FINAL

Privately Insured Spending and Use 2018 Report

Commission Meeting

May 21, 2020

MARYLAND HEALTH CARE COMMISSION

Background

This report examines health care spending and utilization patterns for privately-insured individual, small employer, and large employer markets.

The analysis relies on 2016, 2017, and 2018 data from Maryland's Medical Care Database (MCDB), which contains health insurance enrollment, health care claims of Maryland residents*.

This report is limited to data for Maryland residents who are enrolled in fully-insured and self-insured non-ERISA health plans and under 65 years of age.

Study variation by market segment, geography, age, and service category.

Two additions to the 2018 report: Primary Care Spending and Most Expensive Prescription Drugs among privately insured.

** We excluded the Federal Employee Health Benefit Program PPO data from this year's report because of reporting restriction imposed by the Office of Personnel Management (OPM)*

Challenges of Medical Care Data Base Development (APCD)

Policy actions that have reduced completeness of private market data

- Gobielle vs Liberty Mutual – Supreme Court affirmed the 2nd Circuit Court's ruling exempting ERISA-protected employer sponsored plans.
- Office of Personnel Management decision to claim an ERISA-equivalent exemption.

Technical challenges regarding collection and analysis

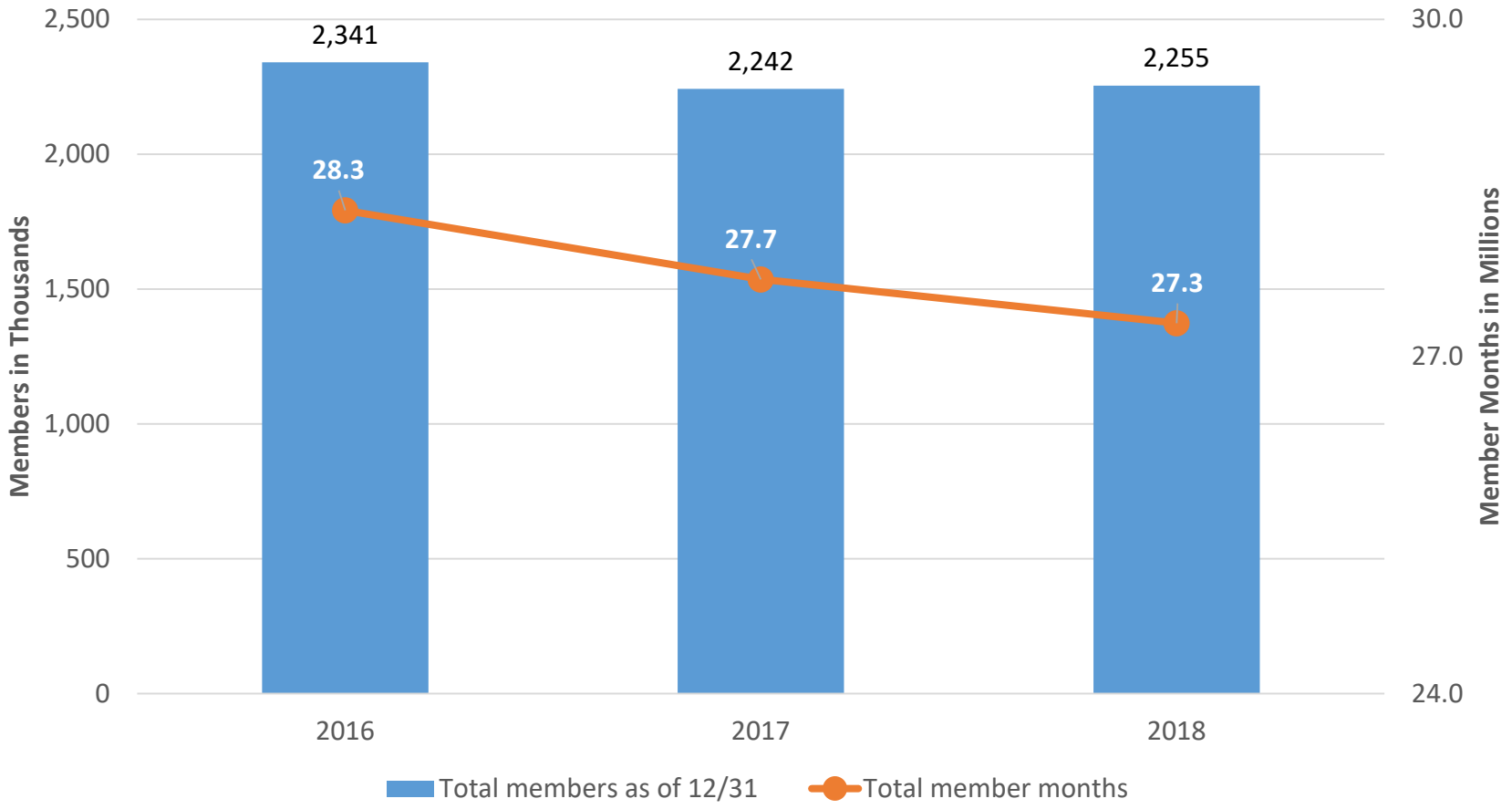
No standard submission format agreed to by all states.

Private payers inability to submit complete data.

Move toward alternate payment systems presents challenges.

Timeliness of information.

