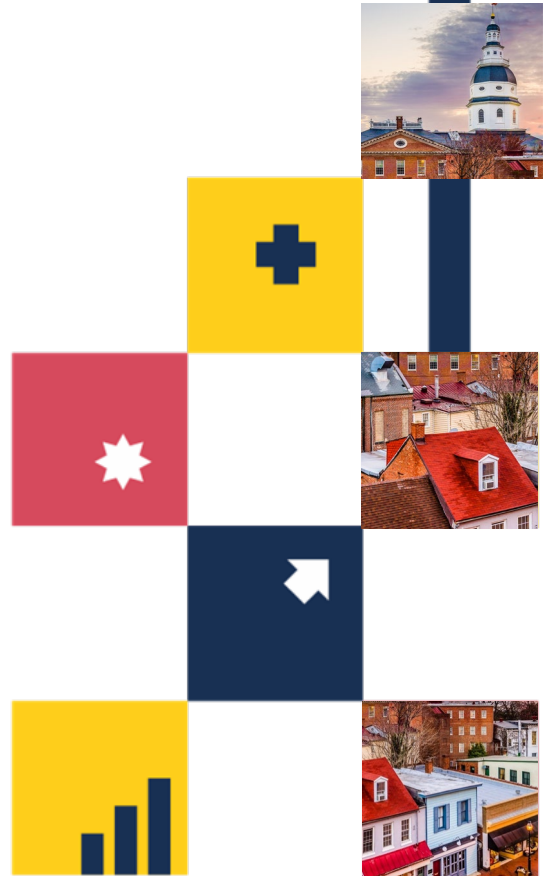


DRAFT

Spending & Use Among Maryland's Privately Insured Report

2020



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Background on the 2020 Privately Insured Report

Each year, the Center for Analysis and Information Systems (CAIS) within the Maryland Health Care Commission (MHCC) examines the Maryland privately insured population's health care spending and use and reports on enrollment trends, population risk, cost, and utilization indicators to inform policymaking.¹ This analysis used 2018, 2019, and 2020 data from Maryland's Medical Care Data Base (MCDB), which contains health insurance enrollment data and health care claims data for Maryland residents.²

Data in the MCDB are submitted quarterly to the MHCC by private health insurance carriers, third-party administrators (TPAs), and pharmacy benefit managers (PBMs). Most private health insurance carriers serving Maryland residents submit MCDB data, including Aetna, CareFirst, Cigna, Kaiser Permanente, and UnitedHealthcare. (Kaiser claims are not included in this report, although information about the Kaiser membership's risk and enrollment is included). This report contains data about Maryland residents who were under 65 years of age and enrolled in fully insured, self-insured non-ERISA (Employee Retirement Income Security Act), and self-insured ERISA (very limited as these payers report ERISA data voluntarily) health plans. Consistent with the 2019 privately insured report, spending was calculated as annual per member spending instead of per member per month (PMPM) spending.

This report excludes self-insured ERISA and Federal Employees Health Benefits (FEHB) health plans due to federal decisions – the 2016 U.S. Supreme Court's ruling in *Gobeille vs. Liberty Mutual Insurance Company* and the U.S. Office of Personnel Management (OPM) barring payers from reporting FEHB data to all-payer claims databases (APCDs) in 2019. These data exclusions accounted for about 44% (1.68 million members) of the MCDB's privately insured population. A 2020 study conducted by the Maryland Health Services Cost Review Commission (HSCRC) using the 2019 MCDB and hospital case-mix (hospital discharge) data found that for patients using hospital services, the case-mix index and age distributions were similar for the subset of patients found in the MCDB relative to the total population of patients observed in the case-mix data. This result implied that despite excluding the self-insured ERISA and FEHB plans, the MCDB represents the general larger privately insured population.³

Kaiser did not provide claim-level payment information because salaried practitioners deliver the bulk of their health care practitioner services. Kaiser also does not report prescription drug claims data due to proprietary restrictions. MHCC is working with Kaiser to develop service-level payment estimates and plans to resolve this issue in future reports using an

¹ Data on self-insured non-ERISA and self-insured ERISA (on a very limited basis) plan products are included in this report.

² Thirty states have developed voluntary or mandatory data systems similar to the Medical Care Data Base. Commonly, these are referred to as an "all-payer claims database" (APCD). Like the MCDB, these APCDs do not include some payers or certain coverage types.

³ Evaluating Maryland Commercial Experience in the MCDB, conducted by HSCRC, February 12, 2021.



approach that Kaiser has used in California, Colorado, and Washington. As in the past, this report includes Kaiser members data in the overall individual market enrollment at the end of a year and the mean risk score results.

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 also are included. This report is one in a series of reports that fulfills the annual reporting requirements on health care spending using information from the MCDB as required under Maryland law. Measures used in this analysis are defined in this report's Appendix B ("Definitions & Methods").

In comparison to the previously published "Spending & Use Among Maryland's Privately Insured (2019 Annual Report)," some of the numbers reported for 2018 and 2019 in the 2020 annual report will not exactly match numbers reported previously for those two years because of an update to the MCDB between reports. Where modifications were made, they were made to all years reported (i.e., 2018, 2019, and 2020). Specific changes include:

- Version V2 of the institutional line dataset was used for the 2019 report, whereas a more current version (i.e., V3) of this file was used for the 2020 report, which resulted in some minor differences in the counts and rates for 2018 and 2019.
- Inpatient and Outpatient facilities utilization and cost were recalculated based on service begin date instead of service end date.
- In the 2019 report, utilization and unit cost trends were separate sections. For the 2020 report, these are discussed together in the same section because the 2020 COVID-19 epidemic influenced changes in utilization that resulted in changes in unit cost.
- Identification and reporting of lab/imaging claims was enhanced from an older version of the Berenson-Eggers Type of Service (BETOS) to a new Restructured BETOS Classification System (RBCS) for the U.S. Centers for Medicare & Medicaid Services (CMS). This resulted in differences in both the lab/imaging and professional service categories compared to prior reports.
- MHCC is in the process of implementing a new database of prescription drug reference tables, which was not available for use in this report. Once implemented and tested, additional information on pharmacy trends can be provided in a separate report.
- Primary care spending is not included in this report but will be included in a separate report.
- The list of flagged chronic diseases was modified, and a separate section for behavioral health was added.
- A new section was added to report on COVID-19 prevalence and trends in telehealth use during 2020.



- Risk scores based on Johns Hopkins Adjusted Clinical Groups (ACGs) have been included in the 2020 report as the mean (i.e., average) score for the population instead of using percentiles (i.e., median) after review and feedback from Johns Hopkins consultants.

Highlights of the 2020 Privately Insured Report

Health care spending for all services combined in 2020 was \$5,732 per capita among the privately insured in Maryland. This represented an increase of 2.2% from 2019. In comparison National Health Expenditures (CMS) reported privately insured healthcare per capita spending of \$5,759, a decline of 2.6% (excluding net cost of private health insurance (NCPHI), Medigap, and Dental) among the privately insured in 2020. Related findings include:

- Per member spending for all services combined increased by about 2.2% in 2020 compared to a 2.6% increase in spending for all services combined in 2019.
- The per member spending trend varied by type of market
 - In the individual market, per member spending declined by 3.7% in 2020 compared to a 2.7% increase in 2019. (Note: The individual market had a 21.9% increase in enrollment compared to 2019 based on member months in 2020).
 - Per member spending in the small employer market increased by about 1.0% in 2020 compared to about 3.3% in 2019.
 - In the large employer market, per member spending grew by about 2.7% in 2020 compared to a 2.6% increase in 2019.
 - During 2020, the individual market had the highest per capita spending (\$7,437), followed by the large employer market (\$5,601) and the small employer market (\$5,124).

Prescription drug, professional services, and inpatient expenditures were the primary contributors to the overall 2.2% increase in per member spending for 2020, while outpatient hospital, outpatient non-hospital, and lab/imaging expenditures declined. Related findings include:

- Per member spending for prescription drugs increased by about 7.2%, professional services spending increased by about 4.8%, and inpatient hospital facility spending increased by about 3.5%. Per capita spending on medical services increased by about 0.2% in 2020. Medical spending (70%) was quite stable compared to prescription drugs spending (30%).
 - The trend in prescription drug spending was driven by a 1.3% increase in utilization and a 5.9% increase in unit cost. The following payers made up about 99.6% of the pharmacy membership in 2020 MCDB data. Each payer Unit Cost 12-month trends are as follows:
 - United Healthcare: 10.1% vs 2.7% in 2019 (15.6% of the pharmacy membership in 2020); Cigna: 7.8% vs -0.4% in 2019 (11.6%



pharmacy membership in 2020); CareFirst: 5.0% vs 0.3% in 2019 (63.5% pharmacy membership in 2020), and Aetna: 2.3% vs -0.7% in 2019 (8.7% pharmacy membership in 2020).

- The trend in professional services spending was driven by a 3.2% increase in utilization and a 1.6% increase in unit cost.
- The trend in inpatient hospital facility spending was driven by a 6.8% decrease in utilization and an 11.1% increase in unit cost. Hospitals were allowed to raise their rates per service to offset low volumes during 2020.
- Per member spending for outpatient hospital facility services declined by 4.7%, outpatient non-hospital facility declined by 2.6%, and lab/imaging declined by 12.7%.
 - The trend in outpatient hospital facility spending was driven by a 14.2% decrease in utilization and an 11.1% increase in unit cost. However, the rate increases were insufficient to offset the low volumes because of the suspension of elective procedures by the State of Emergency due to the COVID-19 pandemic.
 -
 - The trend in outpatient non-hospital facility spending was driven by an 8.0% decrease in utilization and a 5.9% increase in unit cost. Note that this category represented only 2.4% of total spending.
 - The trend in lab/imaging spending was driven by a 15.0% decrease in utilization due to COVID-19 pandemic and a 2.8% increase in unit cost.
- Of the total per member spending rate of \$5,732 in 2020, the service category components included the following (in descending order): Professional services (\$1,732; 30.2%), prescription drugs (\$1,702; 29.7%), outpatient hospital facility (\$930; 16.2%), inpatient hospital facility (\$879; 15.3%), lab/imaging (\$353; 6.2%), and outpatient non-hospital facility (\$136; 2.4%).
- Overall, the mean ACG risk score decreased marginally (1.34 in 2019 v. 1.33 in 2020) across all markets segments. The mean ACG risk score was consistently highest in the individual market (1.62), followed by the large employer market (1.31) and the small employer market (1.20), indicating that the individual market had the highest illness burden. This increased illness burden in individual market is due to migration of Maryland health insurance plan high risk pool members in the individual market.
- Excluding Kaiser, membership in on-exchange as of December 31, 2020, was 96,203 – an increase of 38.0% over 2019. 2020 membership off-exchange was 48,467 – an increase of 11.4% over 2019. These changes were driven due to the impact of an easy enrollment program and special enrollment period to meet the immense need due to the COVID-19 pandemic.

A new section in this 2020 report focuses on behavioral health. Among the findings:

- In 2020, the prevalence of selected conditions among Maryland's privately insured population was (in descending order): Depression or anxiety (13.9%), post-traumatic



stress disorder (PTSD) (4.4%), substance use disorder (1.6%), bipolar disorder (0.9%), and schizophrenia (0.2%). The methodology used to identify behavioral health patients could not account for patients with dual diagnoses. Therefore, patients with dual diagnoses are double counted in these results.

A new section in this 2020 report focuses on COVID-19 cases and telehealth visit trends in 2020. Among the findings:

- During 2020, a total of 51,037 COVID-19 cases and 2,710 COVID-19 hospitalizations were identified among study population in the privately insured claims data. About one in 20 COVID-19 cases were hospitalized in the privately insured population in 2020. The COVID-19 prevalence case rate and hospitalization rate were highest in the individual market. This trend in individual market is likely due to enrollment of high risk pool members in individual market.
- COVID-19 pandemic led to the temporary shutting down of many healthcare settings and a rapid switch to telehealth strategies for patient care. Before March 2020, telehealth claims grew at a very slow rate. With onset of the pandemic, we saw an abrupt spike in telehealth claims in spring 2020 reaching about 40% of total visits. From summer 2020 onwards it started to decline and then leveled off around approximately 20%.

Part 1: The Privately Insured Market in Maryland

This part of the report presents enrollment, spending, risk, utilization, and unit cost data for the privately insured individual, small employer, and large employer markets for the years 2018, 2019, and 2020. Data on variation by demographics (e.g., geography) and service categories are also included. Refer to technical appendix for details about demographics categorization.

