MARYLAND HEALTH CARE COMMISSION

EXPERIENCE FROM 2007

STATE HEALTH CARE EXPENDITURES

Released March 2009 | Marilyn Moon, Ph.D., Chair | Rex W. Cowdry, M.D., Executive Director

MARYLAND HEALTH CARE COMMISSION

Each year the Maryland Health Care Commission (MHCC) reports on the state's expenditures for health care services in accordance with Maryland law. Our goal is to provide reliable information about trends in health care expenditures to help inform health policy deliberations among health policy experts, health care professionals, executives, and legislators.

In 2007, Marylanders spent an estimated $35.8 billion for health care services—including hospital care, practitioner services, prescription drugs, and long-term care. Per capita expenditures in Maryland grew 6 percent from 2006 to 2007, the same as the national growth rate, and the level of 2007 per capita spending in the state ($6,374) is near the national average. The growth in per capita spending in Maryland in 2007 is somewhat slower than the state's longer-term trend of 7 percent (average) per year since 2003. Nationally, per capita spending also grew 6 percent from 2006 to 2007, on par with the longer-term national trend of 6 percent from 2003 to 2007.

Maryland's higher longer-term growth trend in per capita spending compared to the national average—7 percent versus 6 percent—is due in part to the state's higher growth rate in spending for hospital services. Per capita expenditures for hospital services in Maryland grew nearly 50 percent faster than the national average—at an average annual rate of 9 percent versus 6 percent nationally—from 2003 to 2007.

Maryland is embarking on new initiatives regarding the cost and quality of hospital care, based on work that the MHCC and the Health Services Cost Review Commission (HSCRC) have pioneered. These initiatives include adding new evidence-based process measures to the Maryland Hospital Performance Evaluation System and launching new efforts to monitor and improve the rates of hospital-acquired infections through collaborative efforts with the hospital industry. In 2009, Maryland will introduce a new value-based purchasing initiative for hospitals. Maryland hospitals will receive reduced payments if highly preventable complications and events that should never happen, such as wrong-site surgery, occur during a hospital stay. Maryland will be the only state where hospitals are held accountable in this way for all admissions, not just for admissions of Medicare enrollees.

The report would not have been possible without the cooperation of other state agencies, the federal government, and private organizations that provided information. The Commission is grateful to these organizations for assisting the Commission's staff and contractors in the completion of this study.

Rex W. Cowdry, M.D.
Executive Director

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ACKNOWLEDGMENTS

This report required the assistance of many individuals and offices in state government, private industry, and federal government. In particular, the Maryland Health Care Commission (MHCC) wishes to note special contributions from the following individuals and organizations. Patricia Holcomb, Program Evaluation and Legislation, Maryland Department of Health & Mental Hygiene (DHMH), and Babi Lamba, Hilltop Center, University of Maryland-Baltimore County, provided Medicaid expenditure and enrollment information. John Newman, Budget Management Office, DHMH, and Steve Bass, Maryland Department of Corrections, supplied information on government spending. Cynthia Saunders of the Maryland Health Services Cost Review Commission provided estimates of hospital spending.

In constructing spending accounts of this complexity, the MHCC relied on estimates of private insurance expenditures supplied by Calvert Gorman of the Maryland Insurance Administration. As in previous years, Maribel Franey and Carleen Basso at the Centers for Medicare & Medicaid Services (CMS) assisted MHCC with the data use agreements that are necessary before Medicare information can be released. Sharon Tu in the federal government's Office of Personnel Management supplied information on federal employees' insurance coverage. Greg Woskow of TRICARE Management Activity provided spending information on CHAMPUS/TRICARE programs, and Sherri Dunford at the Department of Veterans Affairs provided similar spending data on VA programs. Anne Martin of the Office of the Actuary at CMS provided estimates of expenditures for nontraditional Medicare programs. Information from the Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS) was used in the estimation of private insurance allocations. Ray Kuntz at AHRQ provided advice on the use of the MEPS data files.