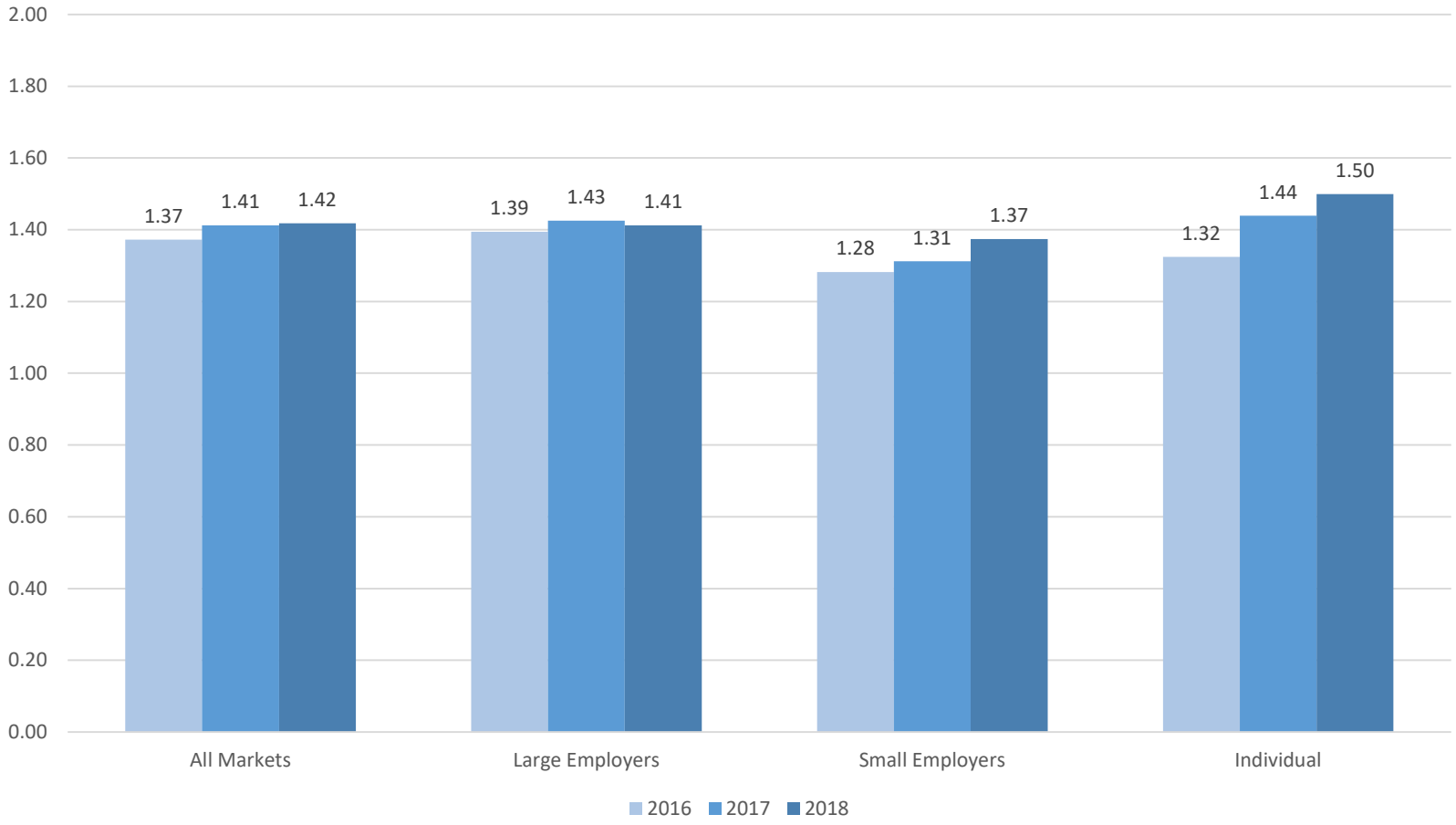
Enrollment Overview as of 12/31 and Member Month, All Markets Combined, 2016-2018



Includes Kaiser and FEHB PPO plans

Median Expenditure Risk Scores by Market Segment (2016 to 2018)

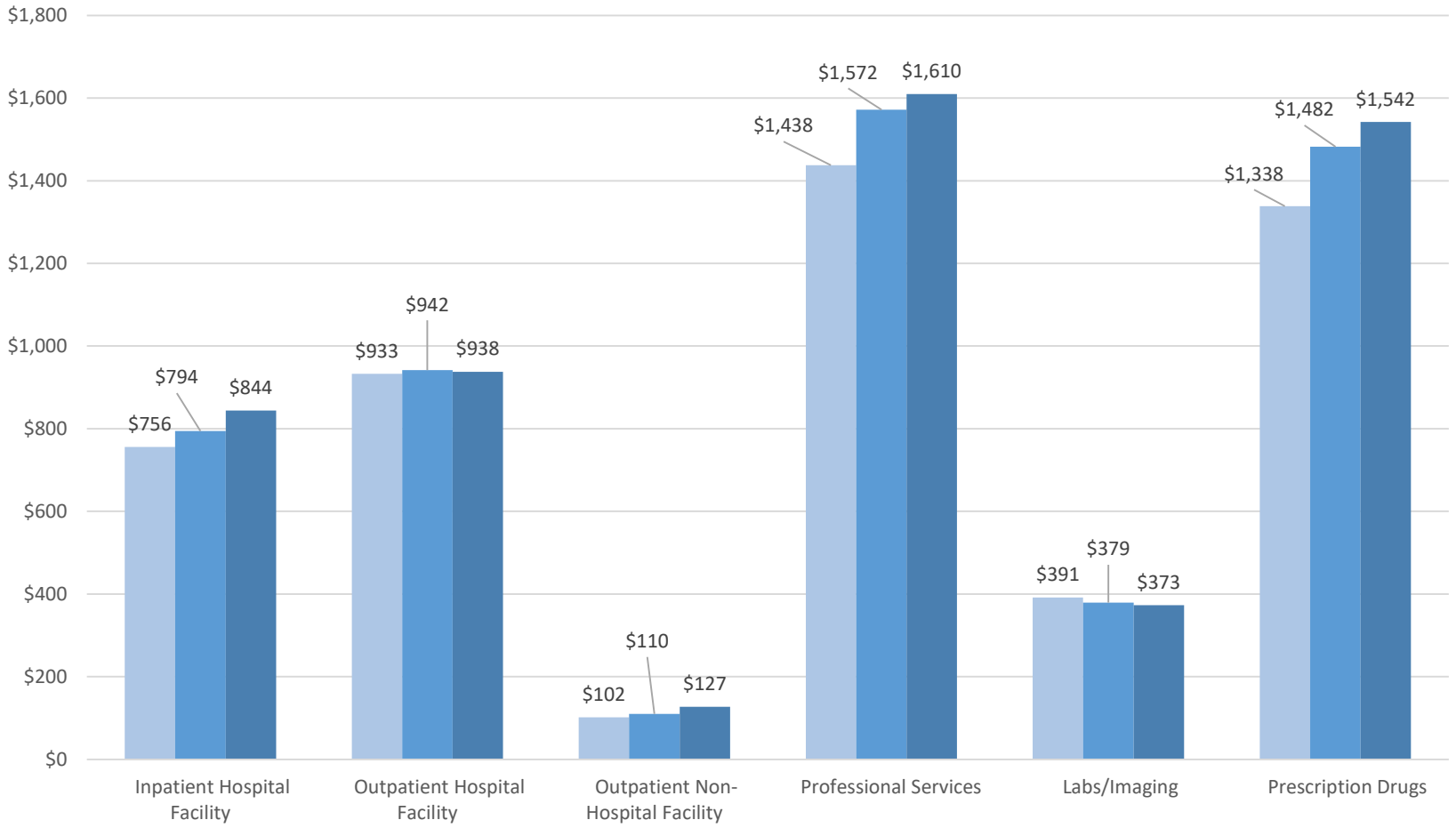
- Illness burden across all market segments increased marginally during 2018 in comparison to previous years.