1.1 Enrollment, Spending, & Risk across Maryland's Privately Insured Markets (2018–2020)

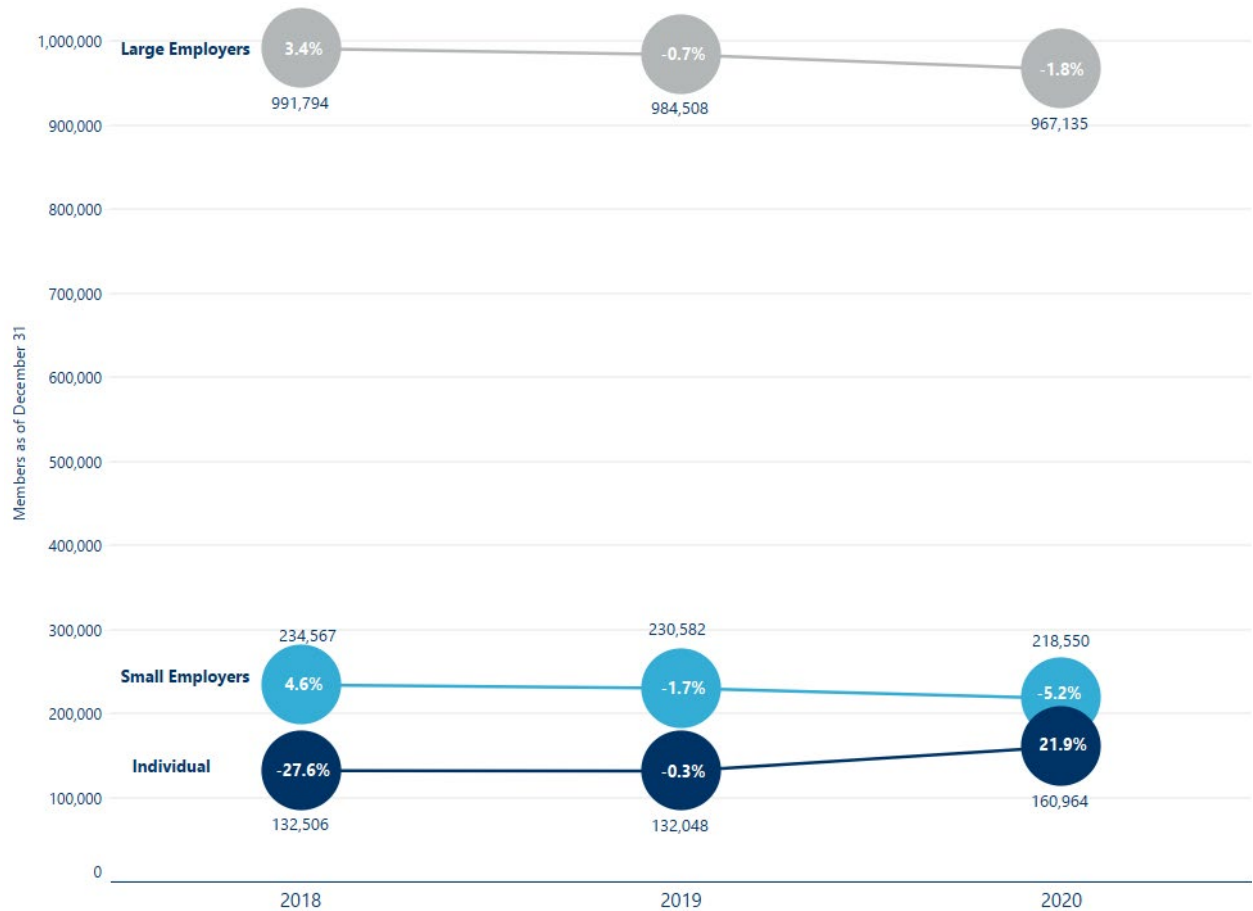
This section provides information on enrollment, spending, and risk (measured through member health status). This information is essential in understanding trends over time in health care costs and insurance participation and how the individual market, small employer market, and large employer market differ. This section also provides information on member out-of-pocket costs across markets and variation in spending across different service types. Among the findings:

- In 2020, there were 1.35 million members under 65 years of age enrolled across the individual, small employer, and large employer markets as of December 31. This was similar to enrollment in 2019. In comparison the data from the State Health Access Data Assistance Center (SHADAC), showed that enrollment among privately insured in Maryland increased by 2% in 2020.
- Overall enrollment in the individual market increased to 160,964 (+21.9%) from December 31, 2019, to December 31, 2020, due to an expanded enrollment period for the Maryland Health Benefit Exchange related to the COVID-19 pandemic (**Exhibit 1**).



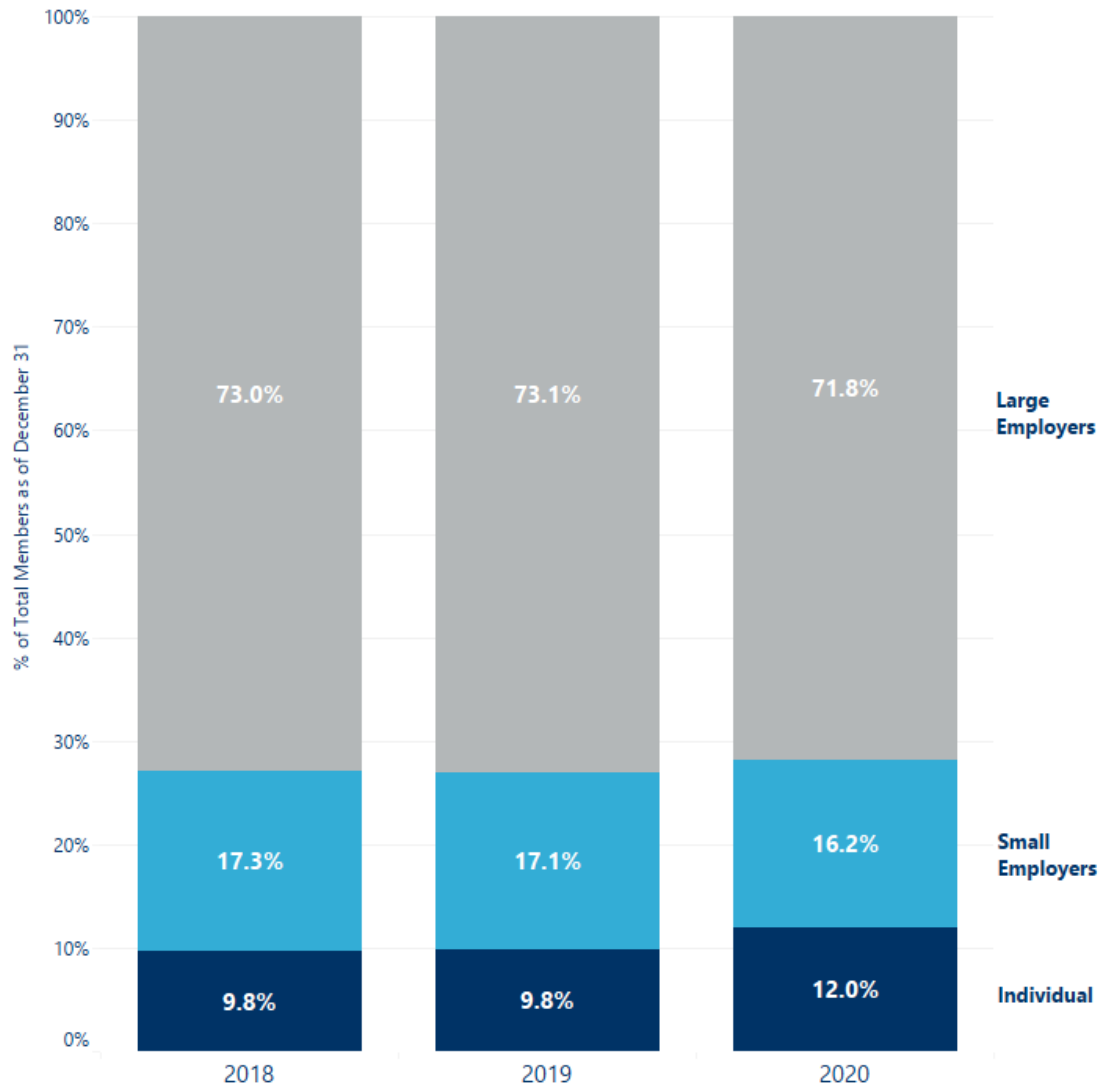
- Enrollment in the small employer market declined to 218,550 (-5.2%) from December 31, 2019, to December 31, 2020.
- Enrollment in the large employer market declined to 967,135 (-1.8%) from December 31, 2019, to December 31, 2020.

Exhibit 1. Enrollment & Percent Change from Prior Year (as of December 31) for Privately Insured Markets in Maryland (2018–2020)



- Exhibit 2** illustrates the proportion of the privately insured population across the individual, small employer, and large employer markets. While the proportion of insured members continued to decline in the small employer and large employer markets, the individual market saw the opposite, increasing from a static percentage from 2018–2019 to 12.0% in 2020. demonstrates the proportion of the privately insured market held by large employers (71.8% in 2020), small employers (16.2%), and the individual market (12.0%).

Exhibit 2. Relative Composition of Members for Privately Insured Markets in Maryland (2018–2020)

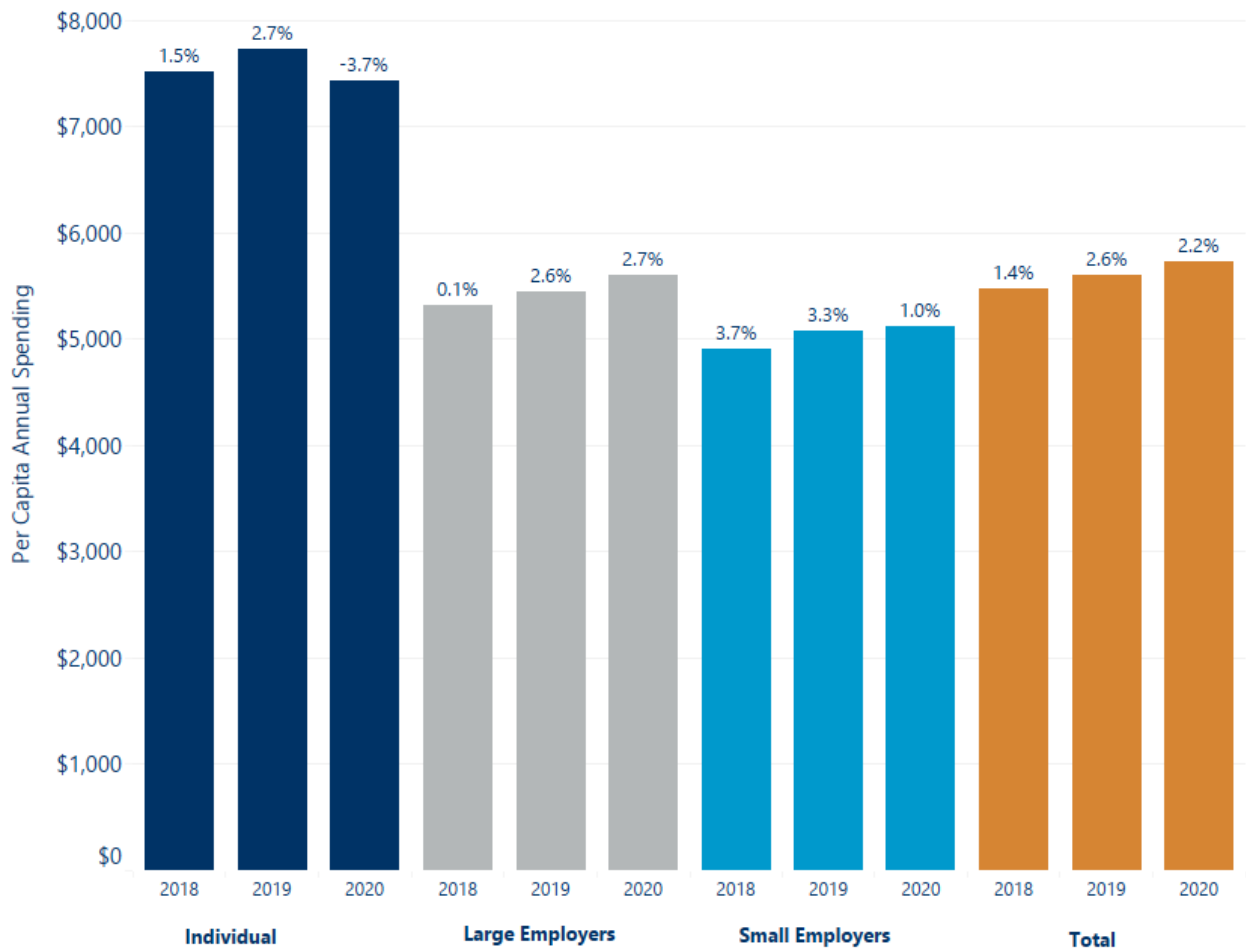


Notes: (1) Some percentages don't add up to 100% due to rounding.



- Per capita spending for all services combined increased by about 2.2% from \$5,609 in 2019 to \$5,732 in 2020 (**Exhibit 3**). This trend was slightly lower than the 2.6% increase from 2018 to 2019. By market segment, the large employer market increased by 2.7% to \$5,601; the small employer market increased by 1.0% to \$5,124; while the individual market declined by 3.7% to \$7,437.

Exhibit 3. Per Capita Total Spending & Percent Change from Prior Year for Privately Insured Markets in Maryland (2018–2020)



- The 2.2% increase in spending between 2019 and 2020 was an overall per capita increase of \$123 from \$5,609 in 2019 to \$5,732 in 2020. Prescription drug (+\$115, +7.2%), professional services (+\$79, +4.8%), and inpatient hospital facility (+\$30, +3.5%) were the primary contributors to the overall 2.2% increase in spending for 2020, while outpatient hospital facility (-\$46, -4.7%), outpatient non-hospital facility (-\$3, -2.6%), and lab/imaging (-\$51, -12.7%) expenditures declined (**Exhibit 4**).
- Some of the declines in outpatient facility and lab/imaging may reflect impacts of the COVID-19 pandemic on delayed elective surgical procedures and diagnostic screening and testing.
- By service category, the highest contributors to 2020 per capita spending were professional services (\$1,732, 30.2% of the \$5,732 total per capita spending), prescription drugs (\$1,702, 29.7%) followed by outpatient hospital facility (\$930, 16.2%), inpatient hospital facility (\$879, 15.3%), lab/imaging (\$353, 6.2%), and outpatient non-hospital facility (\$136, 2.4%).