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SUMMARY

This report presents state health care spending by provider categories and sources of payment. The emphasis of this report is on changes in spending from 2006 to 2007, as well as the longer trend from 2003 to 2007. Spending levels and rates of growth in Maryland are compared with those for the United States.[1]

HOW MUCH DID MARYLAND SPEND FOR HEALTH CARE?

In 2007, Marylanders spent an estimated $35.8 billion for health care services—including hospital care, practitioner services, prescription drugs, and long-term care. Spending per capita in Maryland was near the national average in 2007, having grown at an average rate of 7 percent per year from 2003 to 2007, compared with a national average growth rate of 6 percent per year. In 2007, Marylanders paid $6,374 per person for health care services.

HOW WERE MARYLAND'S HEALTH CARE DOLLARS SPENT?

Hospital inpatient and outpatient care represent the largest single category of health care expenditures in Maryland, accounting for about a third of total health care expenditures in 2007. Together with expenditures for the administration and net cost of insurance, spending for hospital care is the fastest growing category of expenditures in Maryland. Per capita expenditures for hospital services grew nearly 50 percent faster than the national average—at an average annual rate of 9 percent, versus 6 percent nationally—from 2003 to 2007, accounting for 41 percent of the growth in total expenditures over that period.

Most of the growth in expenditures for inpatient care in Maryland from 2006 to 2007 (8 percent) was associated with higher charges per case, reflecting a policy decision beginning in 2004 to increase hospital payments above projected cost growth through 2007, to support recapitalization of the industry and a large rebuilding program. As a consequence, hospital operating profits in Maryland have grown faster than the national average. High growth in expenditures for outpatient care in Maryland (10 percent from 2006 to 2007) reflects not only growth in hospital rates but also growing use of hospital outpatient departments to obtain care. However, notwithstanding fast growth in expenditures for hospital care, Maryland residents continued to pay less per capita for hospital care ($2,069) in 2007 than the national average ($2,206).

[1] Throughout the report, amounts cited in the text may differ from the apparent sum of expenditures in the figures and tables due to rounding.

Access to and reimbursement of physicians and other health care professionals is an ongoing source of concern in Maryland, giving rise to a state Task Force on Health Care Access and Reimbursement that reported recommendations last year. In 2007, per capita expenditures for practitioner services in Maryland ($1,924) were slightly below the national average ($1,983). From 2006 to 2007, expenditures for practitioner services grew much more slowly than the national average (3 versus 5 percent). From 2003 to 2007, the growth in expenditures for practitioner services averaged 5 percent per year, compared with 6 percent nationally.

Per capita, Marylanders spend about 30 percent more for prescription drugs than the national average. In 2007, Marylanders paid $997 per person for prescription drugs, compared with a national average of $767. In 2006, the introduction of the Medicare Part D program picked up a significant amount of private spending for prescription drugs, as well as spending by Medicaid and other public programs, compared with earlier years. From 2006 to 2007, per capita expenditures for prescription drugs in Maryland increased 8 percent, faster than the 6 percent growth in prescription drug expenditures nationally. The faster rate of growth in Maryland may reflect greater insurance coverage for prescription drugs relative to the national average, differences in physician prescribing behavior, or both.

Expenditures for long-term care—including nursing home and home health care—account for about 11 percent share of total health care spending in Maryland. Per capita, Marylanders paid about 7 percent less for these and other miscellaneous health care services in 2007 ($826) than the national average ($892). Expenditures per capita for nursing home care are substantially higher than for home health care—$447 for nursing home care in 2007, compared with $230 for home health care services. This cost difference in part has motivated Medicaid to attempt to serve elderly and disabled beneficiaries in home and community-based settings when possible, driving faster growth in expenditures for home health care. From 2006 to 2007, expenditures for home health care increased 7 percent, while expenditures for nursing home care increased 5 percent.

