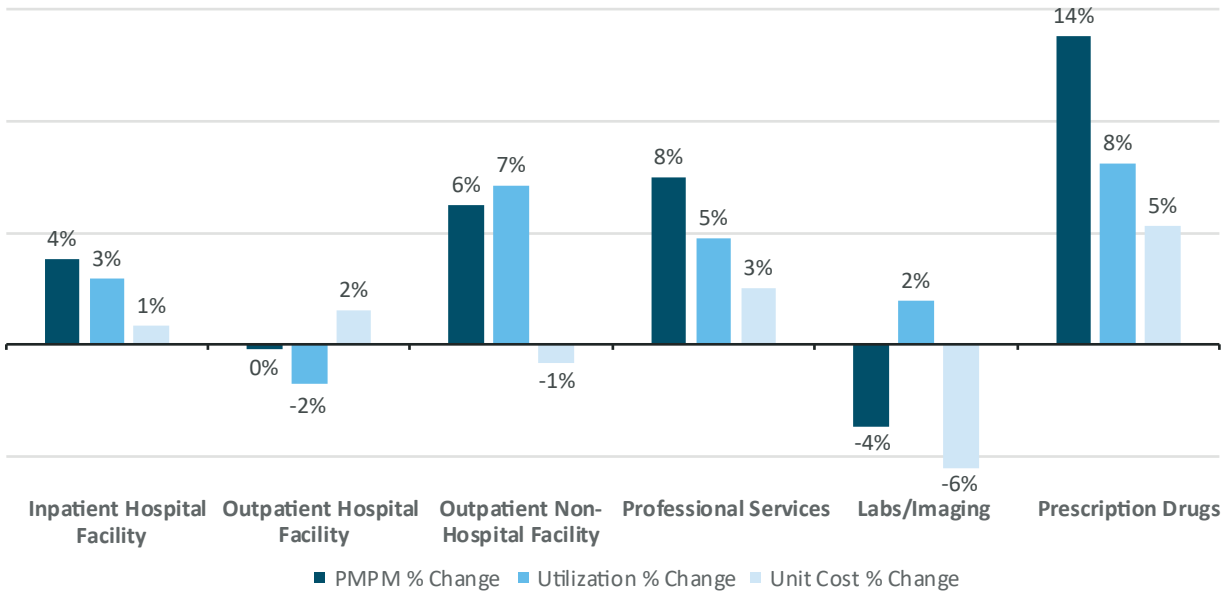
- Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).
- Results exclude Kaiser HMO plans.
- Some calculations in the above exhibit might not be exact due to rounding.
- The large employer market now includes State/Local government and Public Schools of Maryland insured members.
- See Exhibits A1 and A2 in Appendix A for utilization counts per 1,000 members by Market and Service Category (2017).

Drivers of Spending Growth, All Markets Combined: 2017 v. 2016

Increases in utilization mostly drove PMPM spending growth in 2017. Specifically, as shown in Exhibit 7:

- PMPM spending for inpatient hospital facility services increased due to increases in both utilization and unit cost.
- For outpatient hospital facility services, there was no change in PMPM spending due to the offsetting decrease and increase in utilization and unit cost, respectively.
- The overall increase in PMPM spending for outpatient non-hospital facility services was driven by an increase in utilization, offset by a small decline in unit cost.
- The increase in PMPM spending growth for professional services (8%) was driven by increases in both unit cost (3%) and utilization (5%).
- The decrease in PMPM spending growth for labs/imaging was driven by a decline in unit cost, somewhat offset by an increase in utilization.
- The 14% growth in spending for prescription drugs was driven by an 8% increase in utilization and a 5% increase in unit cost.

EXHIBIT 7. Annual Percentage Changes in PMPM Spending, Utilization per 1,000 Members, and Cost per Unit by Service Category, All Markets Combined, 2016 – 2017



Notes:

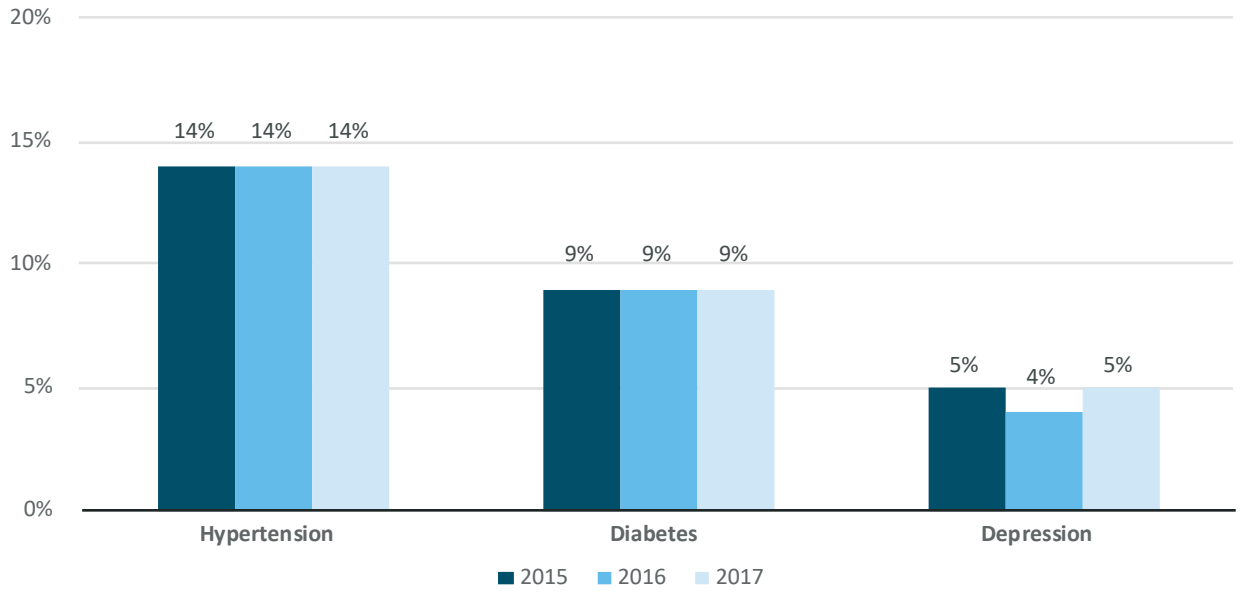
- Prescription drug spending is missing for some Federal Employee Health Benefits Program (FEHBP) members; therefore, drug spending for large employers is calculated using only members who have the prescription drug benefit. (Note: Rx now includes FEHBP PPO and State/Local government and Public Schools of Maryland insured members via PBMs).
- Results exclude Kaiser HMO plans.
- The large employer market now includes State/Local government and Public Schools of Maryland insured members.

Prevalence of Select Conditions, All Markets Combined: 2015, 2016, and 2017

Chronic health conditions such as diabetes, hypertension, and depression are both costly and common.[4] As such, the prevalence of these conditions contributes to health care spending.[5] Many of these conditions can be controlled through treatment and behavioral changes, allowing for potential cost savings and improved quality of life for patients. Understanding the impact of chronic diseases can help health care providers, payers, and government entities make appropriate decisions about resources and policies that address chronic condition treatment and prevention.

As shown in Exhibit 8, the prevalence of all three chronic conditions, hypertension, diabetes, and depression, was stable from 2015 to 2017.

EXHIBIT 8. Prevalence of Select Chronic Conditions, All Markets Combined, 2015 – 2017



[4] http://www.fightchronicdisease.org/sites/default/files/TL221_final.pdf

[5] https://www.cdc.gov/chronicdisease/about/costs/index.htm

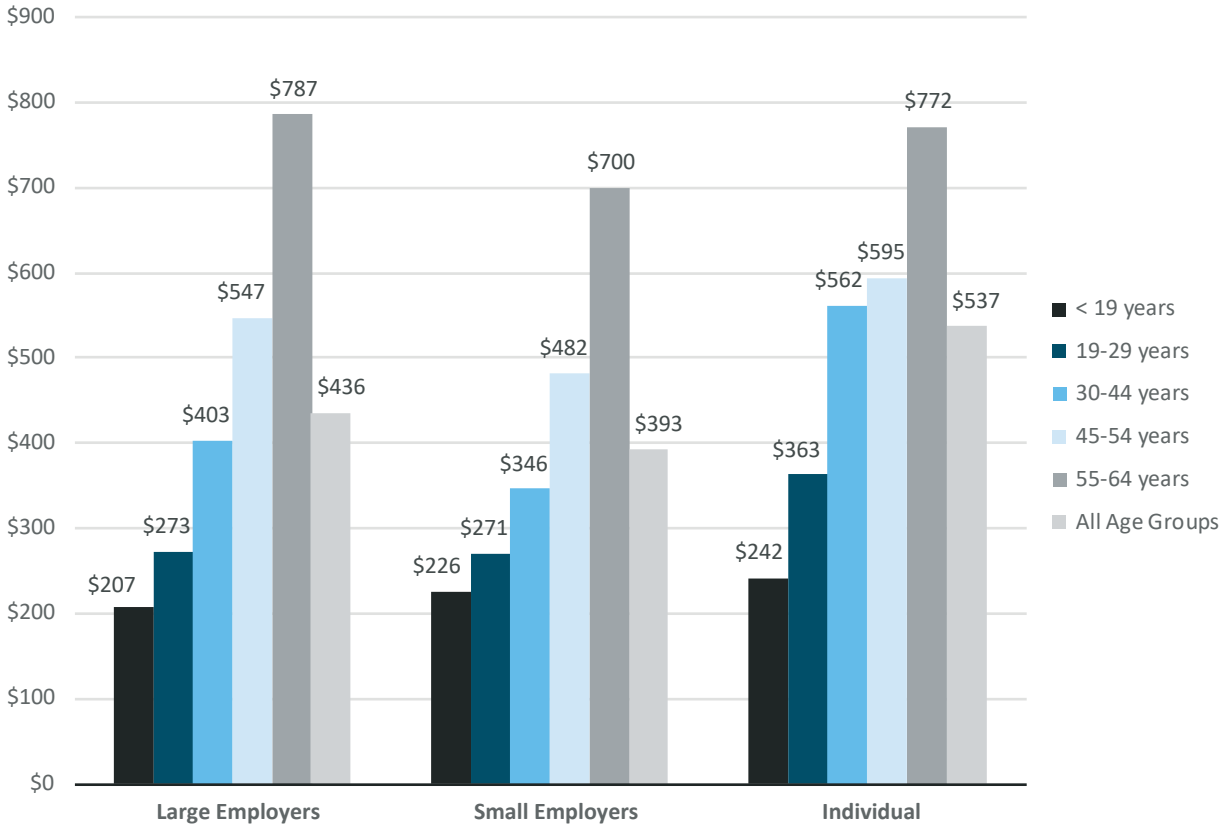
PMPM Spending by Age in Maryland's Privately Insured Markets: 2017

The cost of health care varies by age and is related to the relative health needs of different age populations. This cost variation is an essential factor in understanding health insurance risk pools and the influence of demographic mix by age on health plan costs and sustainability, among other factors.

Exhibit 9 illustrates the following:

- Within each market, PMPM spending increased with age in 2017.
- In 2017, the individual market had the highest PMPM spending for age groups <19, 19–29, 30–44, and 45–54. The large employer market had the highest PMPM spending for the age group 55–64.