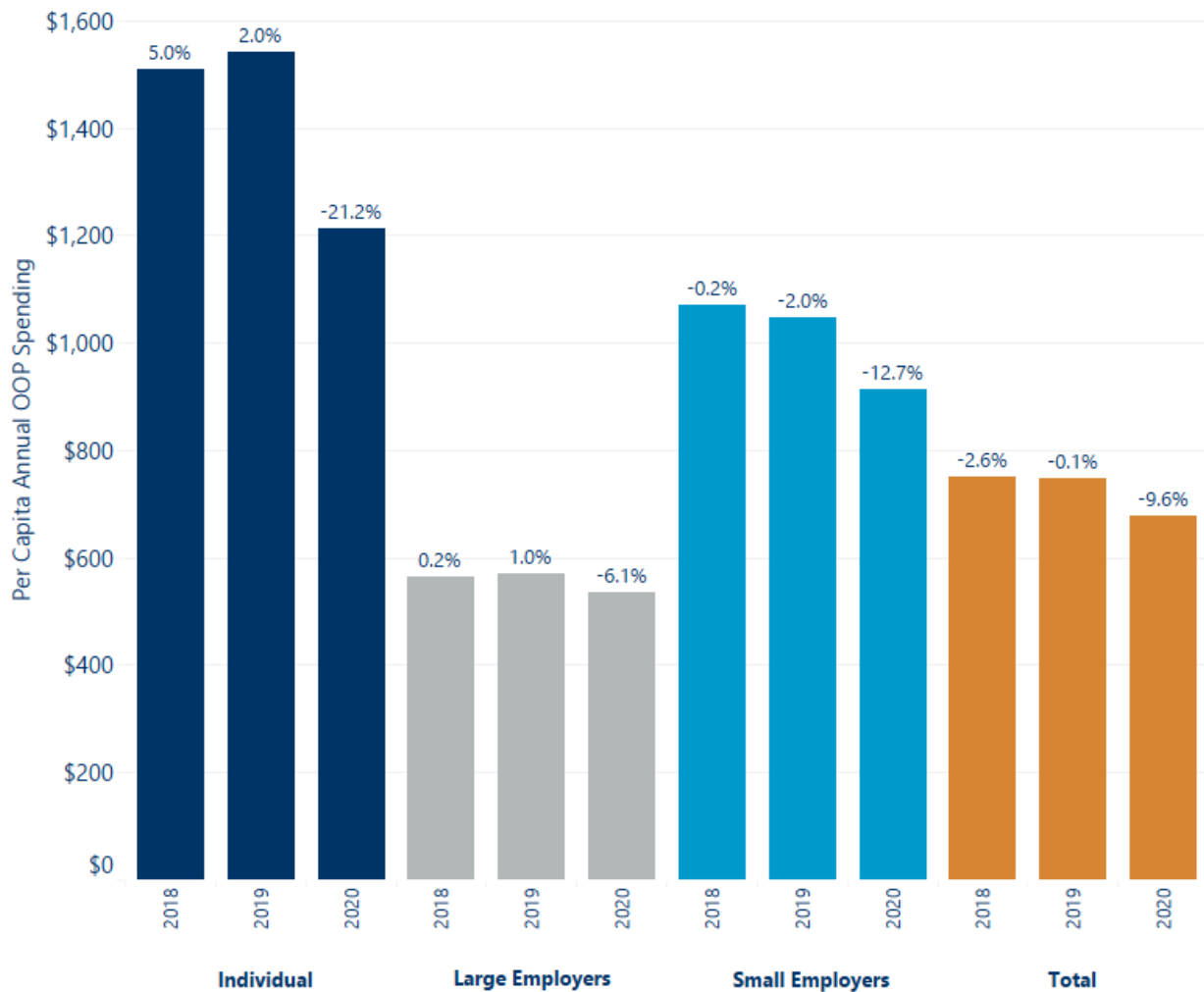
Exhibit 4. Per Capita Spending & Percent Change from Prior Year for Privately Insured Markets in Maryland by Service Type (2018–2020)



- Per capita prescription drug spending increased in the large employer (+8.7%) and the small employer (+6.3%) markets but declined in the individual market (-4.8%). Prescription drug use increased in the large employer (+1.7%) and small employer (+0.4%) markets but decreased for the individual market (-4.1%). Similarly, prescription drug unit cost increased for the large employer (+6.9%) and small employer (+5.9%) markets but declined for the individual market (-0.7%).
- Per capita professional services spending increased for the large employer (+4.6%), small employer (+6.2%), and individual (+1.4%) markets.
- Per capita inpatient hospital facility spending increased in the individual (+4.8%) and large employer (+3.6%) markets but declined in the small employer market (-3.0%). The decrease in small employer market was due to COVID-19 pandemic during which quite a number of small businesses went out of business which resulted in decreased enrollment (4.5%). Outpatient hospital facility and lab/imaging declined across all three markets. Outpatient non-hospital facility (e.g., ambulatory surgery centers, Home Health, outpatient rehabilitation facilities, Federally Qualified Health Centers) spend was the lowest spend of the service types (2.4% in 2020) and declined for the small employer and individual markets but increased slightly for the large employer market.
- In 2020, per capita out-of-pocket (OOP) spending (all services combined) was \$676 (\$534 medical, \$142 pharmacy). Overall OOP spending declined by 9.6% (-12.0% medical, +0.5% pharmacy). Nationally, overall OOP spending declined from 2019 to 2020 by 6.9% (excluding Medicare, Medigap, Medicaid, Tricare, Dental and other health OOP dollars).⁴
- The 2020 trend in medical OOP declined for all three markets – large employer (-8.5%), small employer (-16.0%), individual (-22.3%) (**Exhibit 5**). The trend in pharmacy OOP varied, with slight increases in the large employer (+2.5%) and small employer (+2.4%) markets but a large decrease in the individual market (-14.8%).

⁴ NHE fact sheet. U.S. Centers for Medicare & Medicaid Services (CMS). Page last modified: December 15, 2021. Link verified: April 20, 2022. Link: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

Exhibit 5. Out-of-Pocket Spending & Percent Change from Prior Year for Privately Insured Markets in Maryland (2018–2020)



Risk-scores based on Johns Hopkins ACGs are reported in the 2020 report as the average (i.e., mean) score for the population instead of using percentiles (i.e., median) after review and feedback from Johns Hopkins consultants. Among the findings:

- Overall, the mean ACG score did not fluctuate significantly between 2019 and 2020 years. In 2020, the overall mean risk score was 1.33, a marginal difference of about 0.01 from 2019 (**Exhibit 6**).
- By market segment, the individual market had the highest 2020 mean risk score (1.62) followed by the large employer (1.31) and small employer (1.20) markets. A higher risk score indicates that the market segment population had greater illness burden. The individual market's mean risk score in 2020 was 0.31 more than the

large employer market and 0.42 more than the small employer market. All three market segments had small declines in mean risk score between 2019 and 2020.

Exhibit 6. Mean ACG Risk Score for Privately Insured Markets in Maryland (2018–2020)

Mean ACG Score	2018	2019	2020
Total	1.30	1.34	1.33
Large Employers	1.28	1.32	1.31
Small Employers	1.18	1.22	1.20
Individual	1.64	1.72	1.62

1.2 Unit Costs, Utilization, & Drivers of Cost by Market & Service Category for the Privately Insured Population (2018–2020)

Changes in utilization and unit cost have been drivers of spending, and unit cost may have been the primary cost driver of spending in the United States prior to the pandemic.⁵ The unit cost component is relatively of more minor concern among the Medicare and Medicaid populations for whom the U.S. Centers for Medicare & Medicaid Services (CMS) are better able to restrain cost. There is strong evidence that unit cost growth is primarily driven by market power, which enables providers, drug manufacturers, and others to charge prices substantially higher than the cost of providing their services and products.

Given the impact of the COVID-19 pandemic on service utilization in 2020, it is difficult to separate the impacts of utilization and unit cost, since some dramatic changes in reduced utilization may have impacted unit cost trends. Therefore, in contrast to the 2019 report, this report combines unit cost and utilization into a single section. **Exhibit 7** demonstrates the following:

- Trends in prescription drug and professional services spending were driven by increases in both utilization and unit cost, while trends in inpatient hospital facility, outpatient hospital facility, outpatient non-hospital facility, and lab/imaging spending were driven by lower utilization and higher unit cost. The higher unit cost may, in part, reflect a change in the mix of provided services between 2019 and 2020 due to the COVID-19 pandemic.

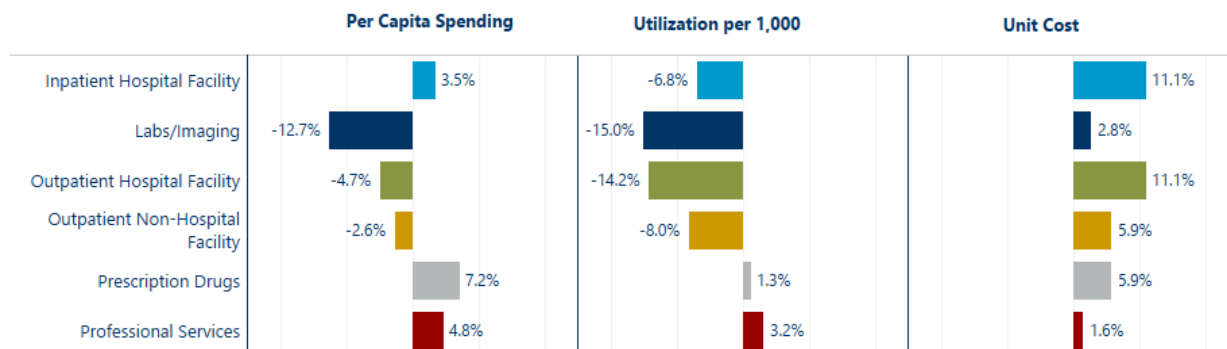
⁵ White J, Hewitt P, Gagnon E, Pantely, S. Rising health care costs: Drivers, challenges and solutions. National Association of Insurance Commissioners (NAIC) Center for Insurance Policy and Research (CIPR). August 2019. Link verified: April 20, 2022. Link: https://content.naic.org/sites/default/files/inline-files/CIPR%20Health%20Care%20Cost%20Drivers%20Study_Second%20Installment_August%202019_0.pdf

Notes: (1) IP hospital facility utilization is days per 1,000 members. (2) OP hospital, non-hospital, and professional services utilization are visits per 1,000 members. (3) Prescription drugs utilization are scripts per 1,000 members. Scripts are normalized to 30-days scripts.

- As noted above in Section 1.1, from 2019 to 2020, per member spending for prescription drugs increased by 7.2%, professional services spending increased by 4.8%, and inpatient hospital facility spending increased by 3.5%.
 - The prescription drug per capita spending increase of about 7.2% in 2020 was primarily driven by an increase in both unit cost (5.9%) and utilization (1.3%). The higher unit cost may, in part, reflect a changing mix of services provided in 2020 due to the COVID-19 pandemic. Nationally, there is evidence of selected drugs with unit cost increases between 2019 and 2020 (e.g., Humira (Adalimumab)).⁶
 - The professional services per capita spending increase of about 4.8% was also primarily driven by an increase in both utilization (3.2%) and unit cost (1.6%).
 - The inpatient hospital facility spending trend was driven by a 6.8% decrease in utilization and an 11.1% increase in unit cost.
- Per member spending for lab/imaging declined by 12.7%, outpatient hospital facility declined by 4.7%, and outpatient non-hospital facility declined by 2.6%. While each of these categories had decreased utilization in 2020, each had increases in unit cost.
 - Lab/imaging spending trend was driven by a 15.0% decrease in utilization and a 2.8% increase in unit cost.
 - Outpatient hospital facility spending trend was driven by a 14.2% decrease in utilization and an 11.1% increase in unit cost.
 - Outpatient non-hospital facility spending trend was driven by an 8.0% decrease in utilization and a 5.9% increase in unit cost.
- Across the large employer, small employer, and individual markets, these same 2019–2020 patterns in utilization and unit cost were primarily consistent.
- Inpatient hospital facility, outpatient hospital facility, outpatient non-hospital, and lab/imaging services had consistently decreased utilization and increased unit cost between 2019 and 2020. Pharmacy and professional services had consistently increased utilization and unit cost.
- The exceptions to these trends in the individual market for prescription drug utilization, and in outpatient non-hospital facility, lab/imaging, and prescription drugs for unit cost. The small employer market also had a very slight decrease in lab/imaging unit cost.