After growth in expenditures for hospital care, expenditures for the administration and net cost of insurance have been the fastest growing component of health care expenditures in Maryland. In 2007, Marylanders spent $3.1 billion for the administration and net cost of insurance, equal to $559 per capita. Per capita, Marylanders spent about 10 percent more in this category than the national average, in part reflecting higher rates of private insurance coverage in the state. From 2003 to 2007, per capita expenditures for the administration and net cost of insurance grew at an average annual rate of 8 percent in Maryland, twice as fast as the national average. From 2006 to 2007, the rate of increase slowed to 5 percent, compared with 6 percent nationally.

Nationally, Medicare administration expenses have grown due to enrollment in Medicare Part D plans and Medicare Advantage (MA) plans. In Maryland also, enrollment in Medicare Part D and, to a lesser extent, MA plans (reflecting relatively low penetration of MA plans in Maryland) has contributed to the growth in the net cost of insurance. To date, Medicare Part D plans, in particular, have paid very low benefits per premium dollar.

WHO PAID FOR MARYLAND'S HEALTH CARE?

In 2007, private insurance and Medicare accounted for the largest shares of health care expenditures in the state—respectively, 39 percent and 23 percent—followed by consumer out-of-pocket spending. In 2007, Marylanders paid 19 percent of health care expenditures out-of-pocket. Medicaid (16 percent) and other government programs (4 percent) funded the balance.

As in past years, Medicare expenditures per enrollee in Maryland substantially exceeded the national average. In 2007, Medicare spent $11,294 per beneficiary in Maryland, compared with $9,824 nationally. Also as in past years, Medicare spending per beneficiary in Maryland grew faster—increasing 7 percent from 2006 to 2007, compared with 4 percent nationally. Much (43 percent) of the long-term growth in Medicare spending for Maryland beneficiaries from 2003 to 2007 was associated with growth in spending for hospital care. Other contributors to long-term Medicare spending growth included prescription drugs and practitioner services, which respectively accounted for 25 percent and 14 percent of Medicare spending growth from 2003 to 2007.

Medicaid expenditures per enrollee in Maryland grew faster than the national average from 2006 to 2007, continuing a longer-term trend of higher expenditure growth. In part, greater expenditures per Medicaid enrollee in Maryland as well as faster growth per enrollee reflect recent efforts to bring compensation to physicians and other health care professionals closer to Medicare payment rates. However, since 2003, payments to physicians and other health professionals accounted for about 16 percent of increased Medicaid spending, while greater spending for hospital care accounted for about half of increased Medicaid spending. Under Maryland's all-payer rate system, Medicaid paid the same rate for hospital care over this period as all other payers. Expenditures for home health care also increased rapidly over this period—accounting for 21 percent of increased Medicaid spending, reflecting the program's efforts to serve beneficiaries in home and community-based settings.

In contrast to high Medicare spending per beneficiary, private insurance expenditures per enrollee in Maryland remained well below the national average. In 2007, private insurance expenditures per privately insured person in Maryland were $3,330, compared with $3,811 nationally. Per capita insurance spending for health care increased faster than the national average from 2003 to 2007: at an average rate of 7 percent per year in Maryland, compared with 6 percent nationally. However, per capita private insurance spending grew more slowly from 2006 to 2007, by 5 percent in Maryland, as private insurance expenditures nationally continued to grow by 6 percent.

Growth in hospital services accounted for about 40 percent of the growth in private insurance expenditures from 2003 to 2007. Expenditures for physician and other professional services accounted for 30 percent, followed by expenditures for the administration and the net cost of insurance (14 percent) and expenditures for prescription drugs (13 percent).

Out-of-pocket spending for health care in Maryland is much greater than the national average and it has grown faster. In 2007, Marylanders spent $1,184 per person out-of-pocket for health care services, nearly 52 percent more than the national average ($779). In general, this difference has remained consistent with

higher personal income in Maryland. However, faster growth in out-of-pocket spending in Maryland may represent increasing burden for lower and moderate income residents. Expenditures for prescription drugs and other professional services continued to account for most out-of-pocket expenditures (respectively, 29 percent and 25 percent) in 2007. However, expenditures for hospital care and physician services were growing components of out-of-pocket spending, reflecting both increased cost-sharing in private insurance plans and increased use of outpatient hospital services.