EXHIBIT 9. PMPM Spending By Age of Member and Market, 2017



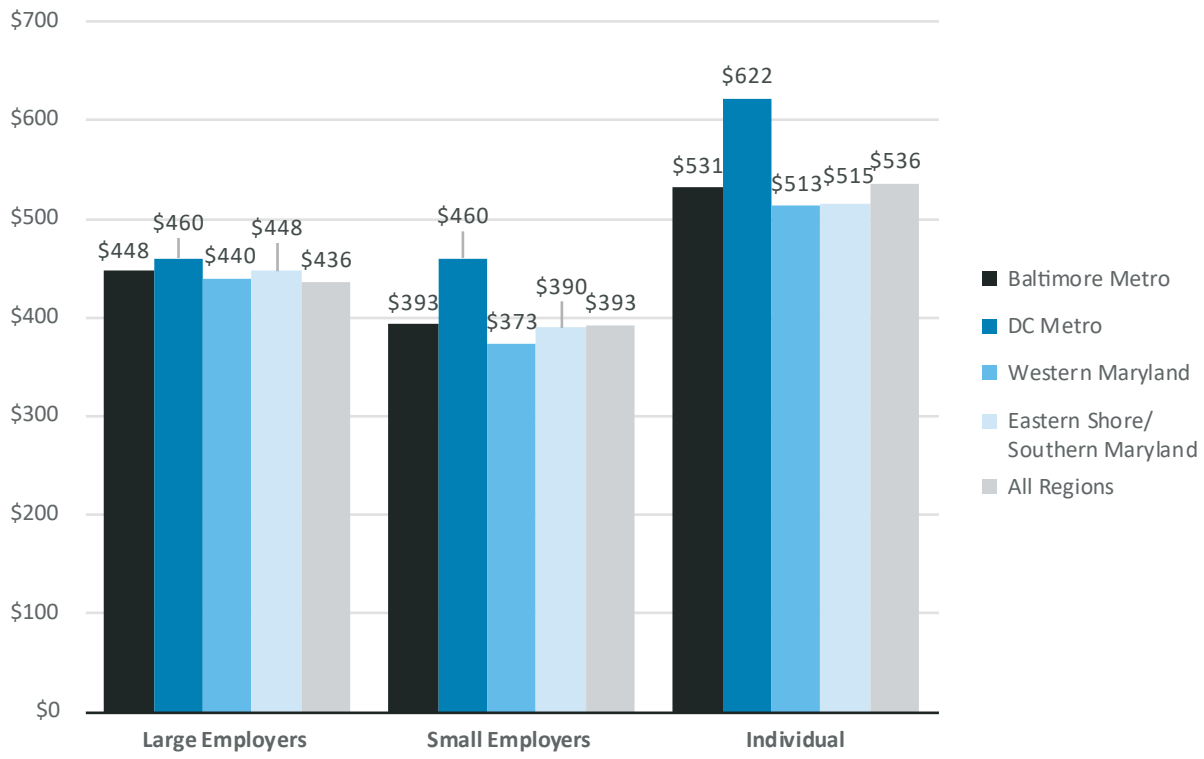
PMPM Spending by Region in Maryland's Privately Insured Markets: 2017

Geographic variation in cost has been a long-standing issue nationally, related both to pricing and variation in utilization. The data in this report provide a comparison of PMPM spending across four geographic regions in Maryland, for each market type.

Exhibit 10 illustrates the following:

- The variation in PMPM spending across regions was small to moderate, with a maximum regional change in PMPM spending at about 23% in the small employer market, 21% in the individual market, and close to 6% in the large employer market.
- Across the three markets, the DC Metro region had the highest PMPM spending levels, while the Western Maryland region had the lowest PMPM spending levels.

EXHIBIT 10. PMPM Spending by Region and Market, 2017



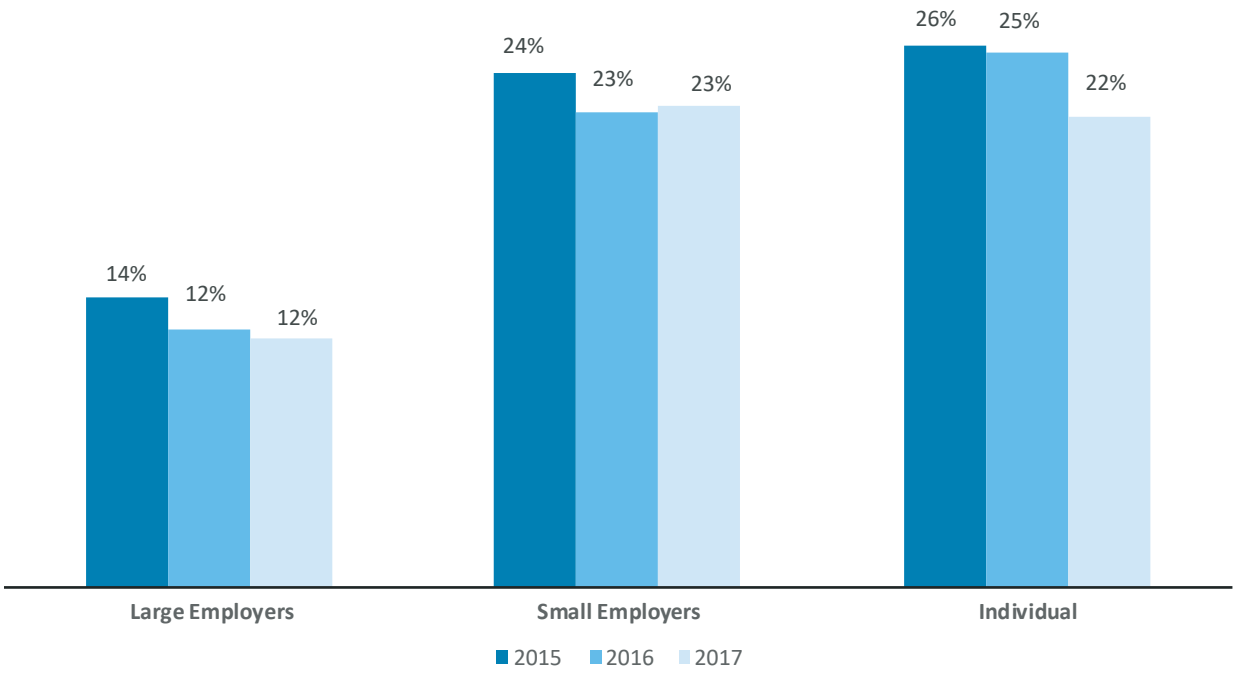
Member and Carrier Shares of Health Spending across Markets: 2015, 2016, and 2017

This section compares the share of health care spending that is paid out of pocket by health insurance members for the large employer, small employer, and individual markets. The burden of health care costs on individuals and payers is an important issue as health care spending continues to increase and consume more significant portions of individual, employer, and government budgets. These data provide some insight into how that burden is shared between individual consumers and carriers in the privately insured markets in Maryland.

Exhibit 11 illustrates the following:

- In 2017, members bore a higher share of the cost of health care in the small employer market (23% of total PMPM spending) followed closely by the individual market (22%), compared to the large employer market (12% of total PMPM spending).
- The member OOP share was slightly higher in the small employer market in 2017, in contrast to 2015 and 2016 when the individual market saw members bearing a higher share of health care costs.
- Across all three markets, the member OOP share declined or remained stable from 2015 - 2017.

EXHIBIT 11. Member Out-of-Pocket Share of Total Spending by Market, 2015 – 2017



PART 2:
The Privately-Insured, Small Employer Market in Maryland

The Affordable Care Act (ACA) created the Small Business Health Options Program (SHOP) to make it easier for small businesses and their employees to shop for and compare plan options online. Today, about 18 states, including Maryland and the District of Columbia, operate a state-run SHOP alongside an individual insurance marketplace. SHOP provisions assist small businesses and small tax-exempt organizations with the cost of covering their employees' health insurance.[6] If a small business has fewer than 25 employees and provides health insurance, it may qualify for a small business tax credit of up to 50 percent (up to 35 percent for non-profits) to offset the cost of insurance, starting with the 2010 federal tax year. This provision can make the cost of providing insurance significantly lower. Before 2014, the small business tax credit was 35 percent (up to 25 percent for non-profits) for qualifying businesses.[7] As of September 2017, about 113 small businesses used the SHOP marketplace in Maryland to cover over 700 individuals. Most of these small businesses (98%) employed fewer than ten employees. The other 2% or so had fewer than 20 employees. For 2017, the health insurance carriers (excluding dental) with certified SHOP plans included Aetna (6 plans), CareFirst (9 plans), Evergreen (13 plans which terminated at the end of September), Kaiser Permanente (15 plans), and United Healthcare (45 plans).[8] This part of the report will highlight enrollment, spending, risk, utilization, and the drivers of spending in the small group market.

Please note that the small group and individual market data in this report are limited to fully insured Maryland residents who are under age 65. Data for insureds covered by Kaiser Permanente are included in enrollment at the end of the year and in risk score analyses but are not included in other data segments of this report.

Enrollment, PMPM Spending, Risk, and Utilization in Maryland's Small Employer Market: 2015 – 2017

This section provides information on enrollment in the small employer health insurance market in Maryland, as well as data on spending, utilization, and risk (as measured through member health status). This information is essential in understanding trends over time in health care spending, consumer OOP costs, and insurance participation.

Exhibit 12 illustrates the following:

- Total members (including Kaiser HMO members) in the small employer market remained stable between 2016 and 2017.
- PMPM spending for all services combined increased by 6% between 2016 and 2017; in contrast, PMPM spending was flat between 2015 and 2016.

6 https://www.commonwealthfund.org/blog/2016/state-run-shops-update-three-years-post-aca-implementation?redirect_source=/publications/blog/2016/jul/state-run-shops

7 http://www.ncsl.org/research/health/small-business-health-insurance.aspx

8 2017 Annual Report of the Maryland Health Benefit Exchange

- Main contributors to this increase in PMPM spending growth in the small employer market include:
  - » Inpatient hospital facility services PMPM spending increased by about 11%.
  - » Outpatient hospital facility services increased by 5%.
  - » Outpatient non-hospital facility services showed no increase in PMPM spending.
  - » Professional services increased by 9%.
  - » Prescription drugs increased by 5%.
- The median expenditure risk scores (excluding Kaiser) increased at a faster rate in 2017 than in 2016. Risk scores increased from 0.21 to 0.25 between 2016 and 2017, compared with a small increase of 0.01 from 0.20 to 0.21 between 2015 and 2016.

EXHIBIT 12. Enrollment, Spending, and Risk Scores in the Small Employer Market

	2015	2016	2017	% Change 2015 to 2016	% Change 2016 to 2017
MEMBERS AS OF DECEMBER 31					
Total members (w/o Kaiser)	230,672	226,475	223,832	-2%	-1%
Total members (w/ Kaiser)	238,197	233,955	233,071	-2%	0%
MEMBER MONTHS					
Total member months	2,650,732	2,740,817	2,579,021	3%	-6%
SPENDING					
PMPM spending, all services combined	$372	$371	$393	0%	6%
PMPM OOP, all services combined	$90	$84	$89	-7%	6%
PMPM OOP, Medical Only	$70	$65	$70	-7%	8%
PMPM OOP, Prescription Drugs	$21	$19	$19	-10%	0%
PMPM SPENDING BY SERVICE CATEGORY					
Inpatient Hospital Facility	$59	$57	$63	-3%	11%
Outpatient Hospital Facility	$66	$65	$68	-2%	5%
Outpatient Non-Hospital Facility	$8	$9	$9	13%	0%
Professional Services	$109	$108	$118	-1%	9%
Labs/Imaging	$33	$31	$29	-6%	-6%
SubTotal (Medical Only)	**$275**	**$270**	**$287**	**-2%**	**6%**
Prescription Drugs[1]	$97	$101	$106	4%	5%
RISK SCORE				**DIFFERENCE (2015 TO 2016)**	**DIFFERENCE (2016 TO 2017)**
Median expenditure risk score (w/o Kaiser)	0.20	0.21	0.25	0.01	0.04
Median expenditure risk score (w/ Kaiser)	0.18	0.20	0.20	0.01	0.01

(1) Individuals can have multiple types of coverage during the year but are counted only once in the total enrollment.

Notes:
- PMPM portion of spending for insurers is overall PMPM (all services combined) less PMPM OOP (all services combined).
- Some calculations in the above exhibit might not be exact due to rounding.