⁶ ICER identifies most significant 2020 US drug-price hikes not supported by new clinical evidence. Institute for Clinical and Economic Review. November 16, 2021. Link verified: April 20, 2022. Link: <https://icer.org/news-insights/press-releases/icer-identifies-most-significant-2020-us-drug-price-hikes-not-supported-by-new-clinical-evidence>

Exhibit 7. Changes in Per Capita Spending, Utilization, & Unit Cost by Service Type in Privately Insured Markets in Maryland (2019-2020)



Part 2: Prevalence of Select Chronic Medical Conditions, All Markets Combined (2018–2020)

The chronic conditions examined in this report include asthma, diabetes, hypertension, obesity, and tobacco-related disorders. Diabetes is the Maryland Total Cost of Care model's priority area for improving population health.⁷

The U.S. Centers for Disease Control and Prevention (CDC) estimate that 90% of annual U.S. health care expenditures are for people with chronic and mental health conditions.⁸ Chronic health conditions contribute to higher health care spending and controlling or preventing them can significantly reduce spending. Hypertension, which was found in 14.4% of privately insured members in Maryland in 2020, is one of the most common chronic conditions in U.S. adults and can lead to conditions such as heart failure and strokes.^{9,10} Diabetes, which was found in 10.6% of privately insured members in 2020, also can lead to serious complications such as kidney failure and blindness.¹¹ Adults with obesity – 9.8% of privately insured members in 2020 – can experience higher annual medical costs, with costs increasing with the condition's increased severity.¹² Tobacco-related disorders, which were

⁷ Maryland total cost of care model. U.S. Centers for Medicare & Medicaid Services (CMS). Link verified: April 22, 2022. Link: <https://innovation.cms.gov/innovation-models/md-tccm>

⁸ Health and economic costs of chronic diseases. U.S. Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion. Link verified: April 22, 2022. Link: <https://www.cdc.gov/chronicdisease/about/costs/index.htm>

⁹ Buttorff C, Ruder T, Bauman M. Multiple chronic conditions in the United States. RAND Corporation. 2017. Link verified: April 22, 2022. Link: http://www.fightchronicdisease.org/sites/default/files/TL221_final.pdf

¹⁰ Tackling G, Borhade, MB. Hypertensive heart disease. StatPearls Publishing. July 1, 2020. Link verified: April 22, 2022. Link: <https://www.ncbi.nlm.nih.gov/books/NBK539800>

¹¹ Put the brakes on diabetes complications. U.S. Centers for Disease Control and Prevention (CDC). Link verified: April 22, 2022. Link: <https://www.cdc.gov/diabetes/library/features/prevent-complications.html>

¹² Cawley J, Biener A, Meyerhoefer C, Ding Y, Zvenyach T, Smolarz BG, Ramasamy A. Direct medical costs of obesity in the United States and the most populous states. J Manag Care Spec Pharm. March 2021. 27(3):354-366. doi: 10.18553/jmcp.2021.20410. Epub 2021 Jan 20. PMID: 33470881. Link verified: April 22,

found in 2.2% of privately insured members, are considered to be the leading cause of preventable illness in the United States.¹³ Asthma, with a prevalence of 5.0% in the privately insured market, often requires emergency care.¹⁴

The identification of members with specific chronic conditions in this report is based on the use of diagnosis codes reported to the MCDB for the Maryland privately insured population during each calendar year. Prescription drug claims data, which could increase the reported rates, does not contain diagnosis codes and therefore was not used. Some conditions, such as tobacco-related disorders, may be significantly under-reported in claims data. These prevalence rates are based on privately insured individuals, ages 0–64 years, and therefore are not comparable to prevalence rates reported by the U.S. CDC or through the Maryland Behavioral Risk Surveillance System. Other sources of disease prevalence data do not include children and may include individuals aged 65 years and older and other populations (e.g., Medicaid), which may result in higher prevalence rates than reported here.

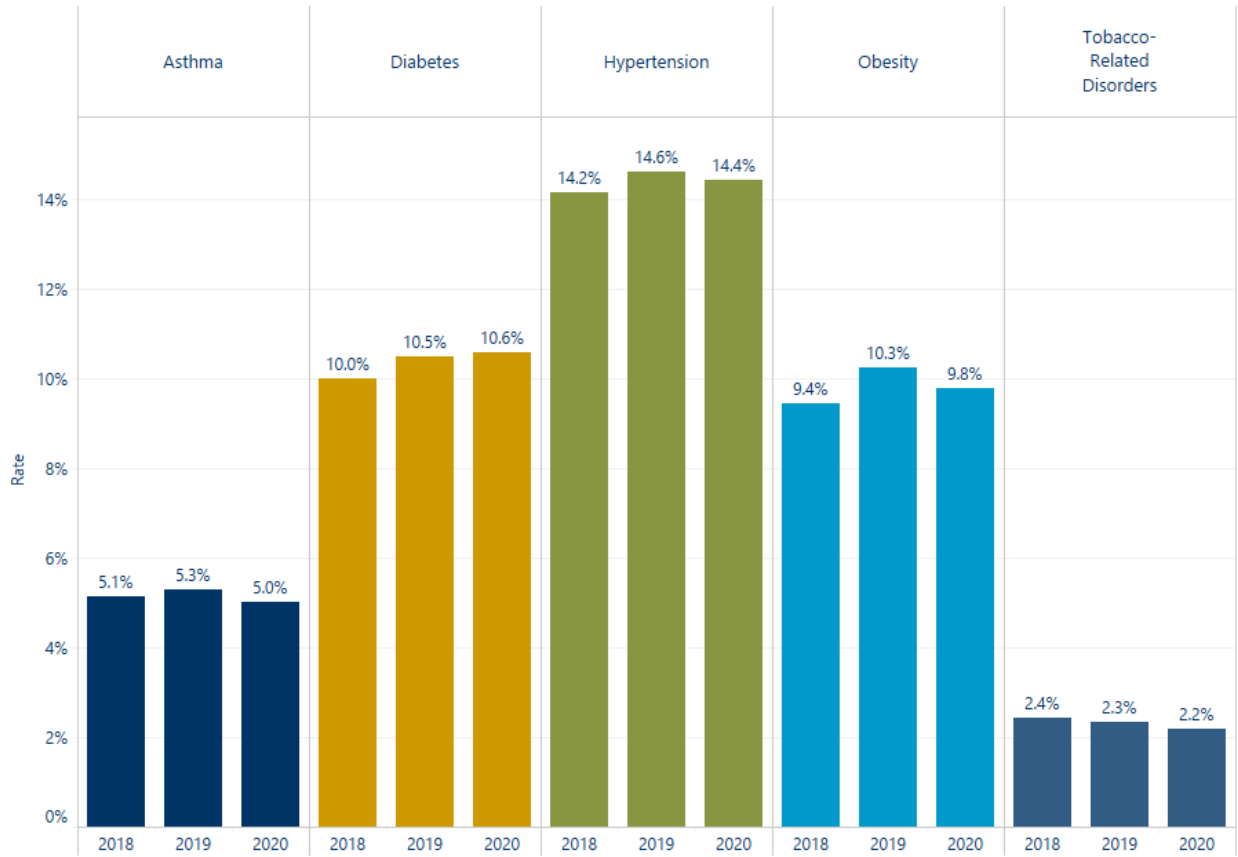
For the privately insured population, the count of members identified in 2020 with these conditions was (in descending order): Hypertension (230,234), diabetes (168,887), obesity (156,150), asthma (79,809), and tobacco-related disorders (34,874). **Exhibit 8** displays the prevalence rates of hypertension, diabetes, obesity, tobacco-related disorders, and asthma, which remained relatively stable over the three years of measurement.

2022. Link: <https://pubmed.ncbi.nlm.nih.gov/33470881>

- ¹³ Smoking & tobacco use: Fast facts and fact sheets. U.S. Centers for Disease Control and Prevention (CDC) Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. Link verified: April 22, 2022. Link: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm
- ¹⁴ Nunes, C, Pereira, AM, Morais-Almeida, M. Asthma costs and social impact. *Asthma res and pract.* January 6, 2017. 3, 1 (2017). Link verified: April 22, 2022. Link: <https://doi.org/10.1186/s40733-016-0029-3>



Exhibit 8. Prevalence Rates of Selected Chronic Conditions for Privately Insured Markets in Maryland (2018–2020)



The Maryland APCD is a rich source of data for further evaluation of the utilization and cost outcomes for these and other chronic and potentially preventable conditions.



Part 3: ACA-Compliant Health Plan Enrollment, Spending, Risk, & Utilization for On-Exchange & Off-Exchange Plans (2018–2020)

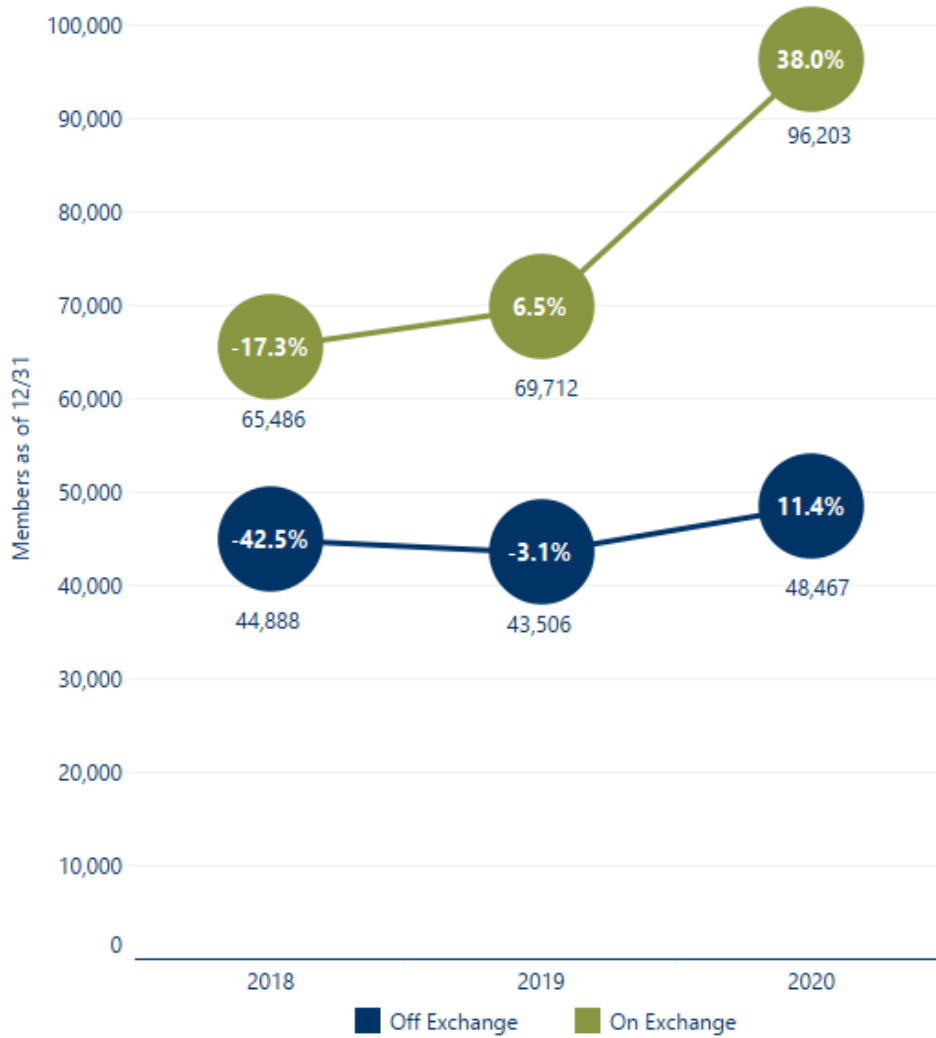
This section provides information regarding enrollment in plans that are compliant with the 2010 U.S. Patient Protection and Affordable Care Act (ACA) in the individual market as well as data regarding spending, utilization, and risk (such as measured through member health status). This information is essential in understanding trends over time in health care spending, consumer out-of-pocket costs, and insurance participation within the ACA-regulated market, which has undergone tremendous change since the launch of health insurance exchanges in January 2014. This section also provides information related to variation in spending across different service types. This section includes data for ACA-compliant plans offered through the Maryland Health Benefit Exchange (MHBE), which provides access to federal premium subsidies for low-income members, as well as data on ACA-compliant plans offered off the exchange.

Exhibit 9 illustrates the following:

- Excluding Kaiser, on-exchange membership as of December 31, 2020, was 96,203, an increase of 38.0% over 2019. Off-exchange membership was 48,467, an increase of 11.4% over 2019. These changes were driven in part by an expanded enrollment period due to the COVID-19 pandemic.
- Including Kaiser, on-exchange membership as of December 31, 2020, was 143,338, an increase of 18.7% over 2019. Off-exchange membership was 59,988, an increase of 8.7% over 2019.
- Excluding Kaiser, average ACG risk scores in 2020 were slightly higher for the on-exchange membership (1.71) than for the off-exchange membership (1.64). However, with Kaiser included, the 2020 on-exchange ACG risk score (1.21) was lower than the off-exchange score (1.38). These relative differences were consistent across 2018, 2019, and 2020.