PROSPECTS FOR CHANGE

In 2007, total health care cost growth in Maryland stabilized at the national average. In many ways, this is a signal accomplishment in the midst of new initiatives to expand Medicaid and small-employer coverage in Maryland, and continued high growth in Medicare expenditures. However, the high cost of health care in Maryland remains a concern. In particular, Maryland's need to constrain expenditures for hospital care, which increased rapidly with allowed rate increases from 2004 to 2007, is forcing changes in hospital payments. Paralleling changes in Medicare payment practices, Maryland will introduce a new value-based purchasing initiative in July 2009, adjusting hospital rates for overall performance on the 19 process measures used in the MHCC Hospital Performance System and reducing or eliminating reimbursement for 12 highly preventable complications that should never occur (so-called "never-events"), such as wrong-site surgery. Maryland will be the only state to hold hospitals accountable in this way for all admissions, not just those treated under Medicare.

The shortage of primary care physicians also is a growing concern in Maryland and nationally. MedPAC, the agency that advises the Congress on Medicare payments, has strongly recommended measures to increase Medicare payments to primary care providers nationwide. In Maryland, a number of proposals to address payment imbalances also are under consideration, but the potential for state action is limited both by ERISA preemption of state regulation that would affect self-insured employer plans and by limited stakeholder enthusiasm for direct regulation of practitioner fees. The potential for a new model of care, the patient-centered medical home (PCMH), appears promising, but evidence for quality and efficiency gains using the model is limited. Like many states, Maryland is working to develop multi-stakeholder demonstrations that align incentives for primary care practices to restructure as PCMHs.

As more Marylanders face unemployment and reduced incomes in the current economy, enrollment in Medicaid and SCHIP is rising. With new federal legislation expanding federal support for these programs, public expenditures for health care likely will increase significantly over the next several years. Under the federal American Recovery and Reinvestment Act of 2009 (ARRA), Maryland expects to receive an estimated additional $1.63 billion in federal Medicaid funding over 9 quarters, while Maryland's federal allotment for SCHIP also will increase (in FY 2009, from an estimated $70.2 million to $184.2 million).

Finally, further weakening of the economy seems likely to increase the number of uninsured in Maryland, due to both job loss and companies' cutting health benefits. Even employers that maintain health insurance benefits may increase the cost-sharing that health plans require, if not also employee contributions to premiums. Enrollment in the new Health Insurance Partnership seems likely to remain slow, due to small

businesses' uncertainty about market conditions and hesitation to offer new benefits until the economy improves.

Nationally and in Maryland, the growing cost of health care and the struggling economy are likely to remain signature issues through 2009 and into 2010. As family incomes fall due to unemployment and worker displacement, reliance on Medicaid and SCHIP is likely to rise, accelerating the growth of public program expenditures with greater federal funding picking up a significant share of the increased fiscal burden. Accounting for a growing share of expenditures for health care, these programs together with Medicare are poised to become even more important drivers of health system change in the coming years, affecting care not only for their enrollees but for privately insured Marylanders as well.

STATE HEALTH CARE EXPENDITURES

ONE MISSION OF THE MARYLAND HEALTH CARE COMMISSION (MHCC) IS TO DEVELOP TIMELY AND ACCURATE INFORMATION FOR POLICYMAKERS, PURCHASERS, PROVIDERS, AND THE PUBLIC, IN ORDER TO PROMOTE INFORMED DECISIONMAKING. This report provides information about total and per capita health care expenditures by Maryland residents in 2007, and the distribution of expenditures by type of service and by source of payment. It compares expenditures in 2007 with those in 2006 and in 2003.

This year's report continues the format that was begun in 2005. A longer, 5-year time series is presented, and state health expenditures are discussed by service and payer type, allowing readers to find information of particular interest more readily. The longer time series provides greater perspective, comparing changes from 2006 to 2007 to the trend since 2003. As with all continuing time series, the past years are reestimated, reflecting both improvements in estimation methods and revisions in the underlying data. As a result, the 2003 and 2006 reestimates may differ slightly from those published in earlier reports and should be regarded as improved estimates.