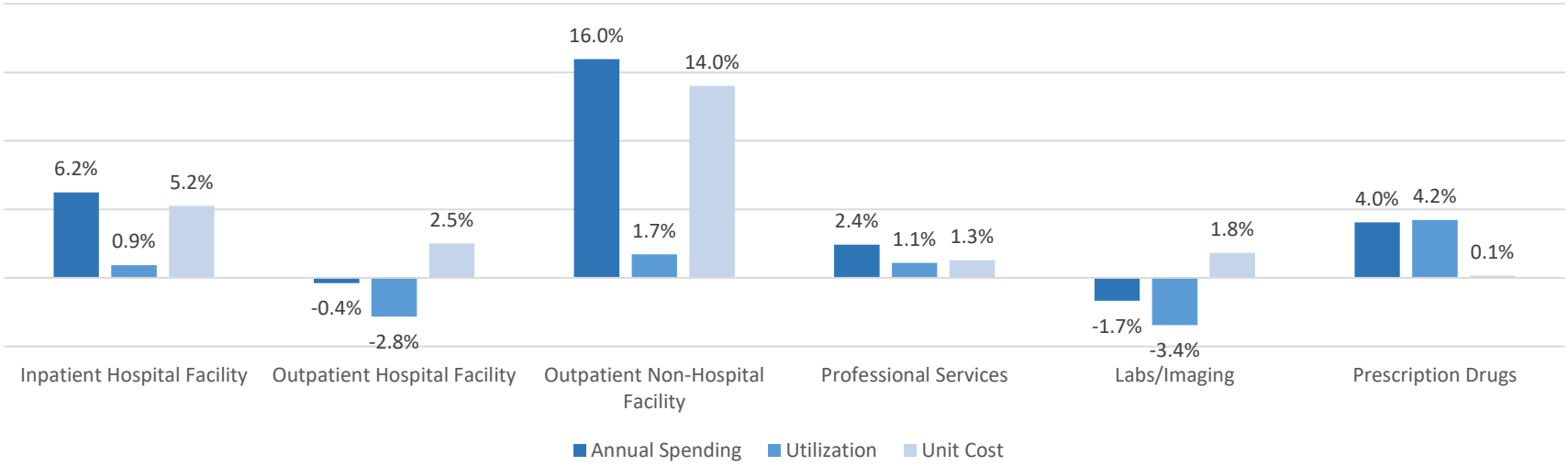
Excludes Kaiser. Results generated using the Johns Hopkins ACG® System Version 11.1, All Rights Reserved

Annual Spend By Service Category, All Markets, 2016-2018

An increase in inpatient hospital facility services per member spending was the primary contributor to the increase in spending for 2018



Annual Changes in Spending, Utilization, and Unit Cost By Service Category, All Markets, 2017-2018

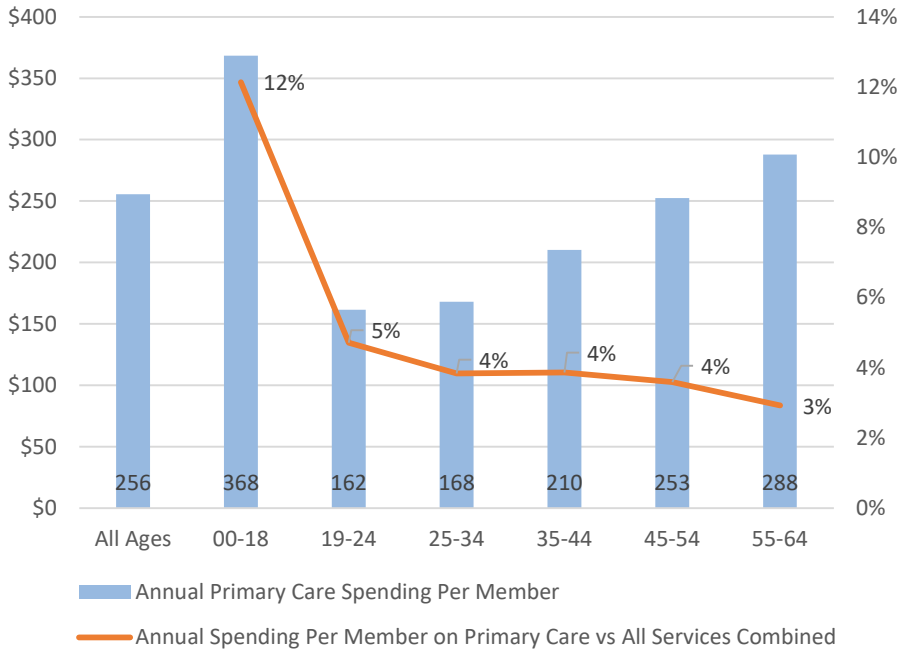


- Per member spending for inpatient hospital facility services increased due to an increase in unit cost compared to utilization as measured by inpatient days per 1,000.
- The overall increase in per member spending for outpatient non-hospital facility services was driven by an increase in unit costs and a small increase in utilization.
- For professional services, there was a small change in per member spending, due to small increases in both unit costs and utilization.