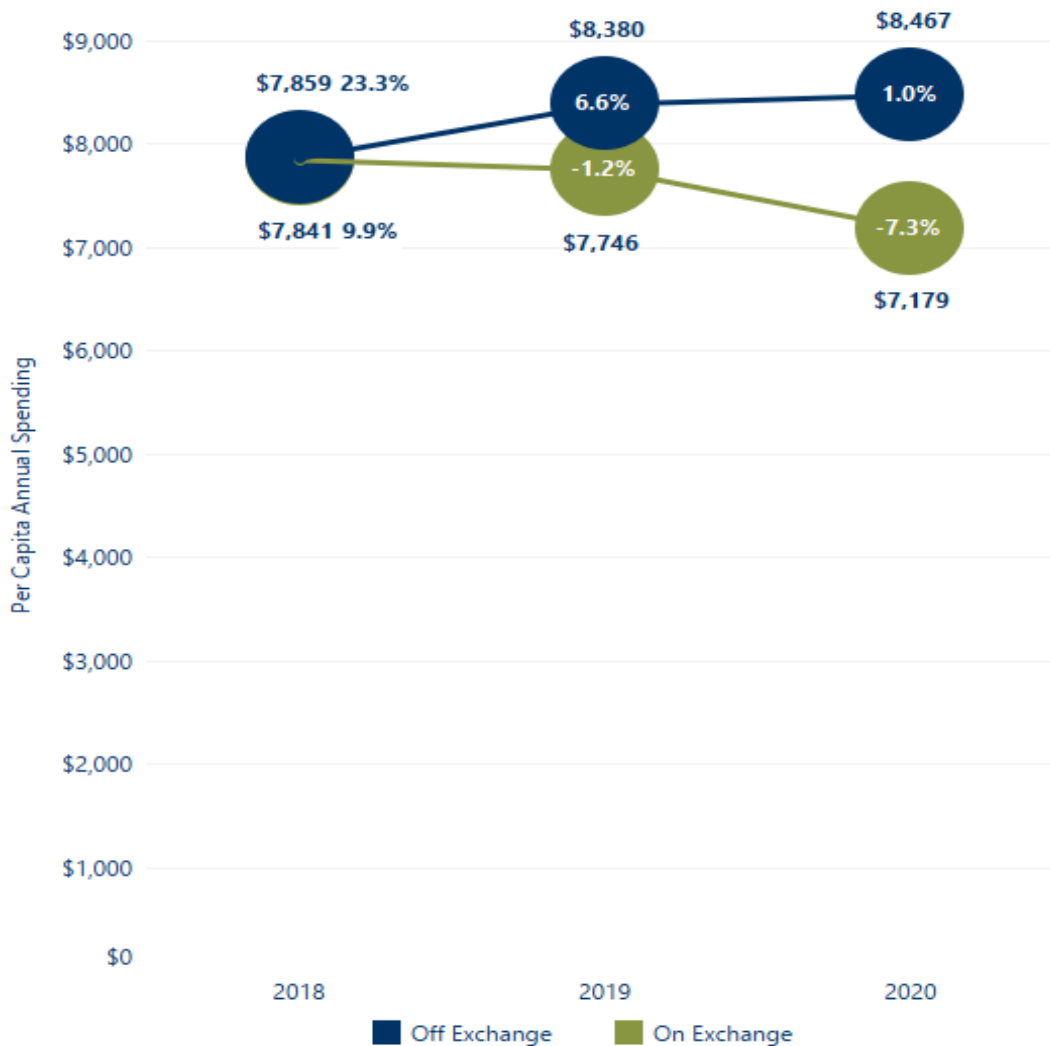
Exhibit 9. On-Exchange & Off-Exchange Enrollment & Percent Change from Prior Year (as of December 31) in Maryland, excluding Kaiser (2018–2020)



Spending results exclude Kaiser. **Exhibit 10** indicates:

- Total per capita spending for all services for 2020 was lower for the on-exchange membership (\$7,179) than for the off-exchange membership (\$8,467) – a divergence from 2018 and 2019, which showed similar per capita spending both on- and off-exchange. The primary drivers of the \$1,288 difference between the two groups in 2020 was lower outpatient hospital facility and prescription drug spending for the on-exchange membership.
- Total per capita spending for all services declined by 7.3% for the on-exchange membership and increased by 1.0% for the off-exchange membership.

Exhibit 10. On-Exchange & Off-Exchange Per Capita Spending & Percent Change from Prior Year in Maryland (2018–2020)

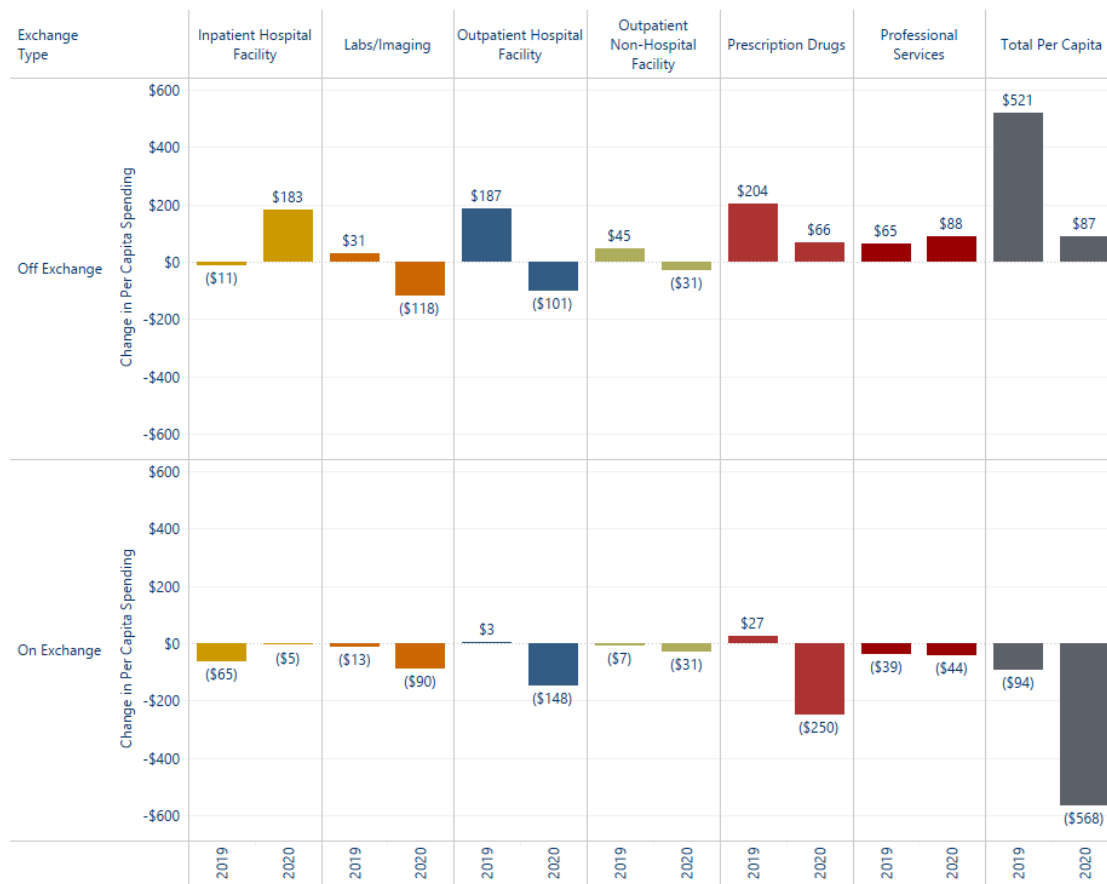


- Total per capita out-of-pocket spending was lower for the on-exchange membership (\$1,000) than for the off-exchange membership (\$1,558) and declined from 2019 to 2020 in both groups (-19.7% on exchange, -23.1% off exchange; not shown in this report's exhibits). As noted earlier in the report, national out-of-pocket spending declined 6.9% (excluding Medicare, Medigap, Medicaid, Tricare, Dental and other health OOP dollars) in part due to decreased utilization during the COVID-19 pandemic.

Exhibit 11 illustrates the following:

- For the off-exchange membership, lab/imaging and outpatient hospital facility spending declined while inpatient hospital facility spending increased between 2019 and 2020.
- For the on-exchange membership, the largest drivers of the downward trend in spending between 2019 and 2020 were outpatient hospital facility and prescription drug spending, but all service categories experienced some decrease.

Exhibit 11. On-Exchange & Off-Exchange Change in Per Capita Spending from Prior Year by Service Category in Maryland (2018–2020)



- In 2020, the mean ACG risk score (excluding Kaiser) was higher in the on-exchange membership (1.71) than in the off-exchange membership (1.64), indicating a slightly higher illness burden among the on-exchange membership.
- When the Kaiser population was included in the 2020 analysis, the mean ACG risk scores decreased for both populations 1.21 for the on-exchange membership and 1.38 for the off-exchange membership.
- Between 2019 and 2020, the mean ACG risk score (excluding Kaiser) showed a difference of 0.04 for the on-exchange membership and a difference of 0.07 for the off-exchange membership. When including the Kaiser population, the mean ACG risk score showed a difference of 0.05 for the on-exchange membership and a remained unchanged for the off-exchange membership
- The significant decline in per capita spending for the on-exchange membership (excluding Kaiser) between 2019 and 2020 was driven by an influx of healthier new enrollees as indicated by the decline in average ACG score in this population.

Part 4: COVID-19 & Telehealth 2020 Results

Previous sections of this report have noted the potential impact of the COVID-19 pandemic on utilization, unit cost, and spending trends for the privately insured. This part of the report provides information on COVID-19 cases for the privately insured population reported through the Maryland APCD. COVID-19 cases were identified using professional and institutional claims with a COVID-19 diagnosis reported in any of the diagnosis fields (e.g., primary, secondary). The prevalence rate of COVID-19 cases was calculated per 10,000 members per year using the following formula:

$$(\text{COVID-19 cases} / \text{member exposed months}) \times (10,000 \text{ members}) \times (12 \text{ months})$$

The hospitalization use rates utilize the same denominator as the prevalence case rates (i.e., not only those members identified with a reported COVID-19-related diagnosis code). The hospitalization rates displayed in **Exhibit 12** are subset to only those members identified with COVID-19 based on reported claims data.

During 2020, a total of 51,037 COVID-19 cases and 2,710 COVID-19 hospitalizations were identified in the privately insured claims data. About one in 20 members with a reported COVID-19 case were hospitalized in the privately insured population in 2020.

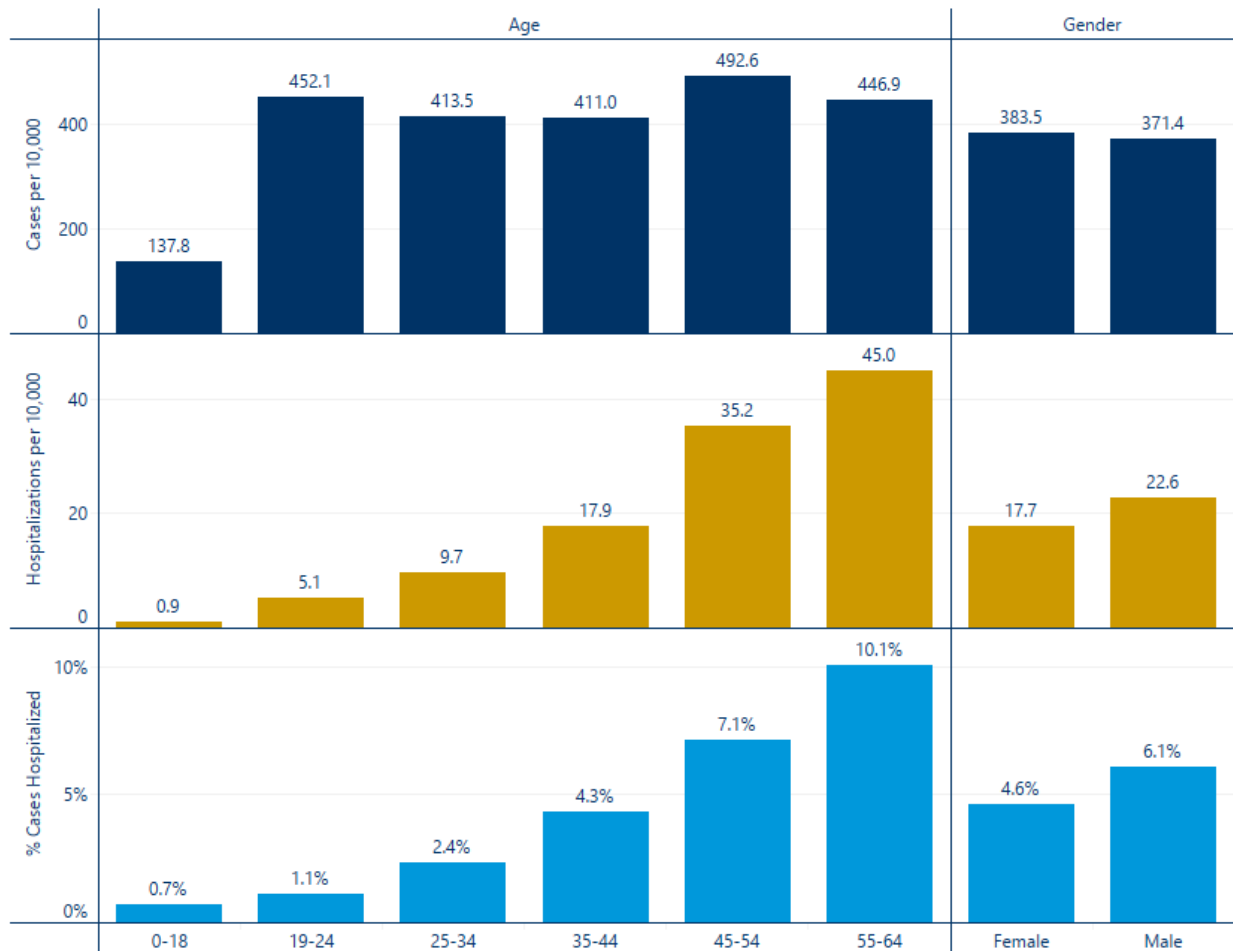
COVID-19 case prevalence rates and hospital use rates are reported by age and gender in **Exhibit 12**. Among the findings:

- The overall 2020 COVID-19 case rate per 10,000 members (377.7) was lowest in children aged 0–18 years (137.8) and was highest in members aged 45–54 years (492.6). Females had a slightly higher rate (383.5) compared to males (371.4).
- The COVID-19 case rate per 10,000 members was highest in the individual market (426.5) followed by the small employer (376.2) and large employer (371.3) markets.



