# Practitioner Utilization: 2003-2004

# Trends within Privately Insured Patients

Maryland Health Care Commission
April 20, 2006

# Report Organization

1. Introduction - Use of practitioner services for under-age-65, privately-insured MD residents.

2. Trends in Payment for Practitioner Services

New Item

3. Utilization and Intensity of Practitioner Services in Maryland

Expanded

4. Cost Sharing For Practitioner Services

# Changes in Patients and Expenditures 2003-2004

- The number of privately insured patients declined.
  - Number treated by HMOs grew and those treated by non-HMOs declined.
  - Consistent with recent coverage reports.
- Spending growth per capita appears to be slowing.
  - Growth was driven by 1-2% increases in fees.
  - 1% increase in resource use per patient.

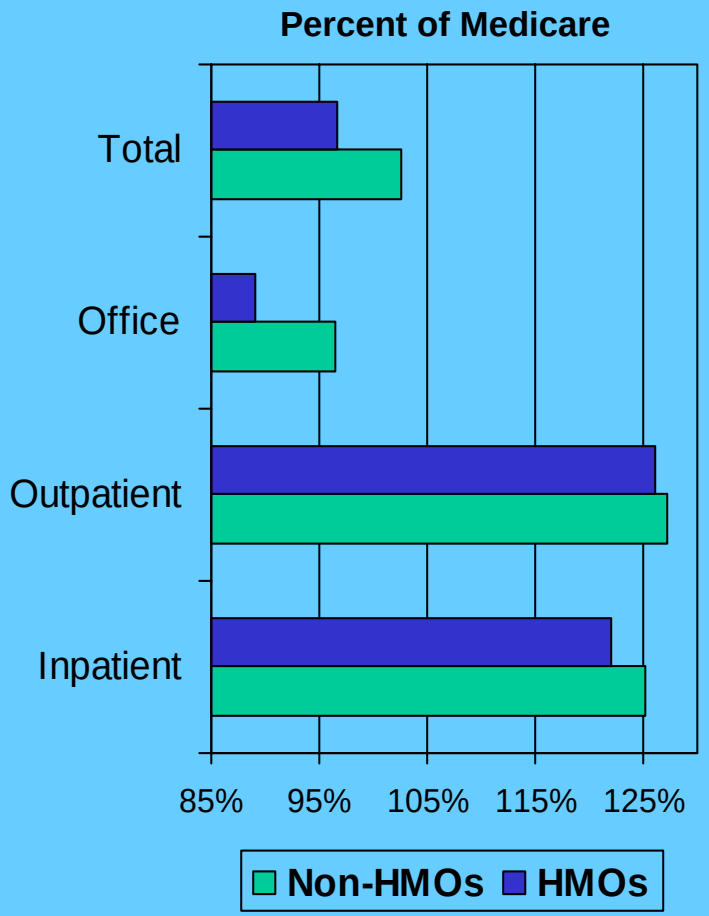
# What Do We Know About the Distribution of Services?

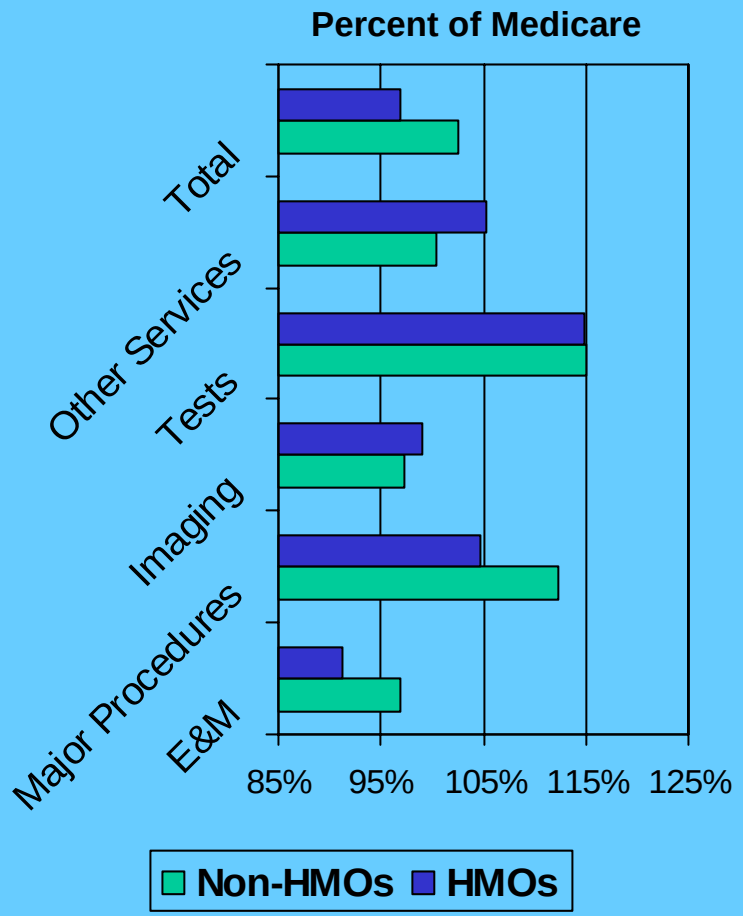
- Routine visits and consultations account for nearly half of all care, major & minor procedures account for one-quarter.
- About three-fourths of services are provided in non-hospital settings.
- Large payers reimburse over three quarters of all non-HMO services and just over two-thirds of care under HMOs.
- Most services are provided by participating providers.