- Prescription drug per member spending also experienced a small increase due to small increases in utilization and the relatively flat trend in unit costs.

- For outpatient hospital facility services, per member spending fell due to utilization declining more than the increase in unit costs.
- The decrease in per member spending growth for labs/imaging services was driven by a decline in utilization, somewhat offset by an increase in unit costs.

Primary Care Per Capita Spending as a Percentage of Total Per Capita Spending* - 2018

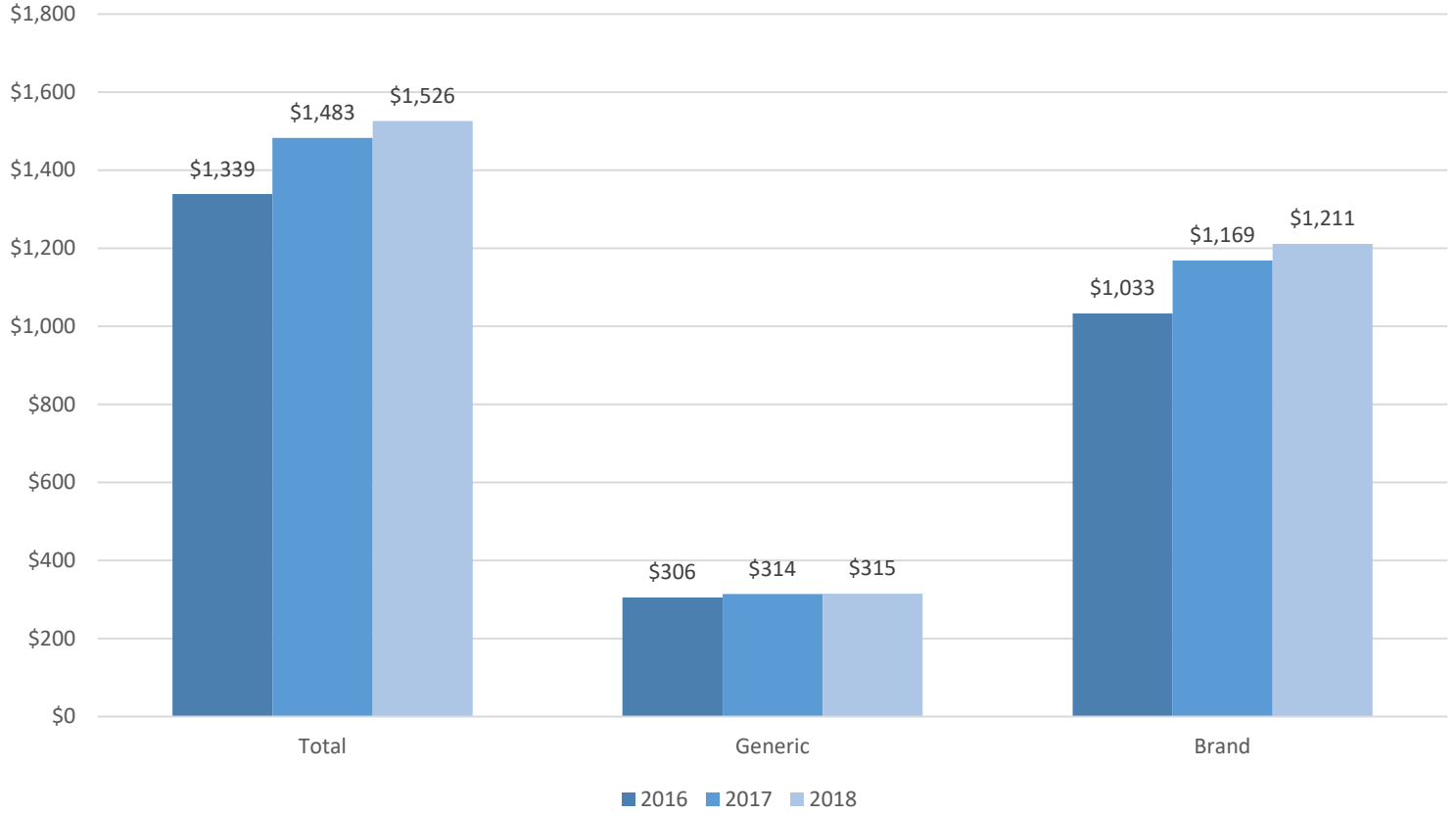


- The percentage of total spending on primary care was 4% in 2018.
- Percent spending on primary care was comparable to the national benchmark values reported by the Milbank Memorial Fund (6.0 (4.6-7.6) for PPO and 6.5 (3.1-9.2) for HMO in 2014).
- Other APCD states reported similar average spending rate on primary care:
  - Washington (4%)
  - Connecticut (5%)
  - Maine (6 – 7%)