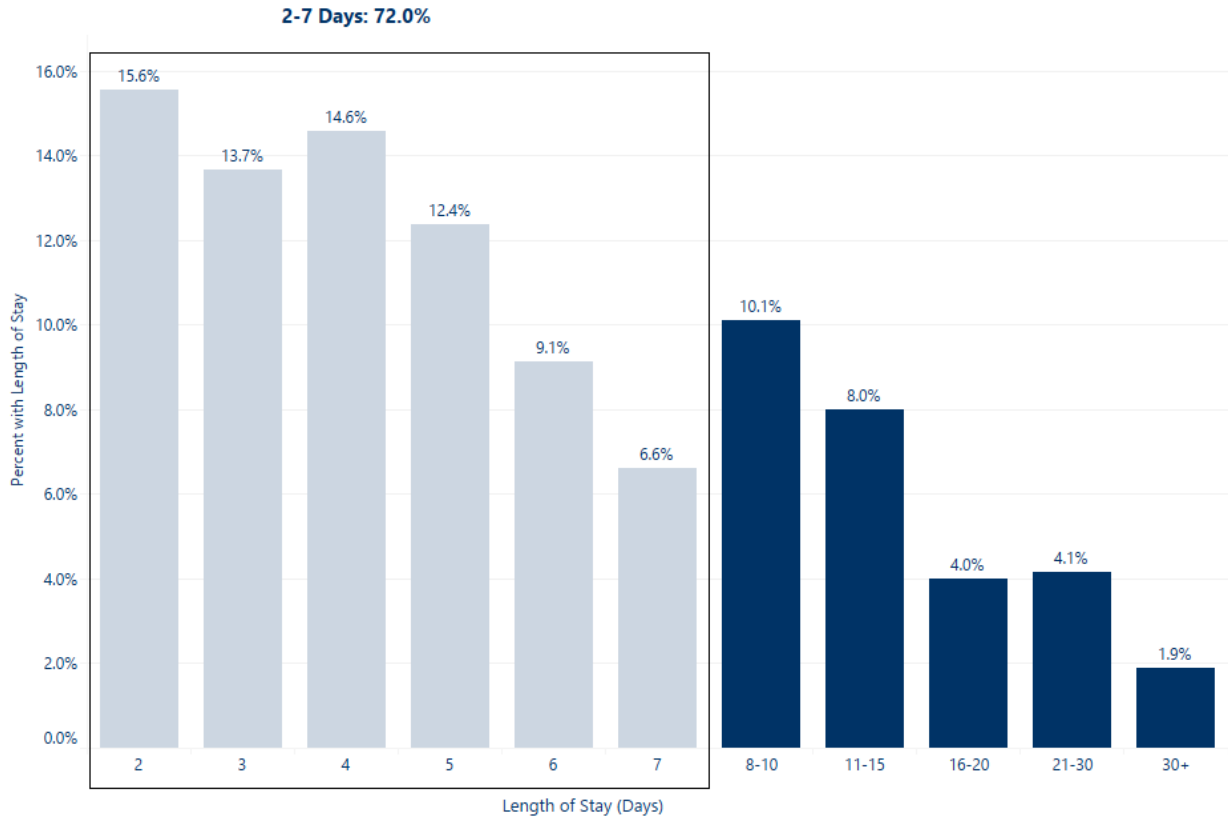
- The COVID-19 hospitalization rate per 10,000 members (20.1) was lowest in children aged 0–18 years (0.9) and highest for members aged 55–64 years (45.0). Unlike the overall COVID-19 case rate, the hospitalization rate for females (17.7) was lower than for males (22.6).
- The COVID-19 hospitalization rate per 10,000 members was highest in the individual market (26.3), followed by the large employer market (20.1) and the small employer market (15.6).
- For the percentage of COVID-19 cases that were hospitalized, the highest percentage was in members aged 55–64 years (10.1%), and males (6.1%) with COVID-19 were more likely to be hospitalized than females (4.6%).

Exhibit 12. COVID-19 Prevalence & Hospitalization Rates per 10,000 & Percent Hospitalized by Gender & Age Group (in Years) for Privately Insured Markets in Maryland (All Markets Combined, 2020)



Length of stay was evaluated for hospitalizations with two or more days spent in the hospital. Of these hospitalizations, 72.0% of hospitalized members stayed in the hospital for two to seven days (highlighted in the light blue columns in **Exhibit 13**, below).

Exhibit 13. COVID-19 Hospitalizations by Average Length of Stay (in Days) for Privately Insured Markets in Maryland (2020) *



* Note that inpatient stays in the analysis were limited to those two days or longer.

The Maryland APCD provides a potentially rich source of data to explore in more detail the utilization and costs associated with COVID-19 treatment.



Telehealth Use Trends by Month During 2020

A key impact of the COVID-19 pandemic was an increase in the utilization of telehealth services. MHCC measures telehealth visits using Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, procedure modifier codes, and place of service codes reported in the claims data. The counts of total visits are based on claims reported in the privately insured professional and institutional claims files.

In 2020, 11,525 (1.0%) of 1.2 million visits were telehealth visits in January (counts not shown in exhibits). Telehealth visits increased during March and peaked at 271,203 (40.4%) of 671,461 total visits in April. Telehealth visits then declined rapidly during May and June, continued to decline more slowly through October, and then had a slight increase in November and December 2020 (see the green trend line below in **Exhibit 14**).

By market segment, trends in telehealth as a percentage of total visits were similar, with the small employer and individual market segments showing slightly higher rates of telehealth use compared to the large employer market.

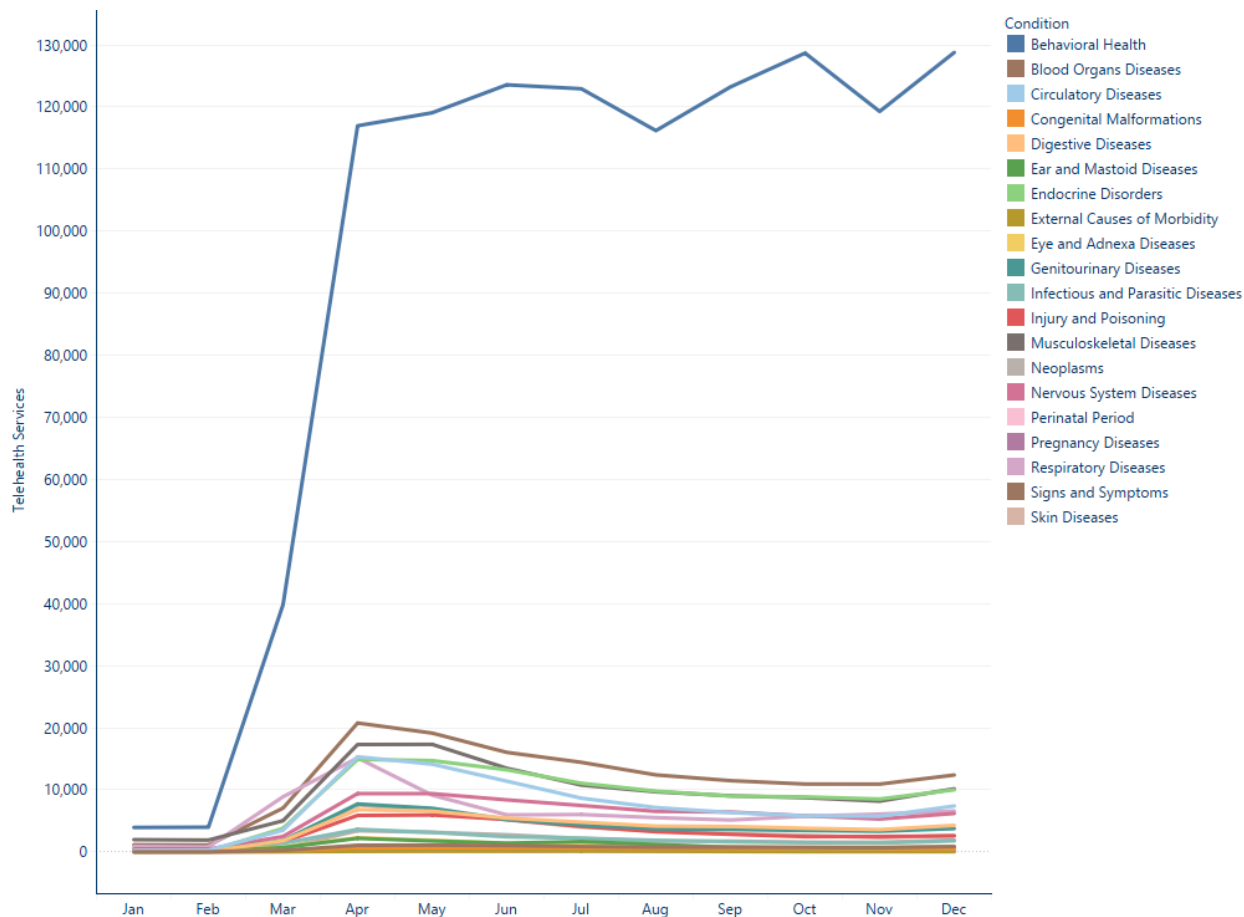
Exhibit 14. Telehealth Visits Per 1,000 Members & Percent of Total Visits by Month for Privately Insured Markets in Maryland (2020)



Telehealth visits increased in every major diagnostic category starting in March 2020. While other categories declined or leveled off during the rest of the year, telehealth for behavioral health services remained high (**Exhibit 15**). During the month of October 2020, behavioral health telehealth visits (128,669) accounted for two-thirds of all telehealth visits (193,096; counts not shown in exhibits).

In summary, health care visits in total declined from March 2020 to April 2020 after the COVID-19 pandemic was declared a national emergency on March 13, 2020. Telehealth visits increased significantly during this time and remained in elevated use through the end of 2020, with telehealth visits for behavioral health leading all other diagnostic categories.

Exhibit 15. Telehealth Visits by Major Diagnostic Category for Privately Insured Markets in Maryland (2020)



Part 5: Behavioral Health in Maryland

This part of the report presents the prevalence data by market sector for privately insured members with reported claims for behavioral health disorders (i.e., bipolar disorder, depression/anxiety, PTSD, and schizophrenia) and substance use disorders.

The National Institute of Mental Health (NIMH) at the U.S. National Institutes of Health (NIH) estimates that nearly one in five U.S. adults lives with a behavioral health condition.¹⁵ A national survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2020 found that 30.5% of adults in need of behavioral health services struggled to find services.¹⁶ Behavioral health conditions represented 4.9 million visits to emergency departments in the United States in 2018 and often led to comorbidities that influenced the cost of health care.¹⁷ For this section of the report, members were identified in the privately insured data using all diagnosis codes on professional and institutional claims.

Among Maryland's privately insured population in 2020:

- 13.9% of members experienced depression or anxiety
- 4.4% of members experienced PTSD
- 1.6% of members experienced substance use disorder
- 0.9% of members experienced bipolar disorder
- 0.2% of members experienced schizophrenia
- The prevalence of behavioral health conditions in the privately insured population remained relatively static from 2018 to 2020, with a slight increase in depression/anxiety and PTSD. The methodology used to identify behavioral health patients could not account for patients with dual diagnoses. Therefore, patients with dual diagnoses are double counted in these results.

¹⁵ Mental illness. National Institute of Mental Health (NIMH) at the U.S. National Institutes of Health (NIH), Office of Science Policy, Planning, and Communications. January 2022. Link verified: April 22, 2022. Link: <https://www.nimh.nih.gov/health/statistics/mental-illness>

¹⁶ Key substance use and mental health indicators in the United States: Results from the 2020 national survey on drug use and health. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, Populations Survey Branch. HHS Publication No. PEP21-07-01-003. NSDUH Series H-56. October 2021. Link verified: April 22, 2022. Link: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>

¹⁷ Cairns C, Kang K, Santo L. National hospital ambulatory medical care survey: 2018 emergency department summary tables. U.S. Centers for Disease Control and Prevention (CDC). May 2021. Link verified: April 22, 2022. Link: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf



Appendix A: Additional Exhibits

Appendix A contains additional exhibits for the report that are useful in understanding greater trends.

Exhibit A1. Percent Change from Prior Year in Unit Cost by Service Category for Privately Insured Markets in Maryland (2018–2020)

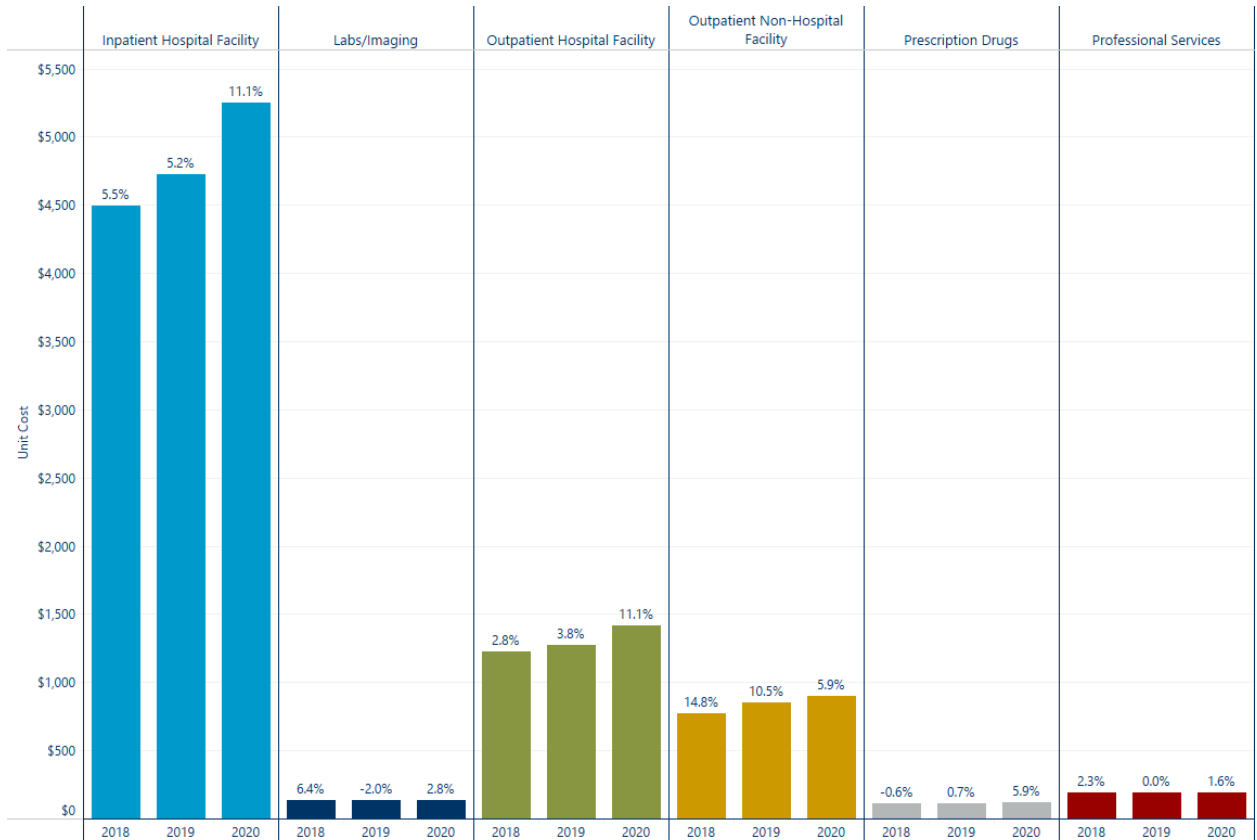


Exhibit A2. Unit Cost by Service Type & Market for Privately Insured Markets in Maryland (2020)