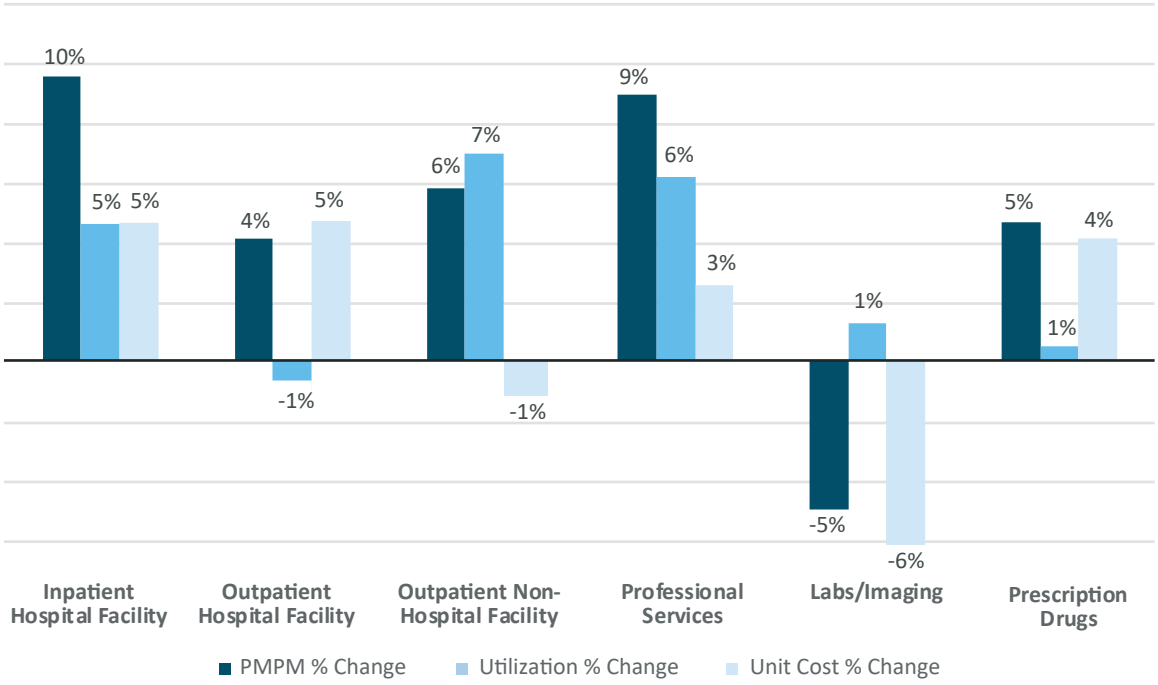
Drivers of PMPM Spending Growth in the Small Employer Market: 2015 – 2017

Increases in unit costs primarily drove PMPM spending growth in 2017—as opposed to utilization increases—for all service categories except outpatient non-hospital facility services, for which spending growth was due to utilization increases.

Exhibit 13 illustrates the following:

- Inpatient hospital facility spending grew by 10% in 2017, with both unit cost and utilization increasing by 5%.
- Outpatient hospital facility spending grew by 4%, driven by a 5% growth in unit cost offset by a 1% decline in utilization.
- Outpatient non-hospital facility spending grew by 6%, with a 7% increase in utilization offset by a 1% decline in unit cost.
- The utilization of professional services increased by 9% in 2017, driven by increases in utilization at 6% and unit cost at 3%.
- PMPM spending for labs/imaging fell by 5%, primarily driven by a 6% drop in unit cost, slightly offset by a 1% growth in utilization.
- The 5% growth in prescription drug spending was driven by a 4% increase in unit cost, supplemented by a 1% increase in utilization.

EXHIBIT 13. Annual Percentage Changes in PMPM Spending, Utilization per 1,000 Members, and Cost per Unit by Service Category in the Small Employer Market, 2016 – 2017



PART 3:
The Privately Insured, Individual Market in Maryland

Part 3 of this report focuses exclusively on the individual health insurance market. This market expanded as a result of reforms under the ACA but has faced instability due to rising premiums, declining insurer participation, and changing federal policy over the past few years. This market was most adversely affected by the health insurance reforms under the ACA.

The MCDB allows comparisons across the entire individual market, including ACA-compliant plans sold on and off the exchange and ACA non-compliant plans. ACA-compliant plans are plans that meet the requirements for minimum essential coverage under the ACA. ACA non-compliant plans do not meet these requirements and, until 2019, individuals in non-compliant plans could be subject to the ACA tax penalties for not maintaining mandatory health insurance coverage. The level of benefits provided to consumers varies between ACA-compliant and non-compliant plans. Also, premium subsidies are available to lower-income consumers enrolled in on-exchange ACA compliant plans; however, premium subsidies are not available under other plan types. In this time of relative market instability in the individual market, it is helpful to be able to track relative changes between these different plan types.

Individual market data in this report are limited to fully insured Maryland residents who are under age 65. Data for individuals covered by Kaiser Permanente are included in enrollment at the end of the year and in risk score analyses but are not included in other data segments of this report.

Enrollment, Spending, Risk, and Utilization in Maryland's Individual Market: 2015 – 2017

This section provides information on enrollment in the individual health insurance market in Maryland, as well as data on spending, utilization, and risk (as measured through member health status). This information is essential in understanding trends over time in health care spending, consumer OOP costs, and insurance participation. This section also provides information on variation in spending across different service types. Finally, this section includes data for both ACA-compliant and non-compliant plans.[9]

Exhibit 14 illustrates the following:

- Total Members (including Kaiser HMO members) in the individual market decreased by about 9% as of December 31, 2017. However, members without Kaiser show a 17% decline at the end of 2017 compared to a 7% decrease at the end of 2016. These results imply that Kaiser's market share in the individual market is increasing rapidly compared to other carriers in Maryland.
- PMPM spending for all services combined increased by about 16% in 2017, higher than the 11% increase from 2015 to 2016.
- Main contributors to this increase in spending growth in the individual market include:
  - Inpatient hospital facility services spending increased by 14% in 2017 v. 4% in 2016.
  - Professional services spending increased by 18% in 2017 v. 10% in 2016.
  - Outpatient non-hospital facility services spending increased by 30% in 2017 v. a 9% decline in 2016.

[9] See Appendix B for a description of ACA-compliant and non-compliant plans.

» Prescription drug spending increased by 33% in 2017 v. 17% in 2016. The following is a breakdown of the 33% increase in prescription drug spending for 2017:

- Brand name prescription drug PMPM spending increased by 34% in 2017, compared to about a 17% increase in 2016. Generic drugs had significantly less of an increase in PMPM spending, of about 17% in 2017 compared to brand-name drugs. Also, this increase in generic drug spending slowed in 2017 compared to 2016, which had a 21% increase. (See Exhibit A5).
- Brand name drug PMPM spending increase was primarily driven by a rise in unit costs of about 23.5% in 2017, compared to a 17.6% increase in 2016. Generic drugs showed lesser increases in unit costs of 4.3% and 4.5% in 2017 and 2016, respectively. The overall (brand and generic combined) increase in unit costs was 17.3% and 6.5% in 2017 and 2016, respectively. (See Exhibit A13).
- An overall increase in prescription drug utilization of about 14% in 2017 was driven by both generic (12%) and brand (9%) increases. (See Exhibit A9).

▪ The median expenditure risk scores (excluding Kaiser) grew at a slightly faster rate in 2017 than in 2016. Risk scores increased from 0.27 to 0.35 between 2016 and 2017 compared with increases from 0.20 to 0.27 between 2015 and 2016.

EXHIBIT 14. Enrollment, Spending, and Risk Scores in the Individual Market (ACA-Compliant and Non-Compliant Plans)

	2015	2016	2017	% Change 2015 to 2016	% Change 2016 to 2017
MEMBERS AS OF DECEMBER 31					
Total members (w/o Kaiser)	249,277	232,586	193,935	-7%	-17%
Total members (w/ Kaiser)	271,929	270,005	245, 233	-1%	-9%
MEMBER MONTHS					
Total member months	3,043,020	2,913,423	2,364,973	-4%	-19%
SPENDING					
PMPM spending, all services combined	$418	$463	$537	11%	16%
PMPM OOP, all services combined	$106	$117	$117	10%	0%
PMPM OOP, Medical Only	$88	$100	$99	14%	-1%
PMPM OOP, Prescription Drugs	$18	$17	$19	-6%	12%
PMPM SPENDING BY SERVICE CATEGORY					
Inpatient Hospital Facility	$71	$74	$84	4%	14%
Outpatient Hospital Facility	$85	$102	$104	20%	2%
Outpatient Non-Hospital Facility	$11	$10	$13	-9%	30%
Professional Services	$113	$124	$146	10%	18%
Labs/Imaging	$39	$37	$36	-5%	-3%
SubTotal (Medical Only)	**$319**	**$347**	**$383**	**9%**	**10%**
Prescription Drugs[1]	$99	$116	$154	17%	33%
RISK SCORE				**DIFFERENCE (2015 TO 2016)**	**DIFFERENCE (2016 TO 2017)**
Median expenditure risk score (w/o Kaiser)	0.20	0.27	0.35	0.07	0.08
Median expenditure risk score (w/ Kaiser)	0.18	0.24	0.25	0.06	0.01

(1) Individuals can have multiple types of coverage during the year but are counted only once in the total enrollment.

Notes:
- PMPM portion of spending for insurers is overall PMPM (all services combined) less PMPM OOP (all services combined).
- Some calculations in the above exhibit might not be exact due to rounding.

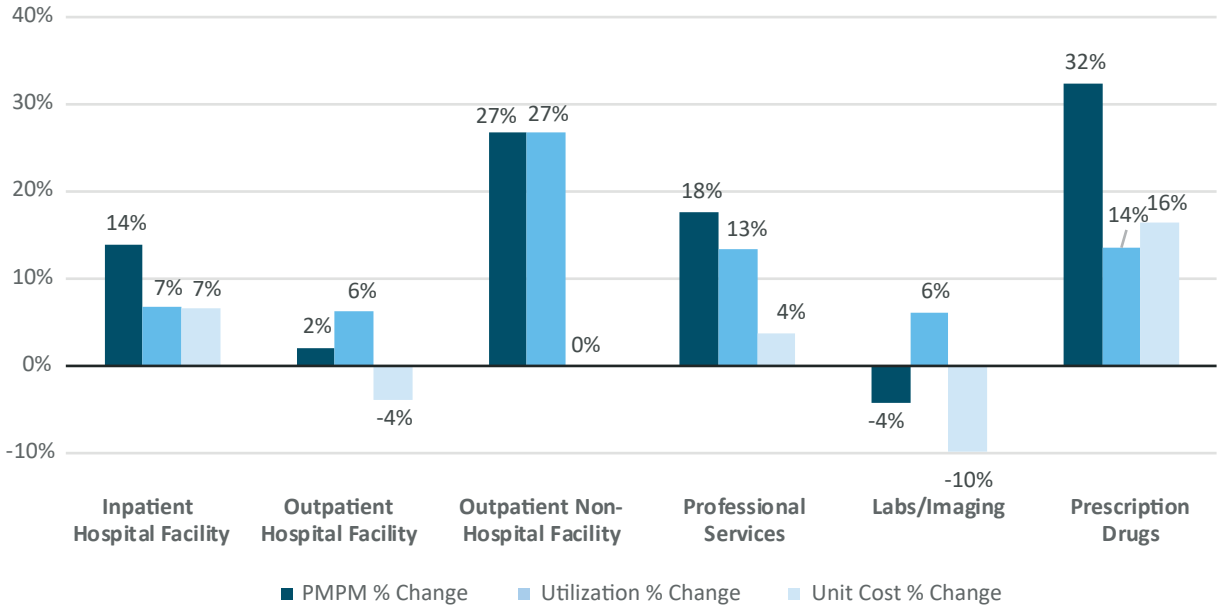
Drivers of Spending Growth in the Individual Market: 2015 – 2017

Exhibit 15 illustrates the following:

PMPM spending growth in 2017 was primarily driven by increases in utilization—as opposed to unit cost increases—for all service categories except prescription drugs, for which spending growth was due to unit cost increases.