* *Total Per Capita Spending include medical and prescription drug spending.*

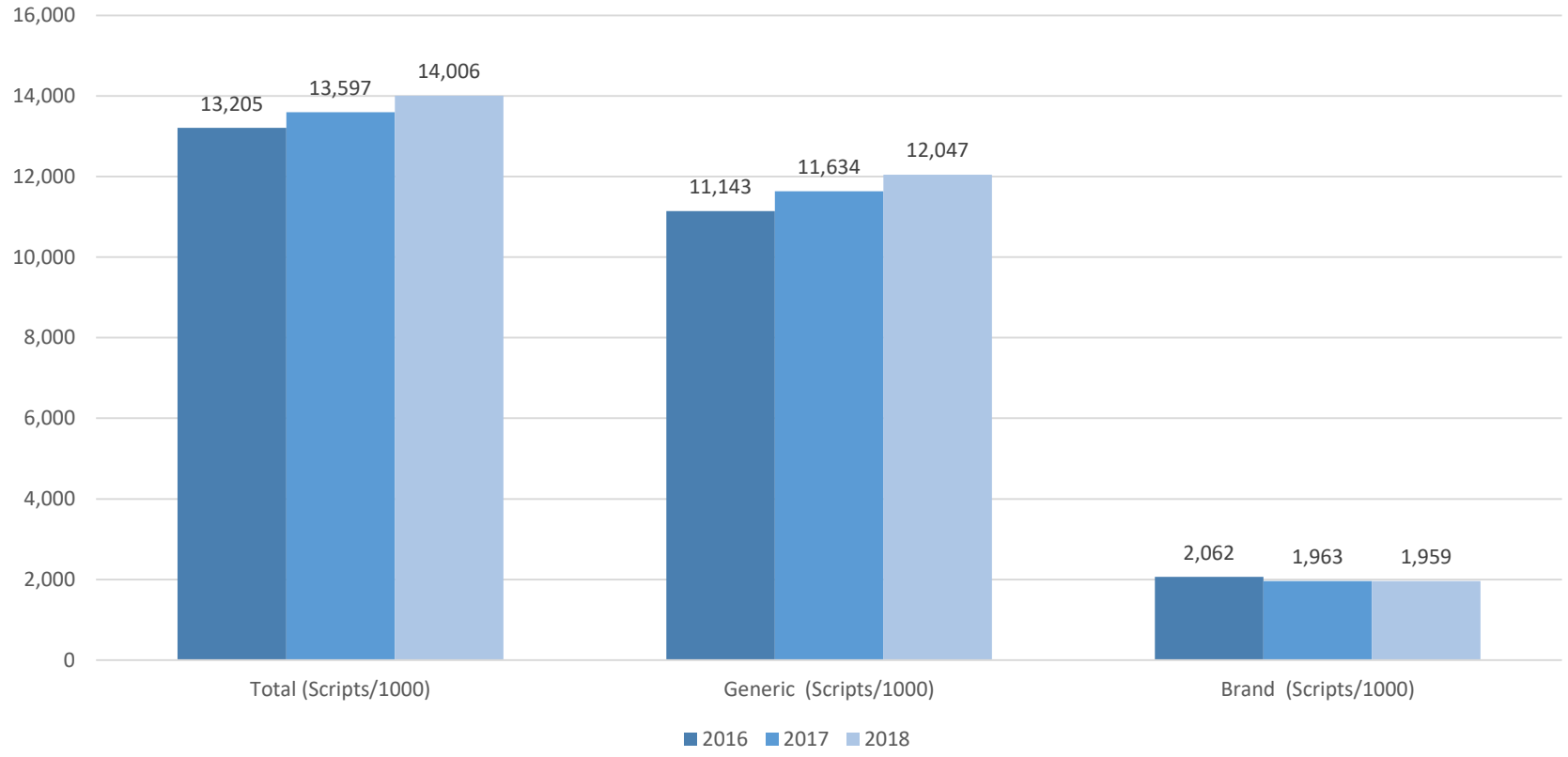
Prescription Drug Annual spending: Generic vs Brand
All Markets Combined 2016 - 2018

- Brand name drugs continue to be the majority of annual spending in comparison to generic drugs.