# Private Sector Fees – Comparisons with Medicare

- In the aggregate, the average private non-HMO fee is 3% above Medicare, and the average HMO-FFS fee is 3% below Medicare.
- Input costs in Maryland are generally above national average.
- In the U.S., the average private fee is about 123% of Medicare.
- Differences in fee levels between large payers and other payers in Maryland market.

# Private Fees Relative to Medicare Vary by Place of Service and Type of Service

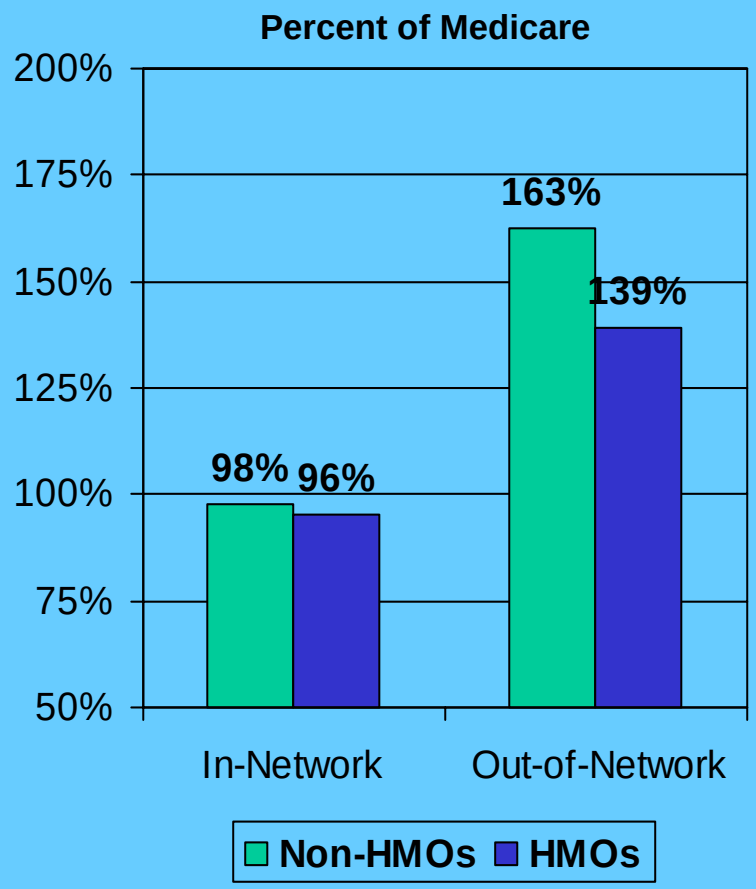



On average Non-HMOs paid $40 per RVU, HMOs $38 per RVU.

Does not include bonuses paid by plans to participating providers.