Private expenditures in this report reflect a series of adjustments to account for shortcomings in reported information. As in previous years, private payer allocations are adjusted to account for undercounting of nonhospital expenditures in MEPS payment estimates, so that a smaller share of private payments are allocated to hospital services and a larger share to other expenditure categories.[2] Also, payments from the MEPS household survey are used to calculate the shares of payments from private insurance attributed to different services. However, this year, total private insurance expenditures are derived from reported private insurance expenditures for hospital care, addressing changes in reported total private insurance expenditures that appear to reflect movement of insured group coverage into self-insured employer plans.

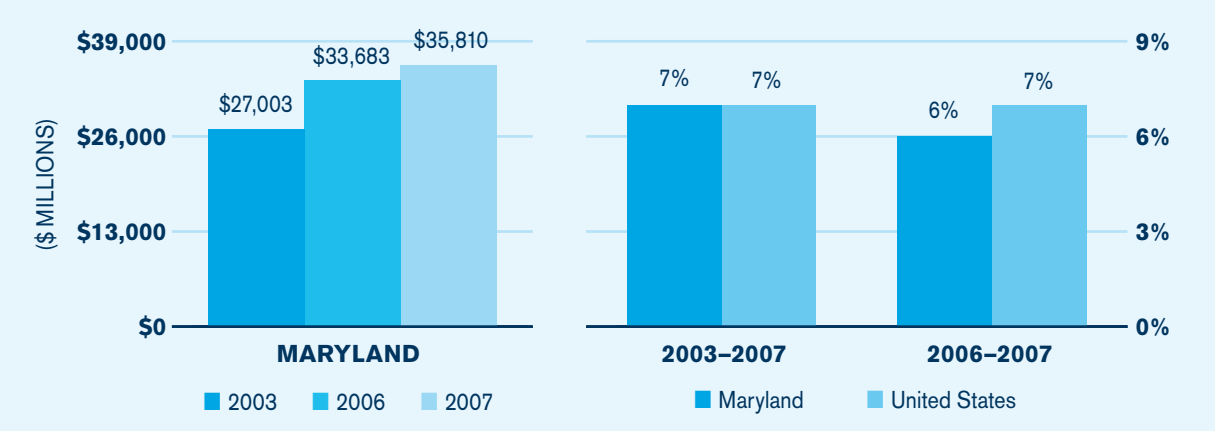
The data sources and methods for estimating Maryland and national expenditures and annual rates of change are described in the Methods section of this report. As in past years, the data supporting all graphics are provided in the Supporting Tables section beginning on page 60.

[2] In each service category, the MEPS-estimated per capita private insurance payments were multiplied by the ratio of the adjusted NHEA estimates to the MEPS estimates. Calculation of these ratios was based on: M. Sing et al. (Fall 2006). Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002. *Health Care Financing Review* 28(1): 25-40. The allocation of hospital payments between inpatient and outpatient services was estimated from HSCRC data and was not affected by this adjustment.

HOW MUCH DID MARYLAND SPEND FOR HEALTH CARE?