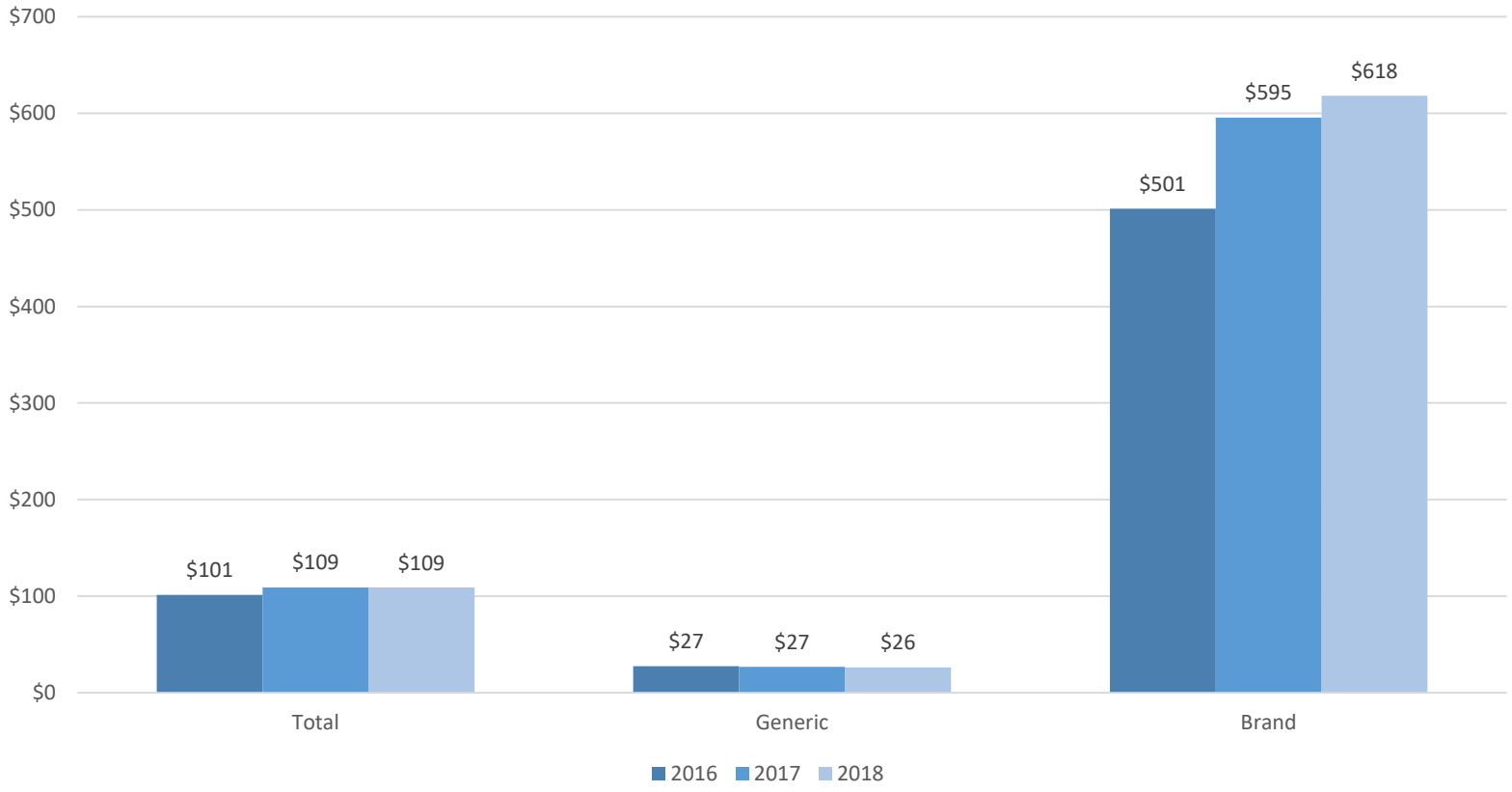


Prescription Drug Utilization: Generic vs Brand
All Markets Combined: 2016-2018

- Brand Drug utilization decreased marginally in 2018 compared to 2017 and 2016.
- Brand drugs comprised 13% of overall utilization compared to generic drugs.



Prescription Drug Unit Cost Changes: Generic vs Brand
All Markets Combined: 2016-2018



Top 25 Expensive Drugs By Spend, All Markets Combined, 2018

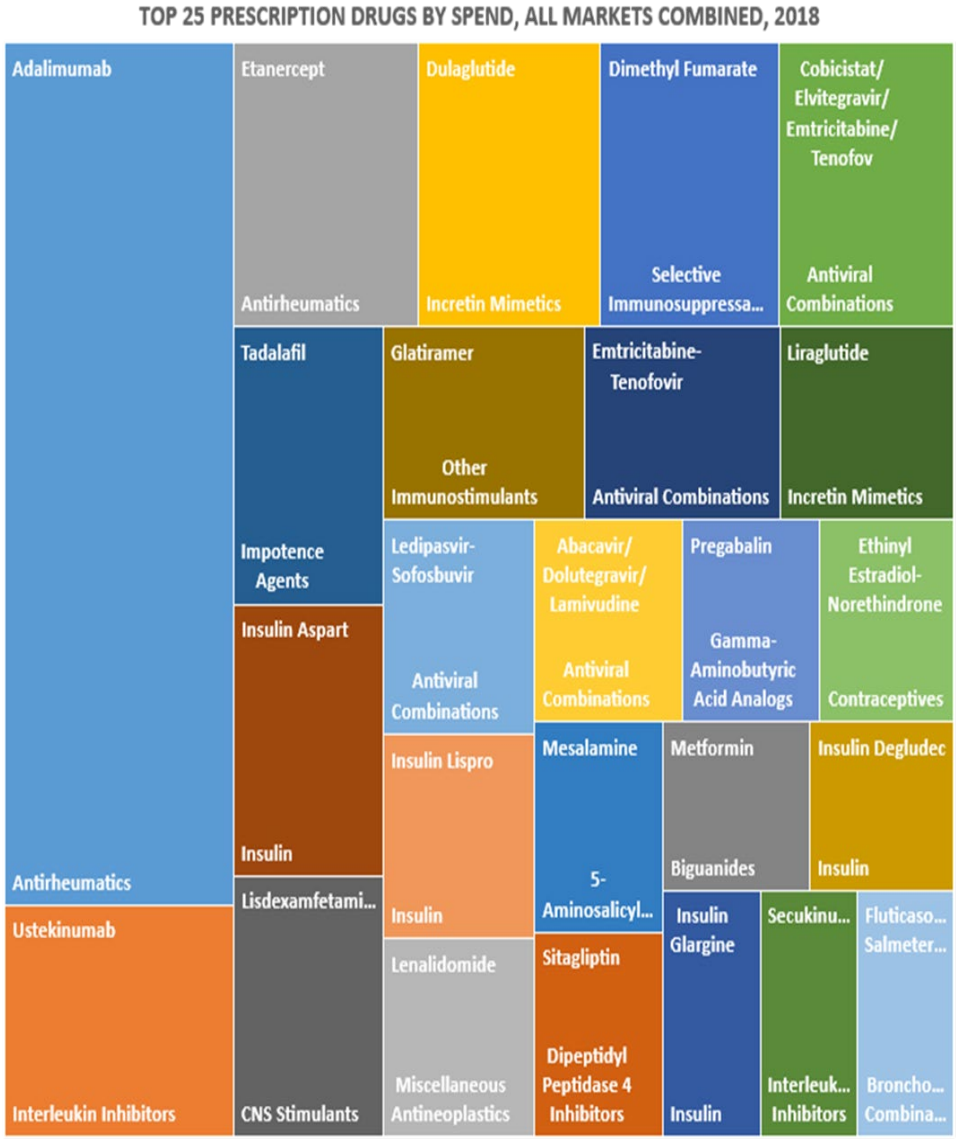
- Top 25 most expensive drugs comprised **8%** of total prescriptions but contributed to **37%** ($0.8 Billion) of the total prescription drugs spending ($2.1 billion)

- Biologics and anti-diabetes drugs comprised **56%** of top 25 most expensive drugs.

- **32%** (8) of the 25 most expensive drugs in MCDB were specialty drugs belonging to biologics category. The 8 biologics in the 25 most expensive drugs were

  - Humira Pen, Humira, Stelara, Enbrel and Cosentyx (prescribed for psoriasis and some types of arthritis)
  - Tecfidera, Copaxone, and Gilenya (prescribed for Multiple Sclerosis).

- 24% (6) of the 25 most expensive drugs in MCDB were anti diabetes drugs. Except for Trulicity (incretin mimetic) all other expensive anti diabetes drugs were insulin injections.