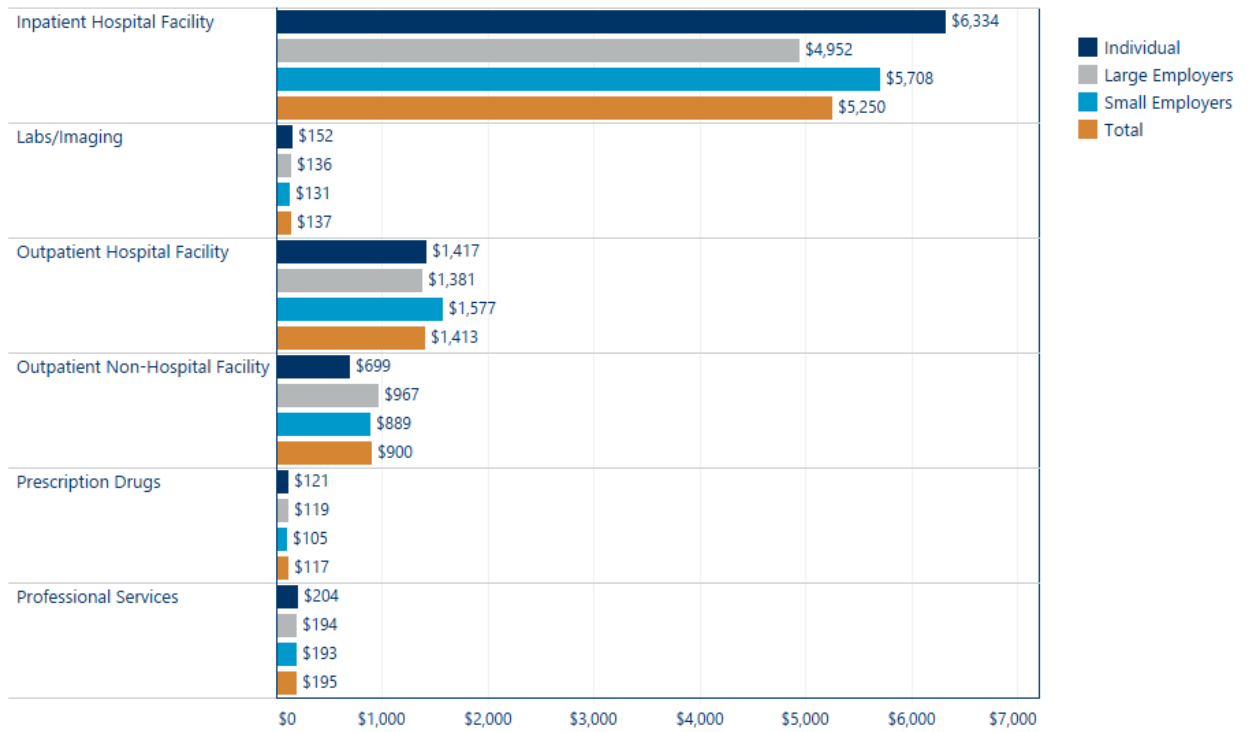
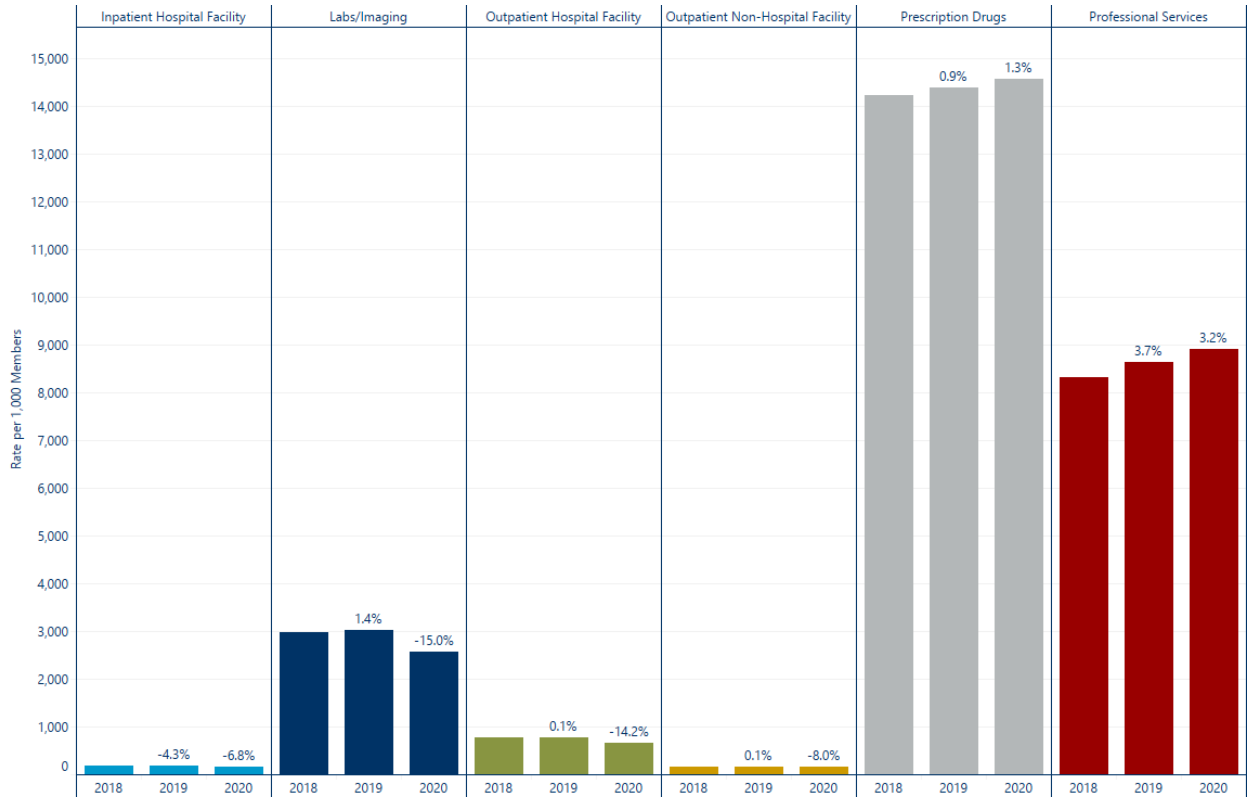


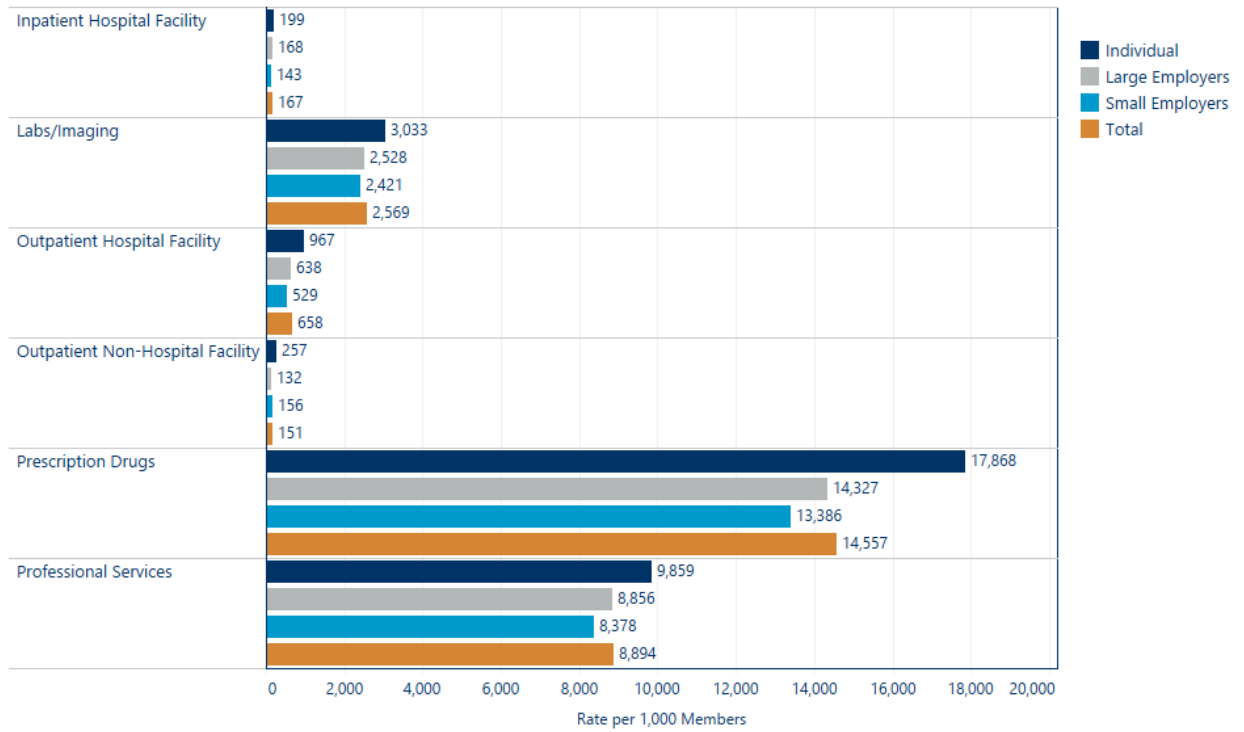
Exhibit A3. Percent Change from Prior Year in Utilization by Service Category for Privately Insured Markets in Maryland (2018–2020) *



* Please note that the percent change for 2017–2018 was not available for inclusion in this exhibit.



Exhibit A4. Utilization per 1,000 Members by Service Type, Privately Insured Markets in Maryland (2020)



Per Member Spending by Age in Maryland's Privately Insured Markets (2020)

Member age has a significant influence on health care spending. The cost variation by age group, illustrated in **Exhibit A5**, is an important element in understanding the impact of demographic factors on health care cost and utilization.

The large employer market had the largest share of privately insured individuals aged 0–18 years, who typically are the least expensive population to insure, accounting for 77.8% of this age group. In contrast, the 0–18 years age group comprised only 6.7% of the individual market and 15.5% of the small employer market.

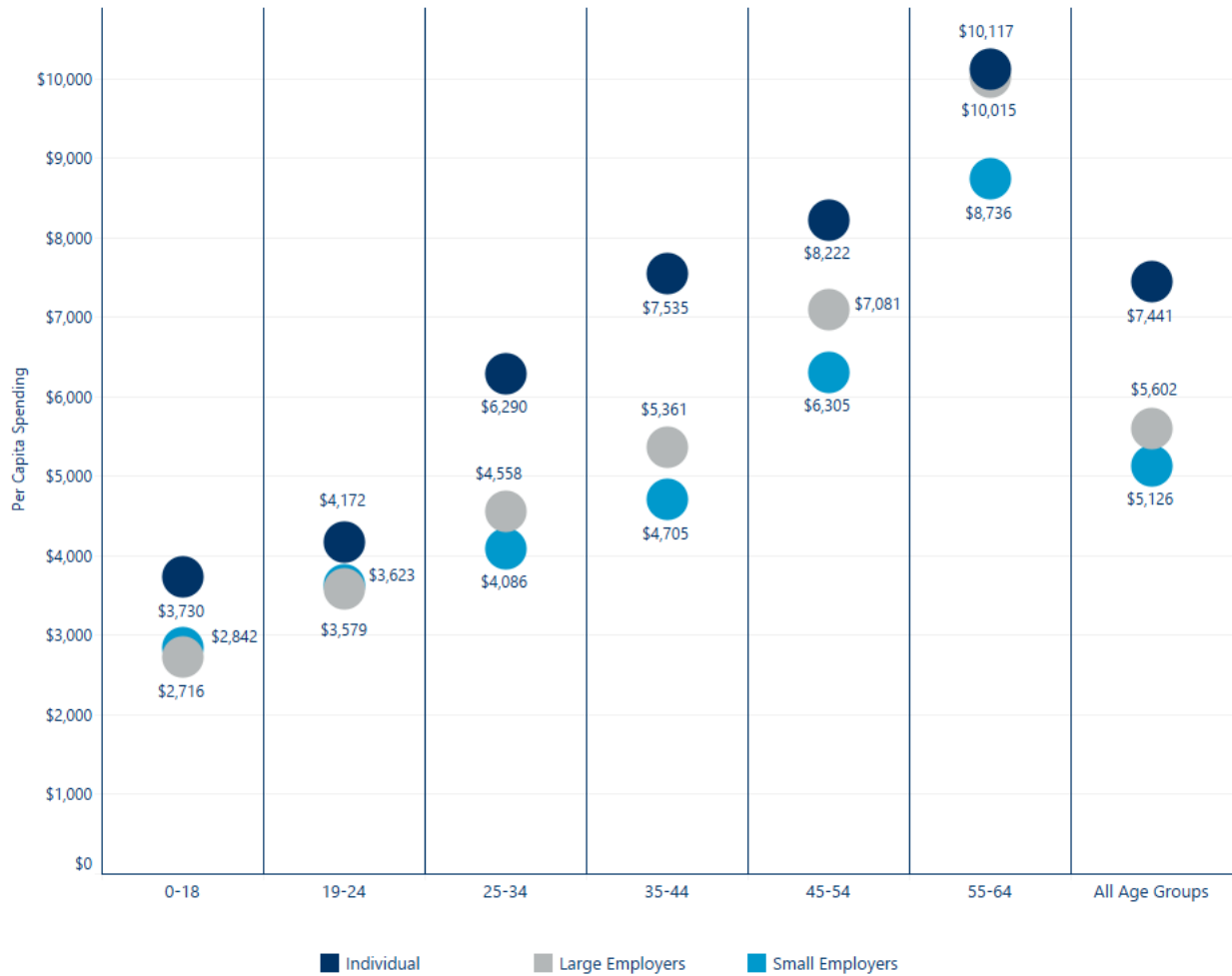
While the most expensive age group, members aged 55–64 years, accounted for 19.1% of all privately insured members, this group comprised 28.1% of the individual market, which affected total per member spending for this market. This age group accounted for 18.0% of the large employer market and 17.7% of the small employer market.