- PMPM spending on inpatient hospital facility services rose by 14%, driven by increases of about 7% in both unit cost and utilization.
- PMPM spending on outpatient hospital facility services increased by 2%, driven mainly by a 6% increase in utilization that was dampened by a 4% decrease in unit costs.
- Outpatient non-hospital facility services experienced a 27% increase in PMPM spending, driven entirely by the rise in utilization.
- PMPM spending for professional services grew by 18%, driven by a 13% increase in utilization and a 4% increase in unit cost.
- Similar to the small employer market, PMPM spending for labs/imaging fell by 4%, primarily driven by a 10% drop in unit cost, offset by a 6% growth in utilization.
- The 32% growth in prescription drug spending was driven by a 14% increase in utilization, supplemented by a 16% increase in unit cost.

EXHIBIT 15. Annual Percentage Changes in PMPM Spending, Utilization per 1,000 Members, and Cost per Unit by Service Category in the Individual Market (ACA-Compliant and Non-Compliant Plans), 2016 – 2017



Notes:
- Results exclude Kaiser HMO plans.
- See Exhibit 3 for unit cost by Market and Service Category (2015 – 2017).
- See Appendix A, Exhibits A1 and A2 for utilization counts per 1,000 members by Market and Service Category (2015 – 2017).

ACA-Compliant Health Plan Enrollment, Spending, Risk, and Utilization: 2015 – 2017 (On-Exchange and Off-Exchange Plans)

This section provides information on enrollment in ACA-compliant plans in the individual health insurance market in Maryland, as well as data on spending, utilization, and risk (as measured through member health status). This information is essential in understanding trends over time in health care spending, consumer OOP costs, and insurance participation within the ACA-regulated market, which has undergone tremendous change since it was established in January 2014. This section also provides information on variation in spending across different service types. This section includes data for ACA-compliant plans offered through the Maryland Health Benefit Exchange, which provides access to federal premium subsidies for low-income members, as well as data on ACA-compliant plans offered off the exchange.

Exhibit 16 illustrates the following:

- At the end of 2017, total members (insureds including Kaiser HMO members) enrolled on the exchange decreased by about 3% compared to a 8% increase at the end of 2016, indicating that member growth on the exchange slowed considerably in 2017. Off-exchange plan enrollment with Kaiser HMO members included declined by about 14% at the end of 2017 compared to no change in 2016. Please note that all PMPM spending (on and off the exchanges) excludes Kaiser HMO members.
- PMPM spending for all services combined for on-exchange members grew by about 25% (up from 6% in 2016), while PMPM spending for off-exchange members increased by about 9% in 2017 (remaining at the same level of increase in 2016). The 25% on-exchange increase in PMPM spending was driven by significant increases in PMPM spending for the following services categories:
  - Inpatient hospital facility on-exchange PMPM spending increased by 25% from 2016 to 2017. This increase was mainly driven by a 19% increase in utilization. Unit costs contributed about 6% to the 25% increase. See Exhibit A17.
  - Outpatient hospital facility on-exchange spending showed an 18% increase, which was primarily driven by a 17% increase in utilization. See Exhibit A17.
  - A 48% increase in on-exchange PMPM spending was observed for outpatient non-hospital facility services. This increase in spending was mainly driven by about a 39% increase in utilization. Unit costs showed about a 6% increase. See Exhibit A17.
  - Professional services experienced a 26% increase in on-exchange PMPM spending, which was primarily caused by a 23% increase in utilization. Unit costs showed about a 3% increase. See Exhibit A17.
  - Finally, prescription drugs had about a 33% increase in on-exchange spending and was driven equally by a 15.4% increase in both utilization and unit costs. See Exhibit A17.
- Out-of-pocket PMPM spending for off-exchange members decreased by about 4% in 2017, while OOP spending for on-exchange members increased by about 8%. This result was expected since on-exchange members have access to federal cost-sharing subsidies, while off-exchange members do not have access to such subsidies.
- PMPM spending growth for outpatient non-hospital facility services was significantly higher for on-exchange members (48%) than for off-exchange members (10%).
- Prescription drug spending growth was slightly higher among on-exchange members (33%) than off-exchange members (31%).
- Median expenditure risk score (excluding Kaiser) increased at a faster rate in 2017 for on-exchange members compared to those enrolled in off-exchange plans.

EXHIBIT 16. On-Exchange v. Off-Exchange Enrollment, Spending, and Risk Scores for ACA-Compliant Insurance in the Individual Market

	2015		2016		2017		% Change (2015 to 2016)		% Change (2016 to 2017)	
	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange	On-Exchange	Off-Exchange
MEMBERS AS OF DECEMBER 31										
Total members (w/o Kaiser)	95,602	114,610	95,388	107,500	78,272	90,141	0%	-6%	-18%	-16%
Total members (w/ Kaiser)	111,756	119,925	121,042	118,433	117,566	101,493	8%	-1%	-3%	-14%
Distribution (w/o Kaiser)	45%	55%	47%	53%	46%	54%	n/a	n/a	n/a	n/a
Distribution (w/ Kaiser)	49%	51%	51%	49%	54%	46%	n/a	n/a	n/a	n/a
MEMBER MONTHS										
Total member months Distribution	1,137,658 45%	1,398,991 55%	1,185,120 47%	1,357,957 53%	981,055 48%	1,063,730 52%	4%	-3%	-17%	-22%
SPENDING										
PMPM spending, all services combined	$449	$433	$478	$473	$597	$514	7%	9%	25%	9%
PMPM OOP, all services combined	$92	$122	$89	$144	$96	$138	-3%	18%	8%	-4%
PMPM OOP, Medical Only	$75	$103	$74	$126	$79	$118	-1%	22%	7%	-6%
PMPM OOP, Prescription Drugs	$17	$19	$15	$17	$17	$20	-12%	-11%	13%	18%
PMPM SPENDING BY SERVICE CATEGORY										
Inpatient Hospital Facility	$80	$73	$83	$73	$104	$76	4%	0%	25%	4%
Outpatient Hospital Facility	$84	$96	$88	$124	$104	$115	5%	29%	18%	-7%
Outpatient Non-Hospital Facility	$11	$11	$10	$10	$15	$11	-6%	-9%	48%	10%
Professional Services	$117	$117	$125	$124	$158	$138	7%	6%	26%	11%
Labs/Imaging	$41	$40	$39	$36	$39	$34	-5%	-10%	0%	-6%
SubTotal (Medical Only)	**$333**	**$337**	**$345**	**$367**	**$420**	**$374**	**4%**	**9%**	**22%**	**2%**
Prescription Drugs	$116	$96	$133	$106	$177	$139	15%	10%	33%	31%
RISK SCORE[3]							**DIFFERENCE (2015 TO 2016)**		**DIFFERENCE (2016 TO 2017)**	
Median expenditure risk score (w/o Kaiser)	0.30	0.21	0.35	0.24	0.47	0.26	0.06	0.03	0.12	0.02
Median expenditure risk score (w/ Kaiser)	0.15	0.17	0.20	0.19	0.26	0.22	0.05	0.02	0.07	0.03

(1) Kaiser HMO plan data are excluded from this report except for membership at the end of the year and median expenditure risk scores.

Notes:

- PMPM spending portion for insurers is calculated as PMPM spending for all services combined less PMPM OOP for all services combined.
- Some calculations in the above exhibit might not be exact due to rounding.

Appendix A: Additional Exhibits

EXHIBIT A1. Annual Utilization of Inpatient and Outpatient Facilities by Market, 2017

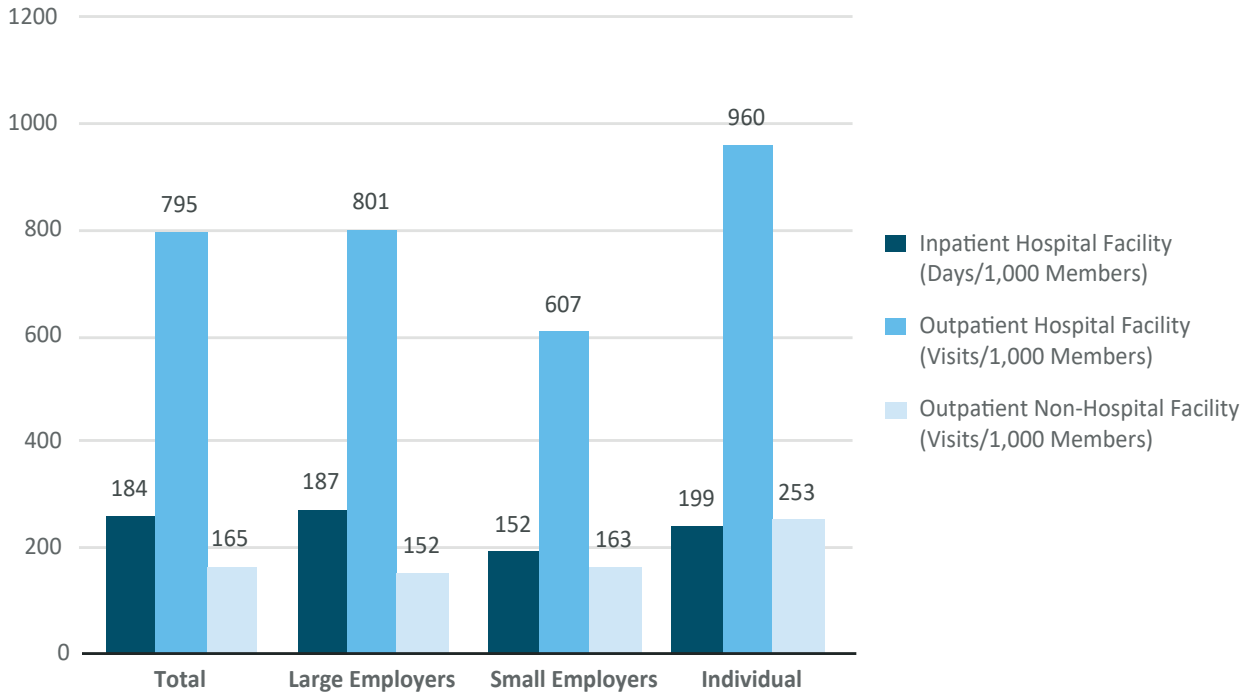


EXHIBIT A2. Annual Utilization of Professional Services, Labs/Imaging, and Prescription Drugs by Market, 2017