# Differences Between Participating and Non-Participating Fees Fuel Policy Debate

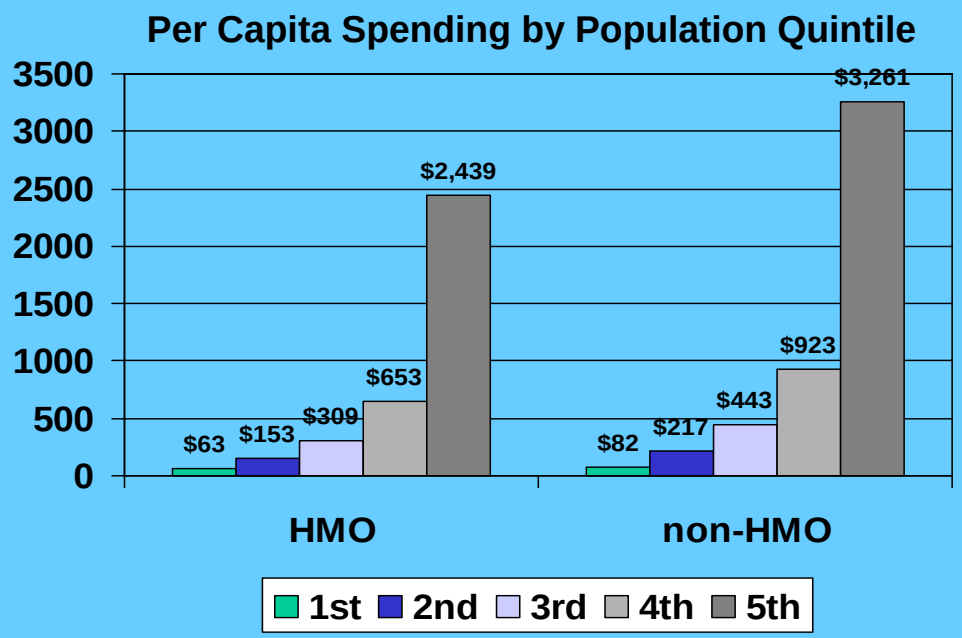



- MHCC estimates that non-participating providers account for 6% of payments in HMOs and 11% in non-HMOs.
- Use of non-participating providers is significant in hospital settings. About 30% of emergency medicine payment is to non-participating doctors.
- Current law sets minimum payment for non-participating providers in HMOs.
- Non-participating providers for non-HMOs bill UCR.

Does not include bonuses paid by plans to participating providers

# Small Share of Patients Account for Majority of Spending

- Patients in the top quintile of users account for 66% of spending.
- Per capita spending in the top quintile is 40 times that in the lowest quintile.
- Pattern is consistent for HMOs and non-HMOs.
- Top quintile's share is less dramatic than for all health care services.
  - Hospital expenditures drive spending for high cost users.



# Patient Share of Spending

- Small increase in out-of-pocket share from 2003 to 2004.
- Patients' share lower in HMOs (12%) than non-HMOs (20%)
  - HMOs offer fixed co-payments, not coinsurance, in lieu of choice.
- Lowest patient share in public employee plans, highest in individual market.
- CSHBP cost-sharing higher than other private products, but lower than individual products. Overall cost-sharing was stable to just slightly higher 2003-2004 (19%-20%).
- Cost sharing declines as level of spending increases.

# Conclusions

- Modest fee increase first reported in 2002 continued in 2004. Overall fees are about 5% higher than 1999. Input prices increased 19%.
- Physician fees track with average Medicare fees. Difference between HMO and non-HMO average payments is small.
- Significant variance in fees by type of service and place of service.
- Differences between in-network and out-of-network rates are dramatic.
- CSHBP patient shares of costs are above, but relatively close to other group products.

# Price Transparency

- **Work with plans and providers to promote consumerism.**
  - Payers are moving toward high performance networks -- providers whose prices are lower or who are deemed to be higher quality or more efficient.
  - Goal is to combine cost, efficiency and quality information.
  - Managed care remains a powerful force in negotiating discounts for enrollees.

- **Need to be realistic and practical about MHCC data.**
  - Existing information gap is wide.
  - For insured, insurers hold more extensive information.
  - No specific physician identification in MHCC data.

# Price Transparency (continued)

- **Pricing information may be helpful to uninsured.**
  - A significant gap exists between participating fees and billed fees (non-participating).
  - Focus on bundled services, office visits, diagnostic tests, some ambulatory procedures.
  - Limit to common specialties.