Exhibit A5 illustrates the following:

- As in previous years, 2020 per member spending increased with age across all markets.
- In 2020, the individual market had the highest per member spending across all age groups.
- The 0–18 years age group has the lowest per member spending across all markets.



Exhibit A5. Per Capita Spending by Age (in Years) for Privately Insured Markets in Maryland (2020) *



* Note: The “All Age Groups” total does not match the total in Exhibit 3 due to some members not having ages in the data.



Per Member Spending by Region in Maryland's Privately Insured Market (2020)

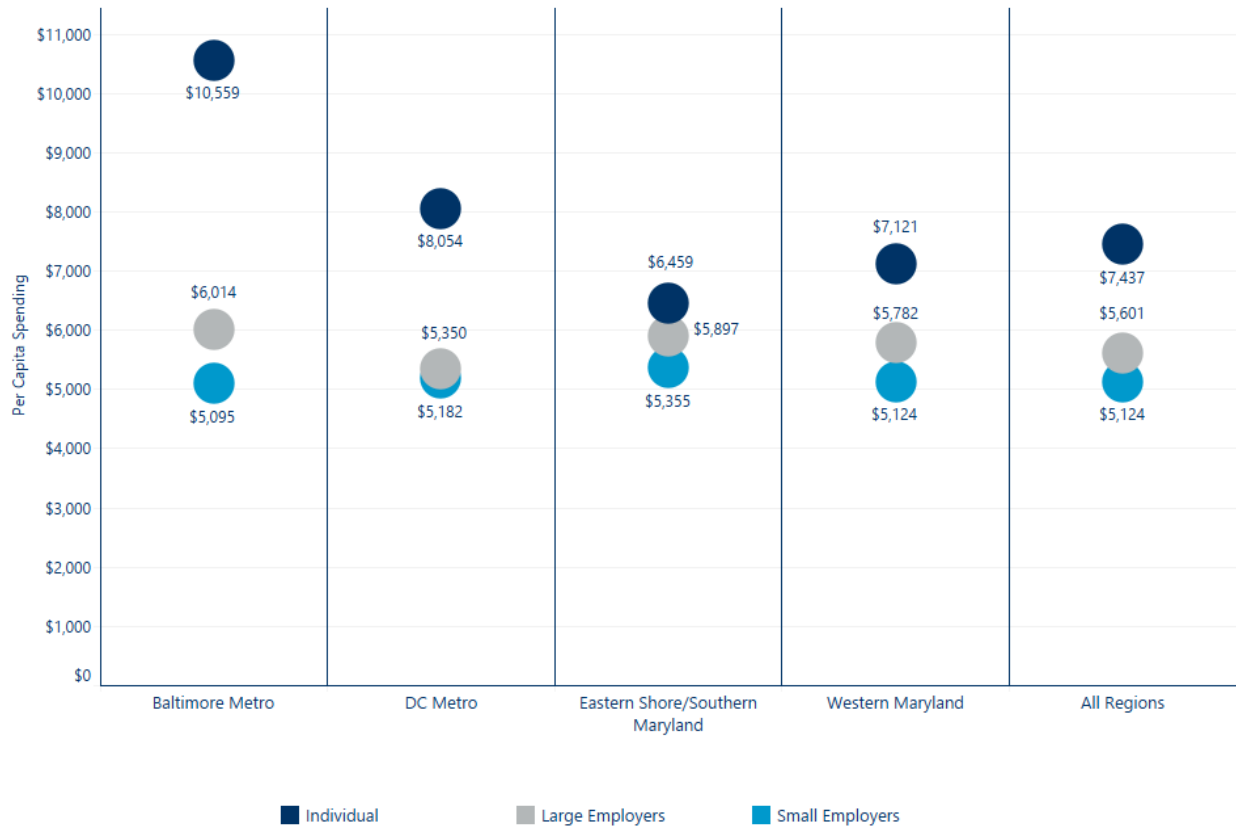
Geography plays an important role in both utilization and cost of health care services. This section of the report compares spending in all Maryland regions to four geographic areas: Baltimore Metro, DC Metro, Eastern Shore / Southern Maryland, and Western Maryland.

Exhibit A6 illustrates the following:

- In all regions, per member spending in 2020 was highest in the individual market and lowest in the small employer market.
- The Baltimore Metro region displayed the most variation in cost across markets, with per member spending in the small employer market (\$5,095) less than half of per member spending in the individual market (\$10,559).
- The individual market showed the most variation in per member spending across regions, ranging from \$6,459 per member in the Eastern Shore / Southern Maryland region to \$10,559 in Baltimore Metro.
- The lowest per member spending in the individual market (\$6,459 in the Eastern Shore / Southern Maryland region) was still higher than the highest per member spending in the other two markets (i.e., \$6,014 in the large employer market in Baltimore Metro and \$5,355 in the small employer market in the Eastern Shore / Southern Maryland region).
- The small employer market showed the least variation in per capita spending, ranging from a low of \$5,124 per member in the Western Maryland region to \$5,355 per member in the Eastern Shore / Southern Maryland region.



Exhibit A6. Per Member Spending by Region & Market (2020)



Appendix B: Definitions & Methods

Data Sources

This report's figures and tables are based on 2018, 2019, and 2020 data 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 insured Maryland residents under the age of 65 years.

Markets

Large Employer: The large employer market refers to businesses with more than 50 full-time employees. All Federal Employees Health Benefits (FEHB) medical data were excluded from the report.

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, including on the Maryland Health Benefit Exchange.

Individual Plan Types

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

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

On-Exchange: This plan type includes ACA-compliant products sold on the Maryland Health Benefit Exchange.

Off-Exchange: This plan type includes ACA-non-compliant products sold off the Maryland Health Benefit Exchange.

Service Category Descriptions

Inpatient Hospital Facility: This category includes non-capitated facility services for medical, surgical, maternity, behavioral health, substance use disorder, skilled nursing, and any other services provided in an inpatient facility setting and billed by the facility.

Outpatient Hospital Facility: This category includes non-capitated facility services for surgical, emergency room, lab, radiology, therapy, observation, and other services provided in an outpatient hospital facility setting, including hospital outpatient departments and free-standing medical facilities billed by the facility.

Outpatient Non-Hospital Facility: This category primarily includes services provided at ambulatory surgery centers, outpatient rehabilitation facilities, clinics, and Home Health outpatient centers.



Professional Services: This category includes non-capitated primary care, specialist, therapy, professional components of laboratory and radiology, and other professional services. This service category also includes “Other Medical” such as non-capitated ambulance, Home Health care, durable medical equipment (DME), prosthetics, supplies, and other services. This category excludes vision exams and dental services not collected in the MCDB.

Lab/Imaging (Radiology) Services: This category includes professional claims with procedure codes classified as imaging or tests using the Restructured BETOS Classification System (RBCS).

Measures

ACG Risk Score: The ACG risk scores included in this report were based on the Johns Hopkins ACG® Software System (©1991-2014, Johns Hopkins University, All Rights Reserved), a risk stratification system that assesses the risk of current utilization based on diagnoses reported in the claims data. A patient file (identifying an eligible individual) was merged with diagnosis codes to produce a series of risk factors and risk scores in straightforward terms. This report used v12 of the Johns Hopkins ACG® Software System, with an updated ICD-10 CM mapping file (Version 12.0; release date: December 18, 2019) to calculate an unscaled concurrent risk score.

Per Member Spending: This amount was calculated as the total aggregate spending during the calendar year (with three months of claims run-out) divided by the number of years insured for all members. Per member spending for medical services and prescription drugs was calculated separately because not all members had prescription drug coverage. All claims incurred in 2020 but paid through March 2021 excluded adjustments for incurred but not reported claims.

Out-of-Pocket (OOP) Spending: This amount was calculated based on the member's cost-sharing responsibility (i.e., the sum of the member's copay, coinsurance, and deductible amounts).

Number of Inpatient Days per 1,000 Members:

- **Inpatient Facility (Hospital and Non-Hospital):** This measure was calculated using the following formula:

$$(\text{Total Number of Inpatient Days} \div \text{Total Medical Member Months}) * 12 * 1,000$$

MHCC introduced the concept of annual per member spending in 2014 and started with admissions per 1,000 members to measure 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.

Number of Visits per 1,000 Members

- **Outpatient Facility:** This measure was calculated using the following formula:



$(\text{Total Number of Outpatient Visits} \div \text{Total Medical Member Months}) * 12 * 1,000$

- **Professional Services:** This measure was calculated using the following formula:

$(\text{Total Number of Visits for Professional Services} \div \text{Total Medical Member Months}) * 12 * 1,000$

- **Lab/Imaging Services:** This measure was calculated using the following formula:

$(\text{Total Visits for Labs and Imaging Services} \div \text{Total Medical Member Months}) * 12 * 1,000$

Number of Scripts per 1,000 Members

- **Prescription Drugs:** This measure was calculated using the following formula:

$(\text{Total Number of Prescriptions Filled} \div \text{Total Pharmacy Member Months}) * 12 * 1,000$

Unit Cost: The unit cost was calculated using the following formula:

$\text{Insurer's Allowed Amount} \div \text{Utilization Count (e.g., number of visits) for that type of service category or drug}$

Notes

Prescriptions have been “normalized” or adjusted to be 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 had medical benefits throughout the reporting period (i.e., 2018, 2019, and 2020).

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

This year’s report bases CPT codes on the Restructured BETOS Classification System (RBCS). In the 2019 annual report, the BETOS 1.0 categorization was used. Therefore, results may vary between the 2019 and 2020 reports.

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

Baltimore Metro: Anne Arundel County, Baltimore City, Baltimore County, Harford County, and Howard County

DC Metro: Montgomery County and Prince George’s County

Eastern Shore / Southern Maryland: Calvert County, Caroline County, Cecil County, Charles County, Dorchester County, Kent County, Queen Anne’s County, Somerset County, St. Mary’s County, Talbot County, Wicomico County, and Worcester County



Western Maryland: Allegany County, Carroll County, Frederick County, Garrett County, and Washington County

Payers Excluded from the Report

The report excludes the following payers (i.e., insurance carriers and third-party administrators or “TPAs”) due to identified data quality issues:

- American Specialty Health (TPA) – This TPA reported virtually no data.
- Harrington Insurance (TPA) – No inpatient claims were reported for September 2018, and data was missing sporadically for other months despite having a significant number of insured members (n ~ 1,000).
- Healthscope (TPA) (public plan only) – No data was reported for this TPA’s public employee group, and no large group inpatient data was reported for January 2018 and October 2018 despite large group members (n ~ 2,300).
- Kaiser – Fee-for-service equivalents were not available from payer.
- UnitedHealthcare Medicare Advantage – Medicare data were excluded from this report.

Required Proprietary Rights Notices on the Privately Insured Report

The expenditure risk score information contained in this report has been processed by a software called The Johns Hopkins ACG® System ©1991-2014, Johns Hopkins University, All Rights Reserved, Version 12. The Unscaled Concurrent Risk Score was used.

Acknowledgments

This report on health care spending and use was conducted by the following staff members from the Center for Analysis and Information Systems staff at the Maryland Health Care Commission:

- Kenneth Yeates-Trotman, *Director*
- Shankar Mesta, *Chief, Cost and Quality*
- Janet Ennis, *Chief, Special Projects*
- Oseizame Emasealu, *Methodologist*

Support for this report was provided by Onpoint Health Data, the MHCC’s contracted data management vendor for the Maryland Medical Care Data Base:

- Jennifer Dodge, *Senior Health Data Analyst*
- Karl Finison, *Director of Analytic Development*
- Tae Park, *Health Data Analyst*

Questions about the report should be directed to Shankar Mesta at shankar.mesta@maryland.gov.



About the Maryland Health Care Commission

The Maryland Health Care Commission (MHCC) is an independent regulatory commission administratively located within the Maryland Department of Health. Andrew N. Pollak, MD, serves as the MHCC's chairman, and Ben Steffen serves as the MHCC's Executive Director.

The Maryland Health Care Commission's contact information follows:

- **Address:** 4160 Patterson Avenue; Baltimore, MD 21215
- **General information number:** 410-764-3460
- **Toll-free number:** 877-245-1762
- **TTY number:** 800-735-2258
- **Fax number:** 410-358-1236
- **Website:** <https://mhcc.maryland.gov>





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