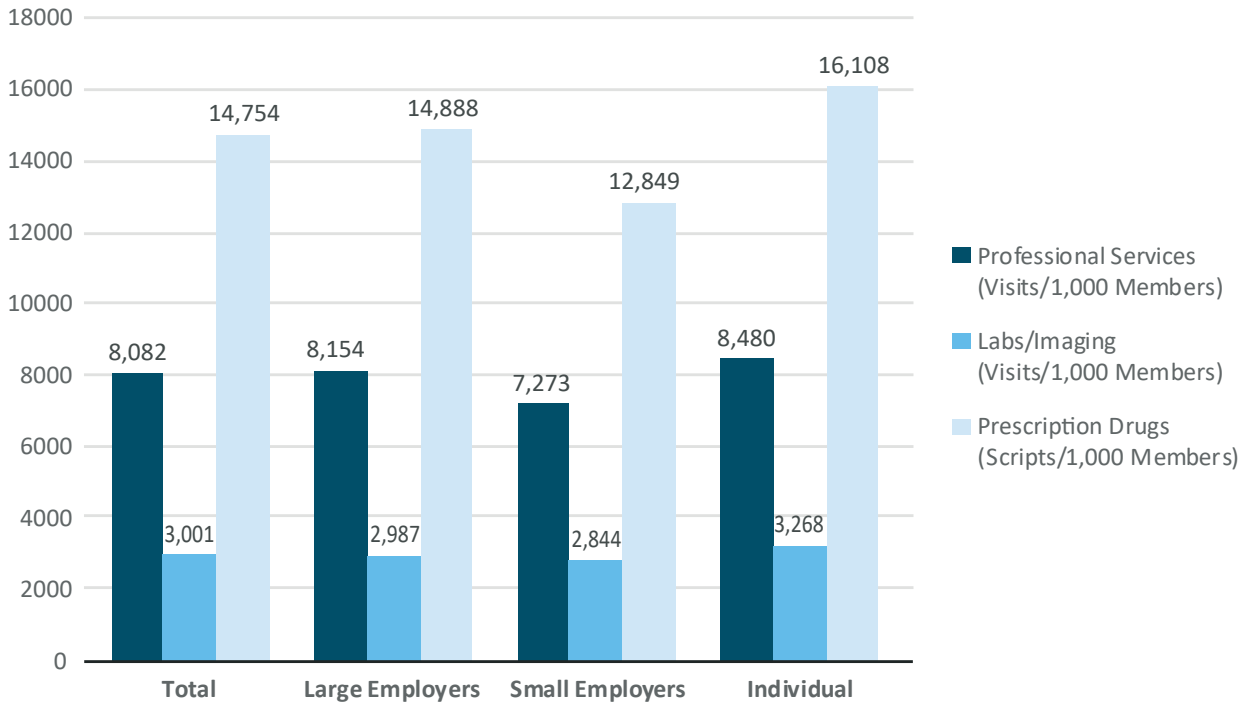


EXHIBIT A3. Hospital Inpatient and Outpatient Utilization, Small Employer Market, 2015 – 2017

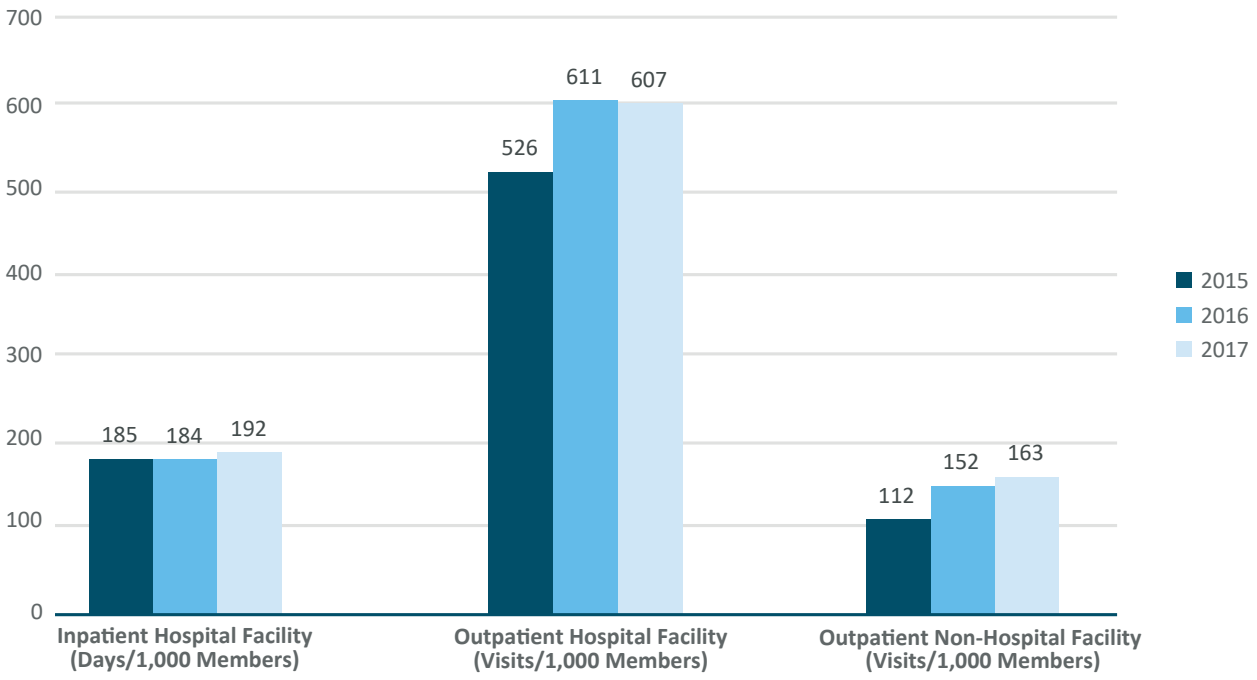


EXHIBIT A4. Utilization of Professional Services, Labs/Imaging, Prescription Drugs, Small Employer Market, 2015 – 2017

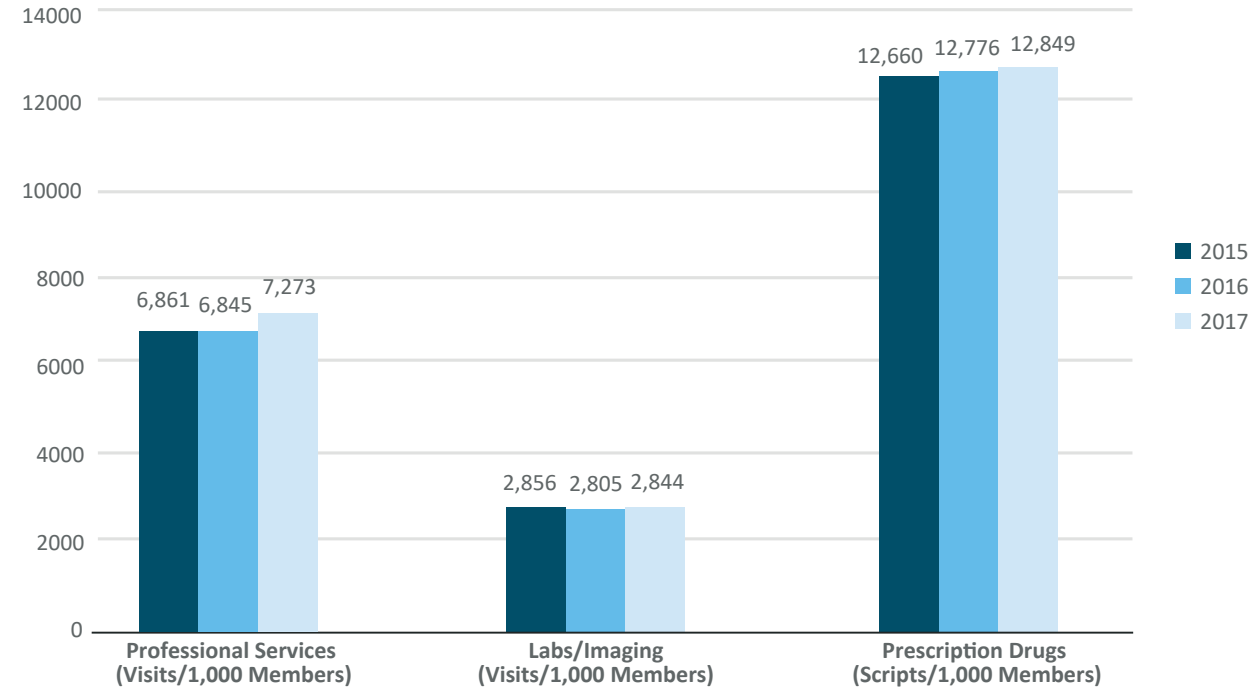


EXHIBIT A5. Prescription Drug PMPM Changes by Drug Type, Individual Market, 2015 – 2017

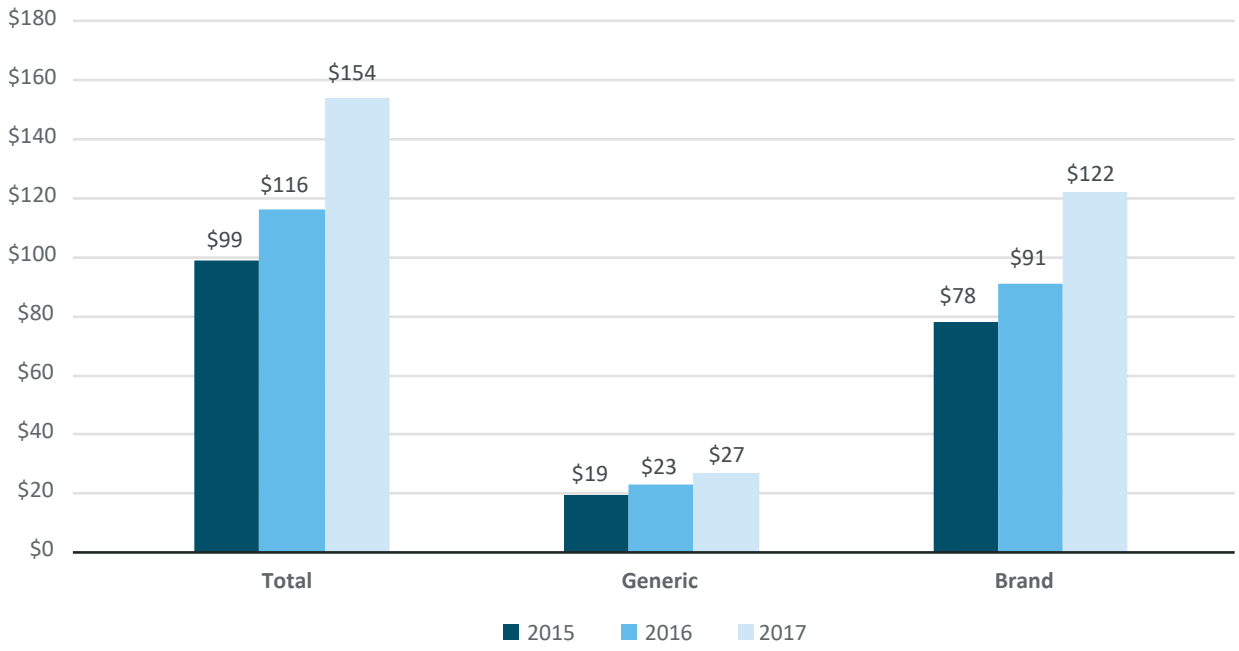


EXHIBIT A6. Prescription Drug PMPM Changes by Drug Type, Small Employer Market, 2015 – 2017

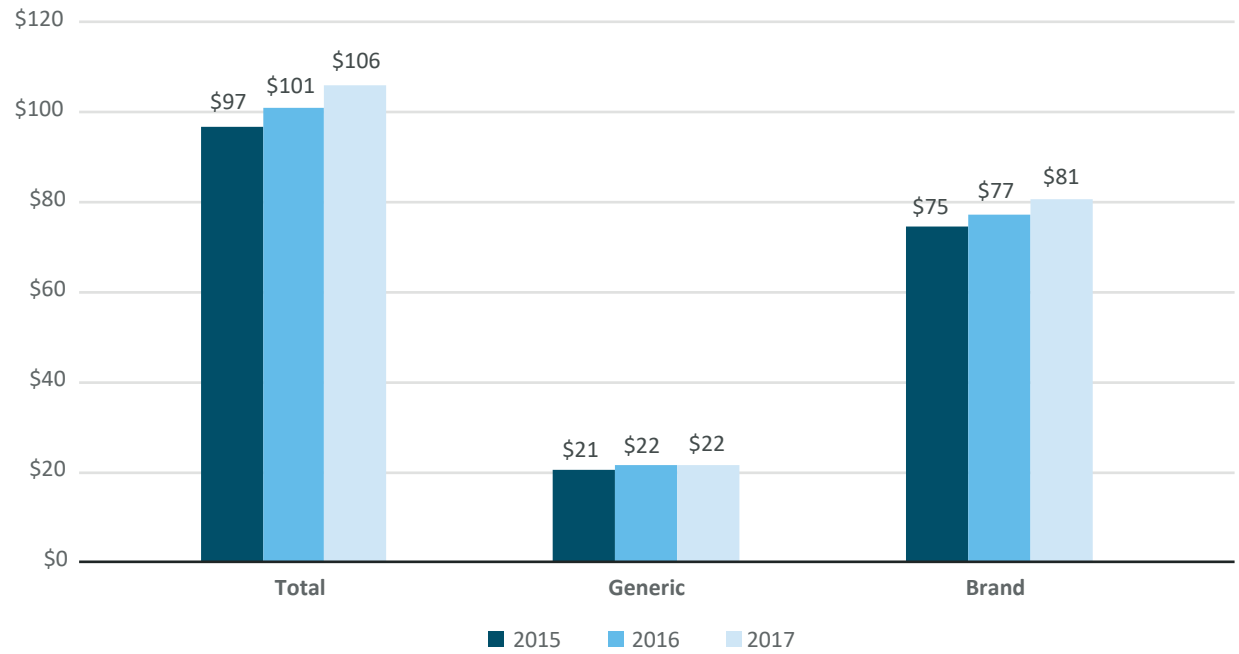


EXHIBIT A7. Prescription Drug PMPM Changes by Drug Type, Large Employer Market, 2015 – 2017