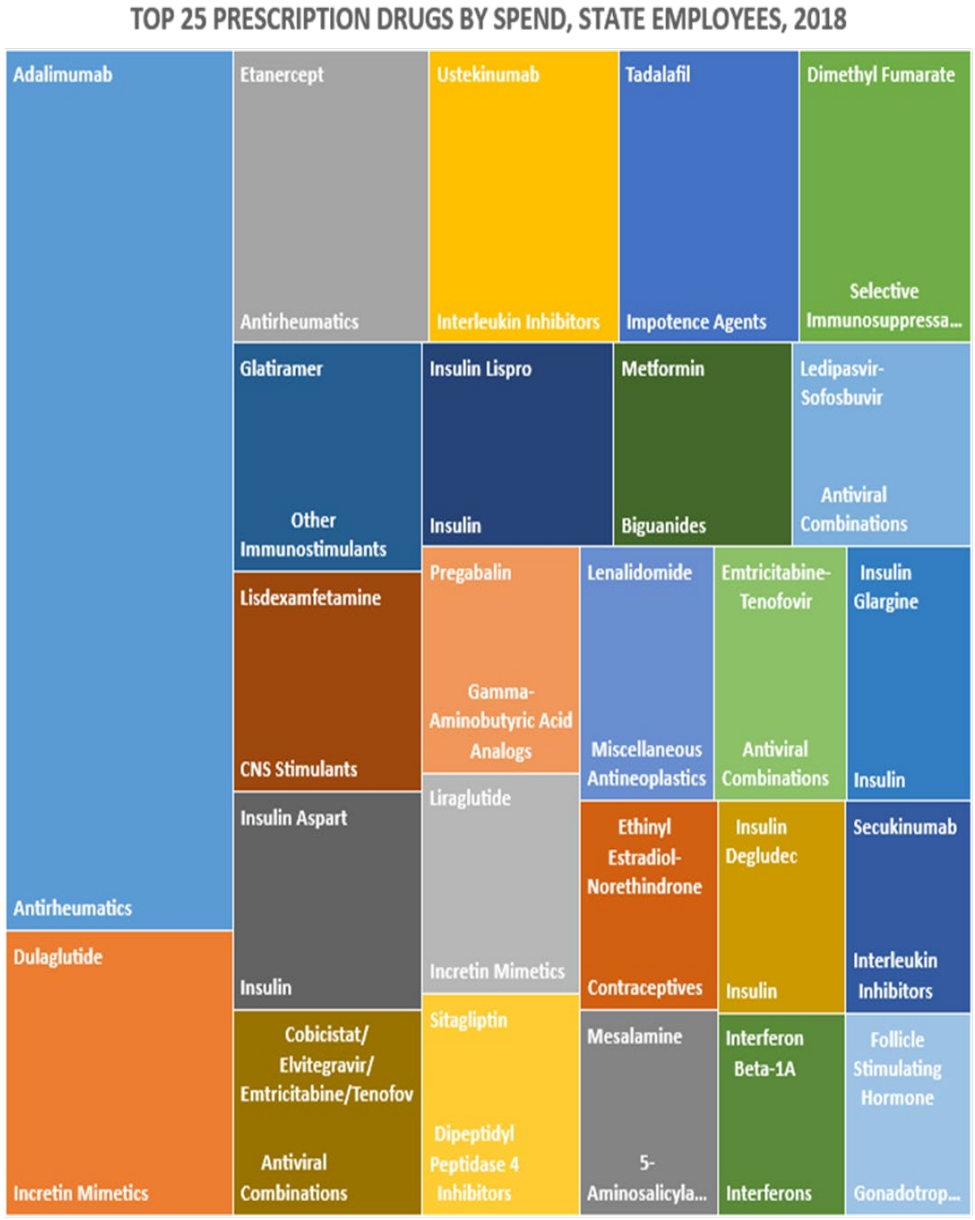


Top 25 Most Expensive Drugs, State Employees, 2018

- Annual prescription spending among State employees was approximately $**1 billion (47%)** compared to overall $2.1 billion in total prescription spending.

- Top 25 most expensive drugs comprised 8% of total prescriptions but cost **36% ($360 million)** of overall spending. This is comparable to all markets percentage cost share.

- Top 5 most expensive drugs among state employees were
    - Humira pen ($5,844 per prescription)
    - Trulicity ($708 per prescription)
    - Enbrel ($4,996 per prescription)
    - Stelara ($9,233 per prescription)
    - Tecfidera ($7442 per prescription)



Takeaway – Annual per member spending in 2018 increased by **2.9%** compared to 2017.

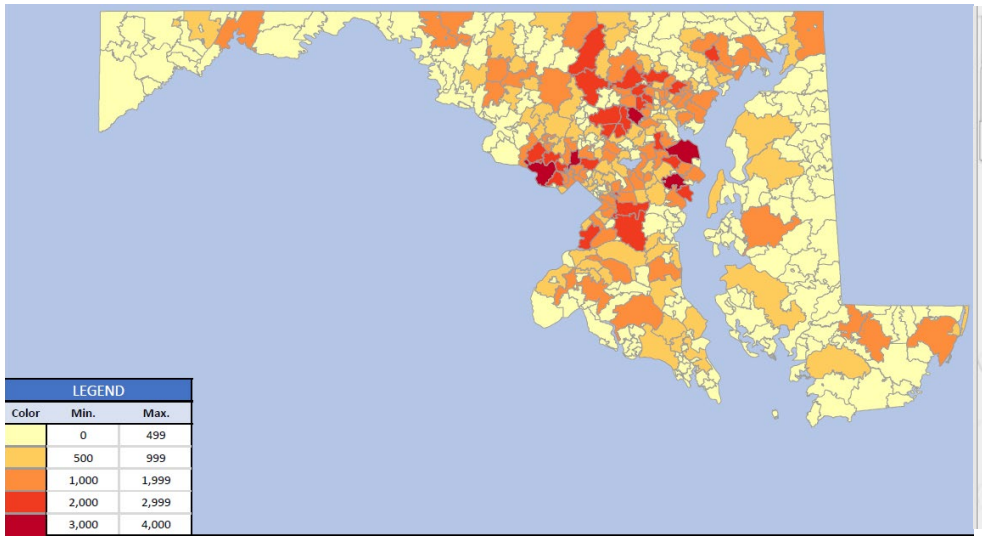
- Overall 2018 annual spending across all markets for all services, increased marginally by 2.9% in 2018 compared to about 6.5% in 2017.
  - Individual market spending grew by 15.8% in 2018 (up 0.5%) compared to 2017 which had about a 15.3 % increase.
  - Small group spending increased by about 4.9% in 2018 compared to 5.4% in 2017
  - Large group spending increased marginally by 1.8% in 2018 compared to 5.4% in 2017
- Maryland's privately insured population illness burden marginally increased from 2017 to 2018 at 1.42, for all markets combined.