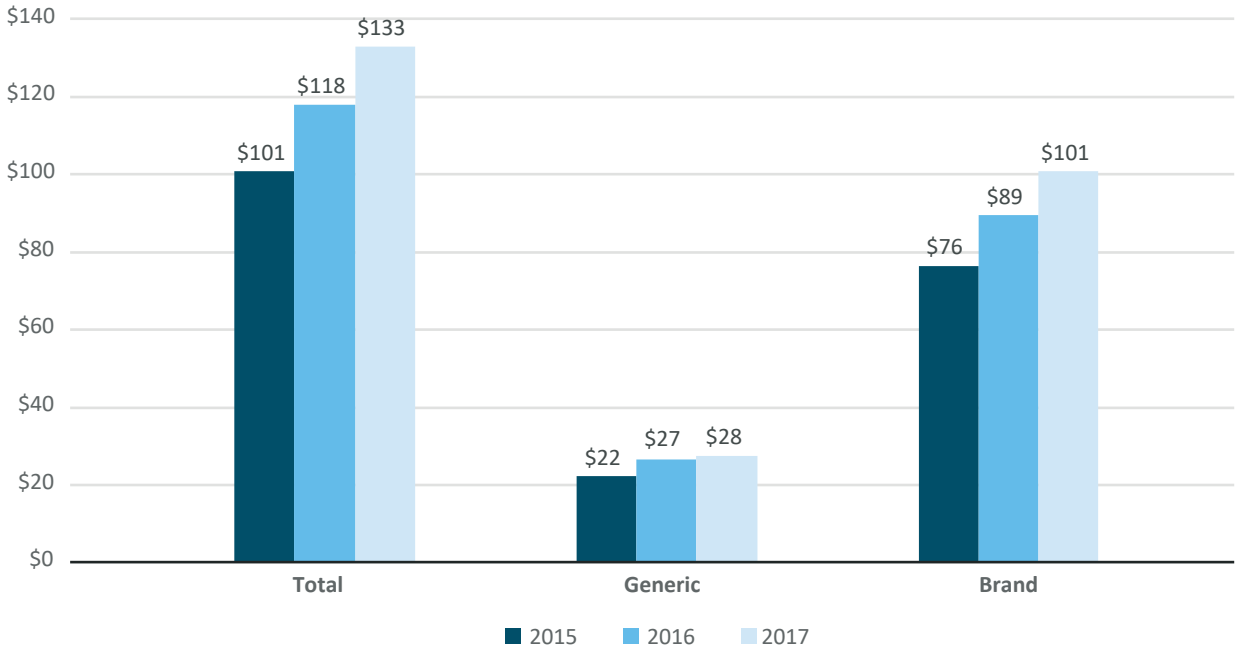


EXHIBIT A8. Prescription Drug PMPM Changes by Drug Type, All Markets Combined, 2015 – 2017

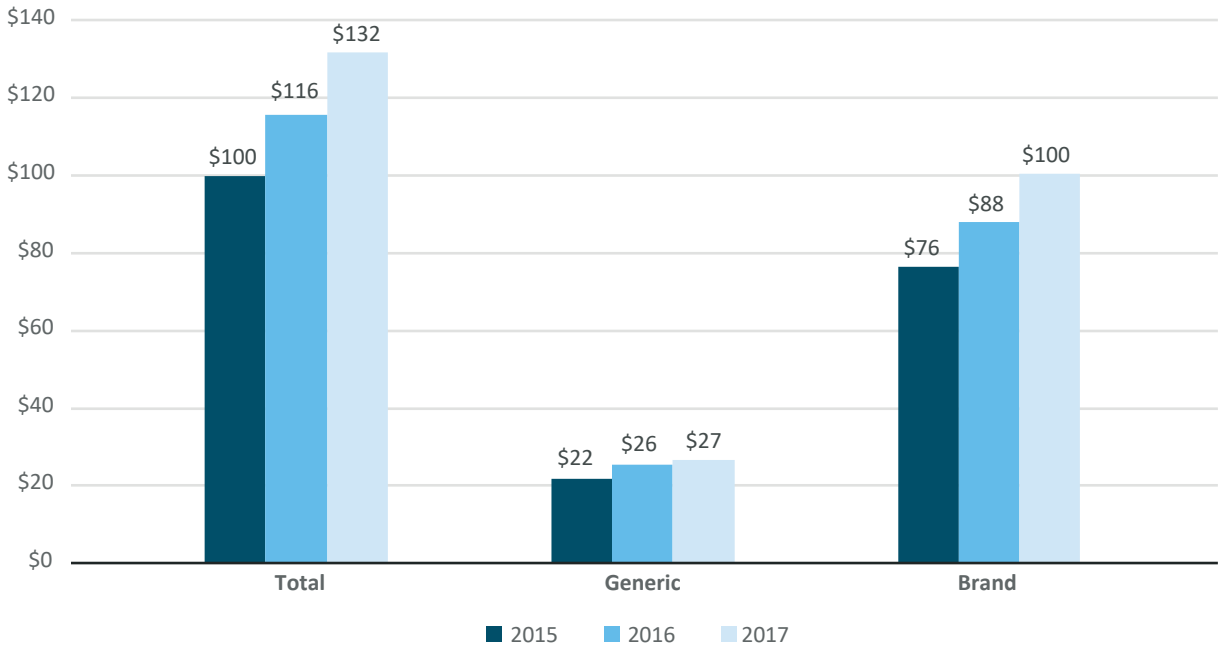


EXHIBIT A9. Prescription Drug Utilization Changes by Drug Type, Individual Market, 2015 – 2017

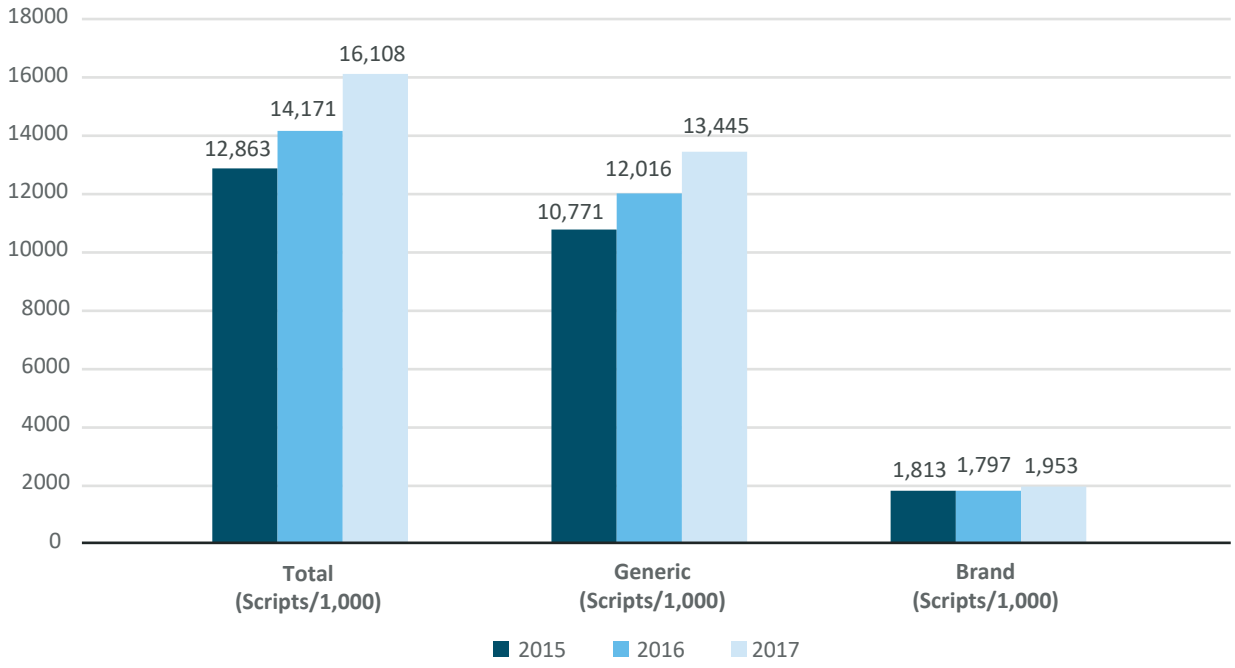


EXHIBIT A10. Prescription Drug Utilization Changes by Drug Type, Small Employer Market, 2015 – 2017

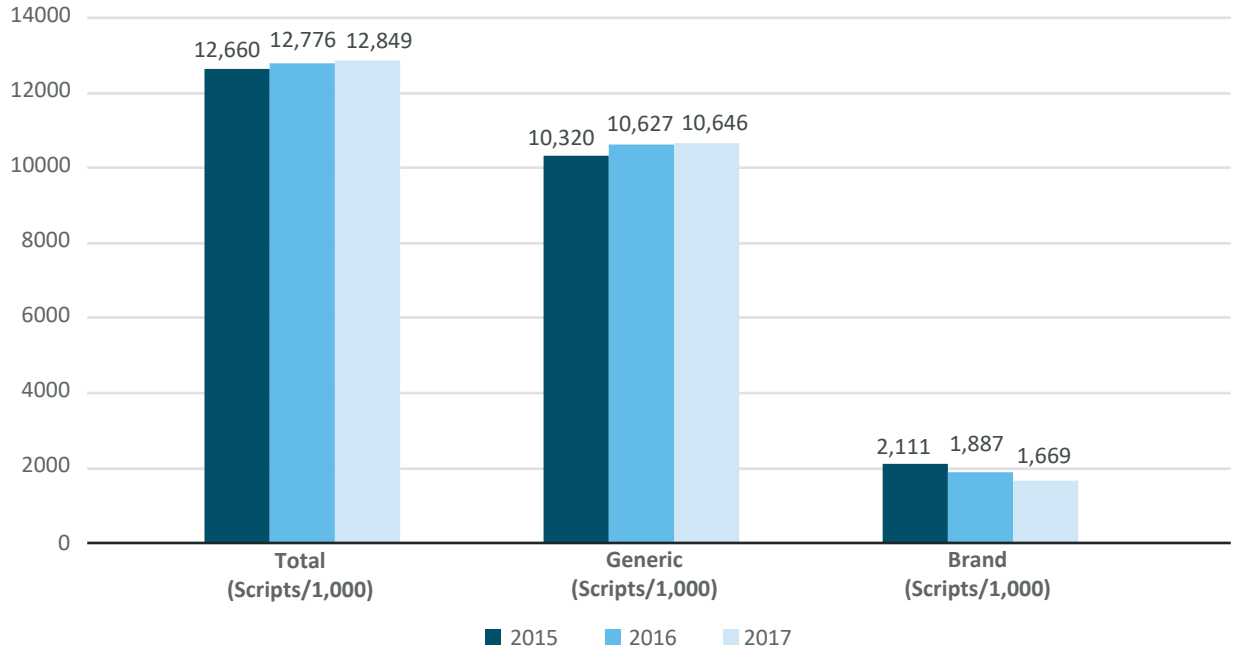


EXHIBIT A11. Prescription Drug Utilization Changes by Drug Type, Large Employer Market, 2015 – 2017

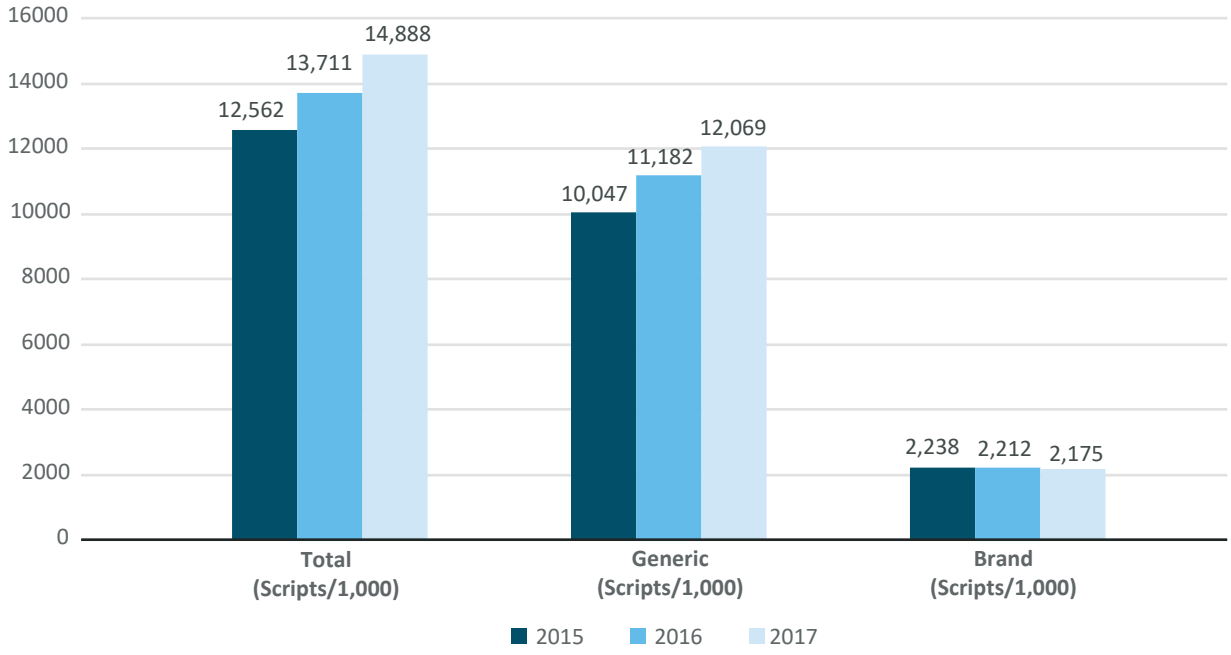


EXHIBIT A12. Prescription Drug Utilization Changes by Drug Type, All Markets Combined, 2015 – 2017

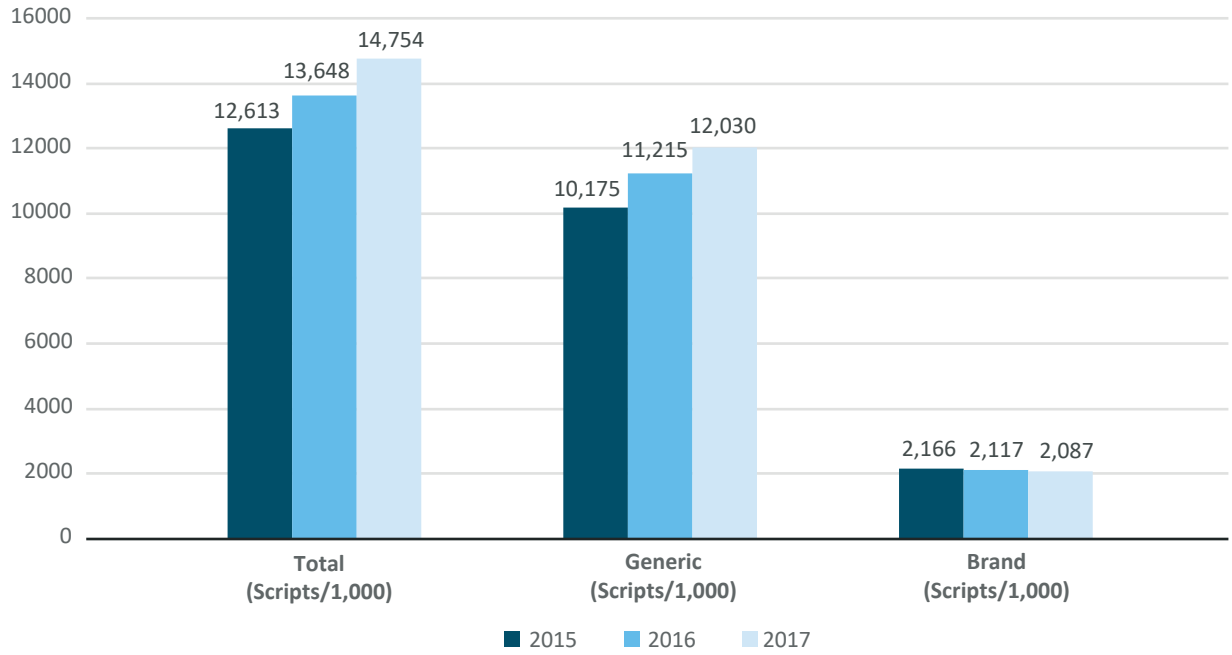


EXHIBIT A13. Prescription Drug Unit Cost Changes by Drug Type, Individual Market, 2015 – 2017

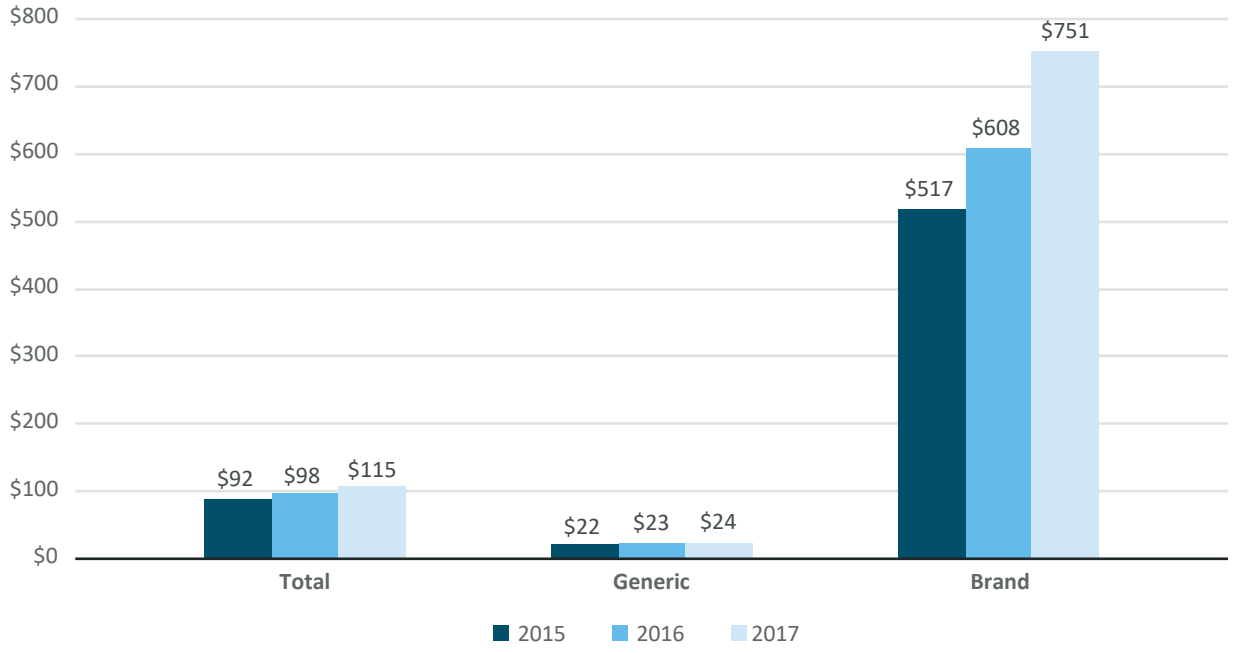


EXHIBIT A14. Prescription Drug Unit Cost Changes by Drug Type, Small Employer Market, 2015 – 2017

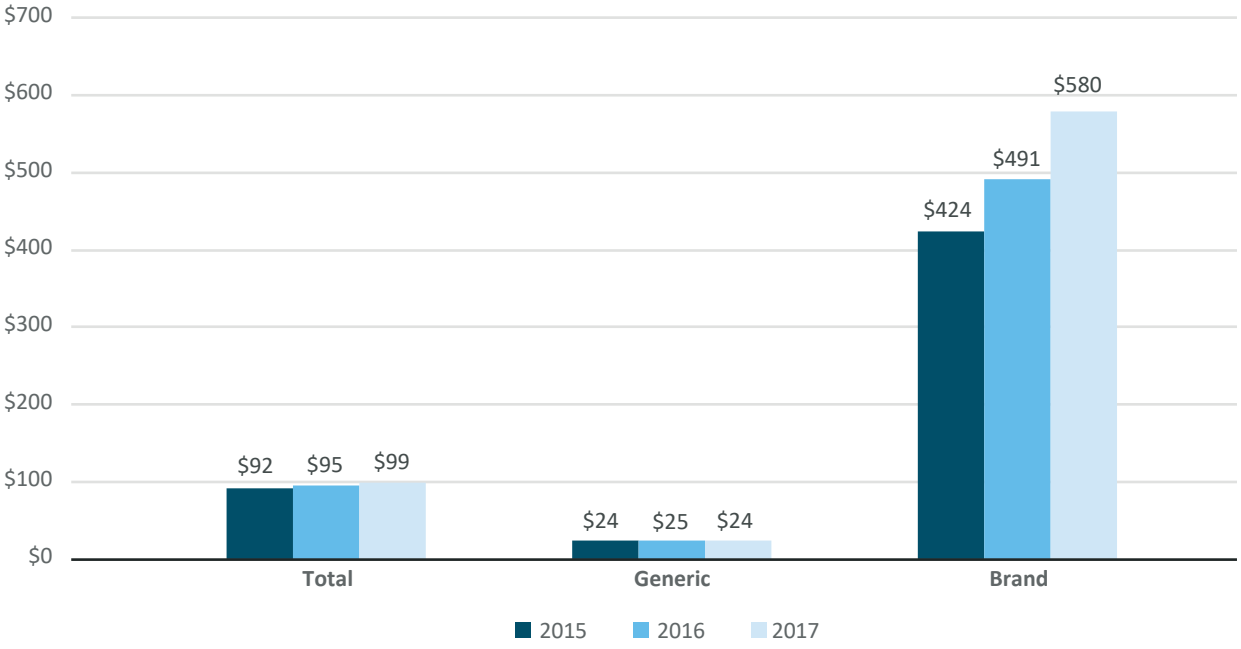


EXHIBIT A15. Prescription Drug Unit Cost Changes by Drug Type, Large Employer Market, 2015 – 2017