Examples on How MCDB Can be used in COVID-19

Identify Members at Higher Risk From COVID-19*

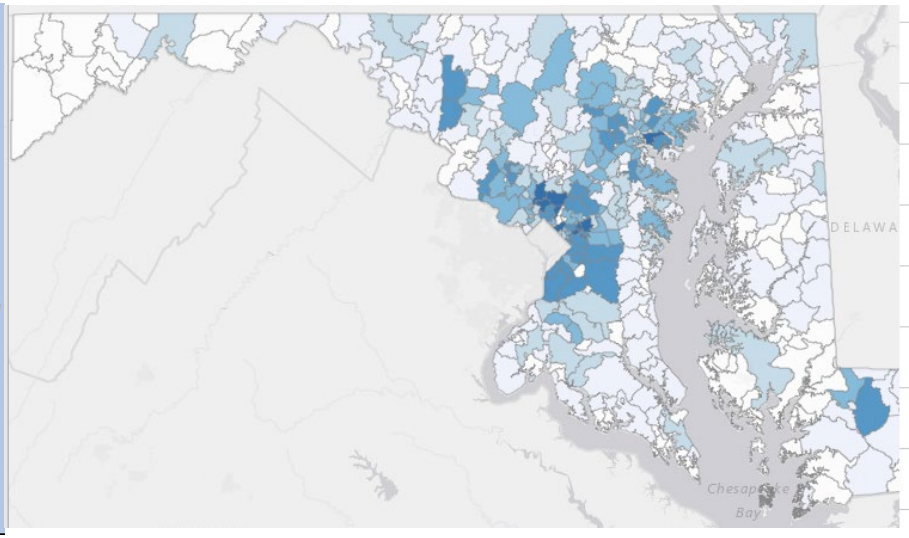
Vulnerable population defined as people ≥ 60 years old and are diagnosed with heart disease, diabetes, lung disease, hypertension, and cancer

Heatmap Calculated as of 04/09/2020



Source :Medical Care Data Base (MCDB)

MD COVID-19 Data Dashboard* as of 05/20/2020



Source :Maryland Emergency Management Agency

Top 5 Vulnerable Regions:

Zip Code	No. of Patients	City	County
21122	3,630	Pasadena	Anne Arundel
20906	3,500	Silver Spring	Montgomery
20854	3,476	Potomac	Montgomery
21401	3,210	Annapolis	Anne Arundel
21228	3,122	Catonsville	Baltimore

Identify Members with Mental Health Disorders

- Staff provided number of privately insured patients diagnosed with Mental Health Disorders to the Behavioral Health Administration

	Mental Health Disorders Patients by Age Group Distribution as of 12/31/2018										
	00-05	06-12	13-17	18-21	22-25	26-44	45-54	55-64	65+	Total	Total %
Anxiety	423	5,572	9,845	10,860	11,514	53,514	32,101	33,114	1,411	158,354	52%
Bipolar	3	71	517	1,226	1,656	5,118	2,815	2,908	137	14,451	5%
Depression	28	905	6,100	7,913	7,722	33,194	22,669	27,017	1,360	106,908	35%
Somatic Disorder	19	62	90	107	130	797	707	815	32	2,759	1%
PTSD	9	144	417	647	834	3,321	1,890	1,562	60	8,884	3%
Dissociative Disorder	5	36	84	119	61	209	154	176	9	853	0%
Unspecified Mood Disorder	204	824	2,006	1,283	965	3,858	1,820	1,742	84	12,786	4%
Total	691	7,614	19,059	22,155	22,882	100,011	62,156	67,334	3,093	304,995	100%

- Deputy Secretary requested counts of all Maryland residents who are receiving services for anxiety, depression, and PTSD statewide

- Data was provided by gender and county as well.

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Future Analysis using MCDB Relating to COVID-19

- Identifying Diagnosed COVID-19 cases in the MCDB
  - Use following ICD10 codes for claims incurred prior to 4/1/2020
    - B9729 code and one of the following encounters:
      - J1289 – Pneumonia
      - J208 – Acute bronchitis
      - J40 – Bronchitis, non-acute
      - J22, J988, J80 – Respiratory disease
      - R05 – Cough
      - R509 – Fever
      - R0602 -Shortness of breath
      - R430 – Anosmia (loss of smell)
  - Use following ICD10 code U071 for claims incurred on or after 4/1/2020
- Look at Telehealth utilization over time to see how it impacts healthcare spending for professional services

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Realities and Potential of Medical Care Data Base (APCD)

Significant Realities

- Most analytic systems used in health care policy operate use claim data.
- Best source to monitor performance of Maryland insurance markets – collaborations with MHBE and MIA
- Important to assess private market under TCOC
- Source of info for quality and cost transparency work
- Respond to evolving health issues

What we can do

- Increase integration with clinical data
- Address short term policy setbacks – OPM
- Accelerate timeliness and completeness of claim info
- Expand users

Required Proprietary Rights Notices on Privately Insured Report

- The information herein contained has been processed by a software called The Johns Hopkins ACG® System ©1990, 2016, Johns Hopkins University, All Rights Reserved

- Version 11.1 was used in the report to generate expenditure risk score results depicted on slide 5. The Unscaled Concurrent Risk Score was used.

- Version 11.1 was used to identify members at higher risk for COVID-19 as depicted on slide 16. The Johns Hopkins ACG® System team provided a custom-built filter that was applied in the software to identify high-risk, vulnerable individuals based on criteria outlined in a document provided by the Johns Hopkins ACG® System team.