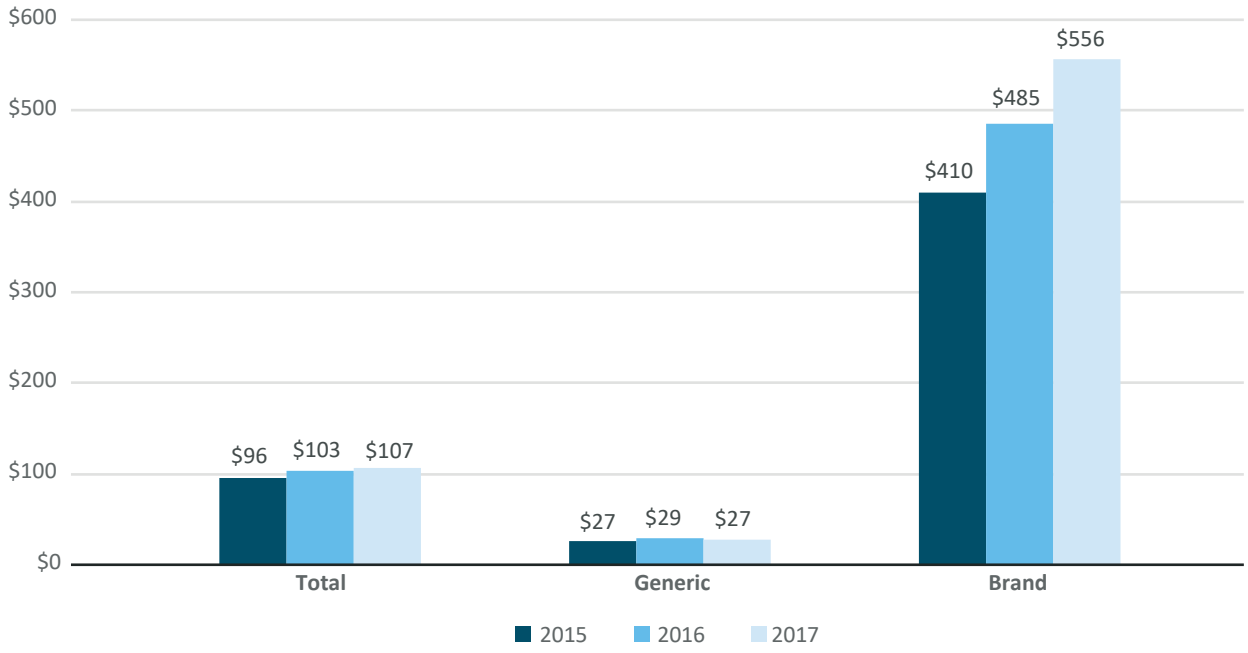


EXHIBIT A16. Prescription Drug Unit Cost Changes by Drug Type, All Markets Combined, 2015 – 2017

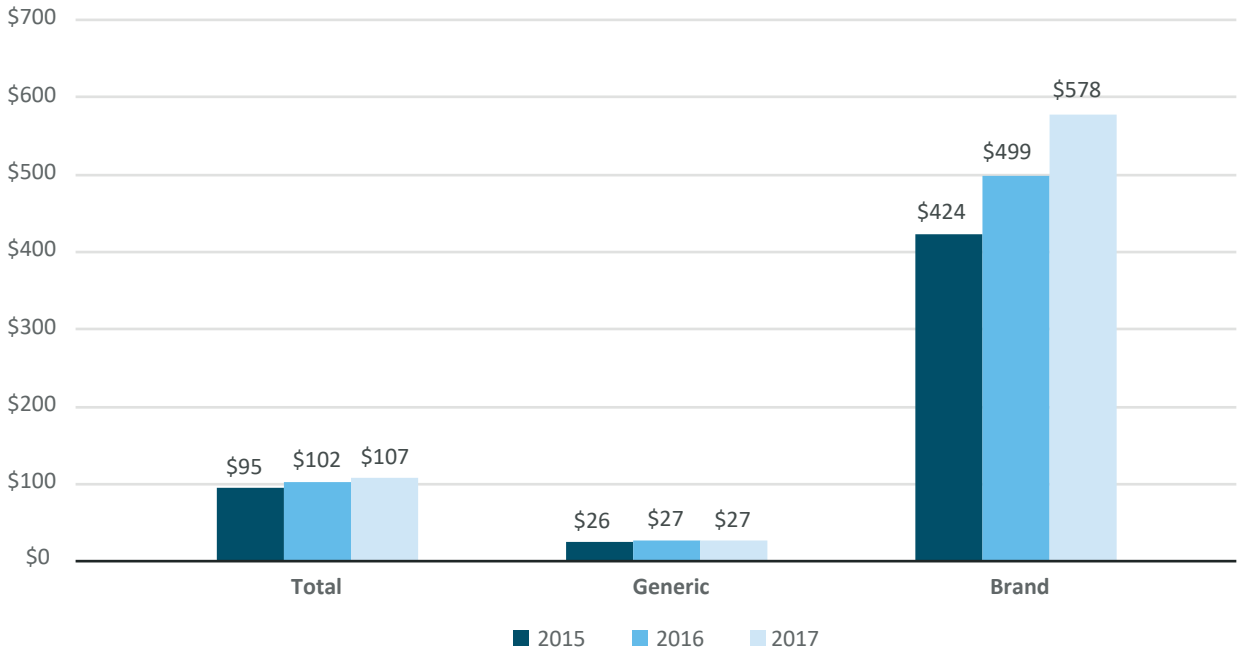


EXHIBIT A17. Individual Market ACA-Compliant PMPM Changes, Utilization, and Unit Cost Changes, 2017 v. 2016

	On-Exchange						Off-Exchange					
	2016 12 Months Ending Trends			2017 12 Months Ending Trends			2016 12 Months Ending Trends			2017 12 Months Ending Trends		
	PMPM	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Utilization	Unit Cost
SERVICE CATEGORY												
Inpatient Hospital Facility	4.1%	6.8%	-2.5%	25.8%	19.0%	5.7%	-0.8%	1.3%	-2.1%	4.2%	-0.8%	5.0%
Outpatient Hospital Facility	3.9%	27.9%	-18.7%	18.4%	17.1%	1.1%	29.5%	67.4%	-22.6%	-7.6%	1.4%	-8.9%
Outpatient Non-Hospital Facility	-5.9%	40.1%	-32.8%	48.1%	39.4%	6.3%	-8.9%	34.3%	-32.2%	14.1%	16.8%	-2.3%
Professional Services	6.9%	2.5%	4.3%	26.1%	23.0%	2.6%	6.9%	1.2%	5.7%	10.8%	6.9%	3.6%
Labs/Imaging	-3.9%	-1.0%	-2.9%	0.4%	13.1%	-2.9%	-9.2%	-2.1%	-7.2%	-5.7%	0.7%	-6.4%
Prescription Drugs	14.1%	6.8%	6.9%	33.1%	15.4%	15.4%	11.1%	4.8%	6.0%	31.1%	10.7%	18.4%

Appendix B: Definitions and Methods

Data Sources

The figures and tables in this report are based on 2015, 2016, and 2017 data analyses from Maryland's Medical Care Data Base (MCDB). It includes all members, regardless of whether an individual used any health care services. The data are for privately fully insured Maryland residents (i.e., only those individuals who live in Maryland).

Markets

Large Employer: The large employer market refers to businesses with more than 50 full-time employees. All Federal Employee Health Benefits Program (FEHBP) medical data are included in the report. However, for prescription drugs, some FEHBP spending may not be captured due to a limitation on linking patient encrypted identifiers.

Small Employer: The small employer market refers to businesses with between two and 50 full-time employees.

Individual: The individual market refers to members who purchased a health benefit plan directly from an insurer, not through an employer.

Individual Plan Types

ACA-Compliant: This includes non-grandfathered plans only.

ACA non-Compliant: This includes grandfathered plans only.

On-Exchange: Includes ACA-compliant products sold on the Maryland Health Benefit Exchange.

Off-Exchange: Includes ACA non-compliant products sold off the Maryland Health Benefit Exchange.

Service Category Descriptions

Inpatient Hospital Facility: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and any other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital Facility: Includes non-capitated facility services for surgical, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility.

Outpatient Non-Hospital Facility: Primarily includes services provided at ambulatory surgery centers, critical access hospitals, clinics, and home health outpatient centers.

Professional Services: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services other than hospital-based professionals whose payments are included in facility fees. This service category also includes "Other

Medical" such as non-capitated ambulance, home health care, durable medical equipment (DME), prosthetics, supplies, and other services (excluding vision exams and dental services not collected in the MCDB). Please note that Labs/Imaging (radiology) is reported separately for this report.

Measures

Expenditure Risk Score is based on the Johns Hopkins ACG® Software System, a risk stratification system that assesses the risk of current utilization based on diagnoses reported in current claims. In straightforward terms, a patient file (identifying an eligible individual) is merged with diagnoses and pharmacy codes to produce a series of risk factors and risk scores.

Per Member Per Month (PMPM) spending is calculated as the total aggregate spending during the calendar year [with 3 months of claims run-out] divided by the total months of coverage for all members during the calendar year. PMPM spending for medical and prescription drugs was calculated separately because not all members had drug coverage. Please note that all claims incurred in 2016 but paid through March of 2017 excluded adjustments for outstanding claims.

Out-of-Pocket (OOP) spending is the member's cost-sharing responsibility.

Inpatient Facility (hospital and non-hospital) (Number of Discharge Days per 1,000 Members) is calculated as the Total Number of Discharge Days/Total Medical Member Months *1000*12. MHCC introduced the concept of PMPM spending in 2014 and started with admissions per 1,000 members as a measure of inpatient utilization to be consistent with what was used by insurance carriers in Actuarial Memoranda sent to the Maryland Insurance Administration (MIA) via rate filings. However, for this year's report, MHCC elected to use discharge days per 1,000 members, which is more widely used in the health policy community.

Total Discharge Days are the sum of the number of days spent in the hospital for each inpatient who was discharged during the time examined (2015, 2016, 2017, respectively), regardless of when the patient was admitted (discharge basis).

Total Discharges are the number of inpatients released from the hospital during 2015, 2016, and 2017, respectively.

Outpatient Facility (Number of visits per 1,000 Members) is calculated as Total Number of Outpatient Visits/Total Medical Member Months *1000*12.

Professional Services (Number of visits per 1,000 Members) is calculated as Total Number of Visits for Professional Services/Total Medical Member Months *1000*12.

Labs/Imaging (Number of visits per 1,000 Members) is calculated as Total Visits for Labs and Imaging Services/Total Medical Members Months *1000*12.

Prescription Drugs (Number of Scripts per 1,000 Members) is calculated as Total Number of Prescription Drugs Filled/Total Prescription Drug Member Months *1000*12.

Unit Cost is the insurer's allowed amount for the claim divided by the utilization count (e.g., number of visits) for that type of service category or drug. Price trend (part of unit cost) represents the change in price per service paid to providers. It is driven by billed charge trend, provider contractual changes, technology, and cost shifting. Intensity (mix of services) of services trend, the other part of unit cost, measures the changes in types of services rendered. In other words, intensity occurs when a more expensive treatment replaces a treatment or procedure. For example, today, MRIs are frequently used instead of less costly X-rays, thereby increasing unit costs. In some cases, MRIs are being used in addition to X-rays, increasing unit costs even more.

Notes

Prescriptions have been "normalized" or adjusted so that they are counted based on a 30-day supply of medication. Therefore, each 90-day prescription is counted as three 30-day prescriptions.

Prescription drug member months are for those pharmacy members who also have medical benefits throughout the experience period (2015, 2016, and 2017, respectively).

For outpatient, professional, and labs/imaging services, all visits in each service category that occur on the same day are counted as one visit.

County Definitions for Regions per the Maryland Insurance Administration (MIA)

Baltimore Metro means Baltimore City, Baltimore County, Harford County, Howard County, and Anne Arundel County.

DC Metro means Montgomery County and Prince George's County.

Western Maryland means Garrett County, Allegany County, Washington County, Carroll County, and Frederick County.

Eastern Shore/Southern Maryland means 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.

Acknowledgments

This analysis on health care spending and use was conducted by the Center for Analysis and Information Systems staff (Kenneth Yeates-Trotman and Janet Ennis, Editor) of the Maryland Health Care Commission. The report was primarily written by Niranjana Kowlessar of Social & Scientific Systems Inc. Parts of the report were written by Kenneth Yeates-Trotman. Questions about the report should be directed to Kenneth Yeates-Trotman.

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

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