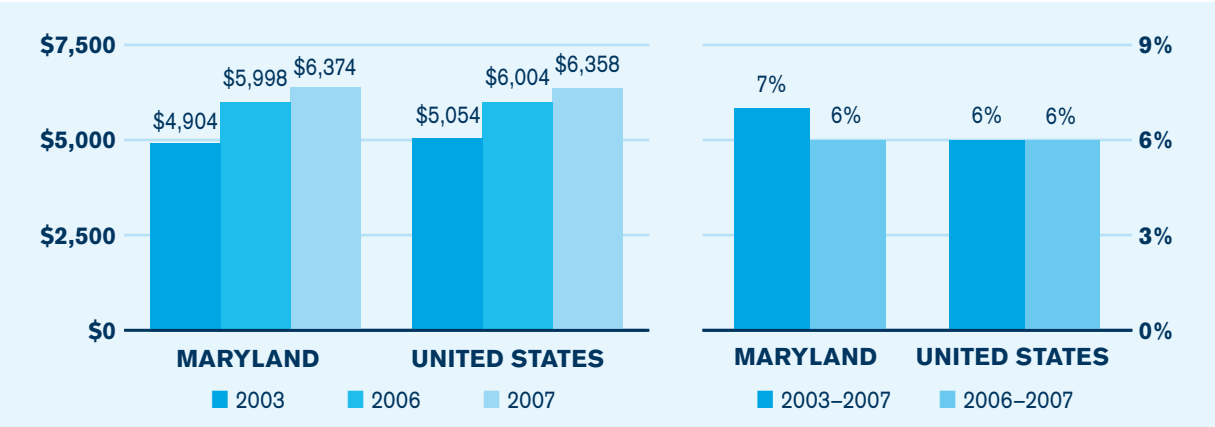
In 2007, Maryland residents spent an estimated $35.8 billion for health care services, compared to $33.7 billion in 2006 and $27.0 billion in 2003 (Figure 1). Health care expenditures in Maryland grew 6 percent from 2006 to 2007, more slowly than either the national average (7 percent) or Maryland's longer-term growth trend from 2003 to 2007 (also 7 percent).

FIGURE 1: Estimated Health Care Expenditures and Rate of Growth



Per resident, health care expenditures in Maryland are approximately equal to the national average. In 2007, Marylanders spent an average of $6,374 per person for health care, compared with the national average expenditure of $6,358 per person (Figure 2). In contrast, Marylanders spent about 3 percent less than the national average in 2003. However, growth in per capita spending (like growth in total spending) in Maryland exceeded the national rate of growth between 2003 and 2007, eliminating any appreciable difference between Maryland and the national average by 2006. From 2003 to 2007, per capita health care expenditures in Maryland grew at an average rate of 7 percent per year, about a percentage point faster than the U.S. average. More recently, from 2006 to 2007, per capita medical expenditure growth in Maryland slowed to 6 percent, approximately equal to the national average.[3]

FIGURE 2: Estimated Per Capita Health Care Expenditures and Rate of Growth, Maryland and U.S.



[3] Per capita expenditure growth rates are consistently lower than total expenditure growth rates due to increases in population.

HOW WERE MARYLAND'S HEALTH CARE DOLLARS SPENT?

Hospital inpatient and outpatient care together continue to represent the largest single category of health care expenditures in Maryland, accounting for nearly a third of total health care expenditures in 2007. Inpatient care accounted for 24 percent of total health care expenditures in 2007; outpatient care (including emergency room visits, outpatient surgeries, and outpatient clinic visits) accounted for 8 percent of total health care expenditures (Table 1).

TABLE 1: Estimated Health Care Expenditures by Service Category in Maryland

SERVICE CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$27,003**	**100%**	**$33,683**	**100%**	**$35,810**	**100%**
Inpatient	6,043	22	7,994	24	8,618	24
Outpatient	1,959	7	2,742	8	3,009	8
Physician Services	4,892	18	5,929	18	6,204	17
Other Professional Services	3,788	14	4,524	13	4,608	13
Prescription Drugs	4,389	16	5,191	15	5,601	16
Nursing Home Care	2,042	8	2,389	7	2,512	7
Home Health Care	979	4	1,207	4	1,289	4
Other Services	665	2	751	2	839	2
Administration and Net Cost of Insurance	2,247	8	2,955	9	3,131	9

Physician services and other professional services together account for the next largest share of health care expenditures in Maryland—about 30 percent of total expenditures in 2007. Physician services accounted for 17 percent, compared with 13 percent spent for other professional services.[4]

Three categories of expenditures account for nearly all of the balance of health care expenditures. Inpatient and outpatient prescription drugs accounted for 16 percent of total expenditures in 2007, while long-term care services—including nursing home care (7 percent) and home health care (4 percent)—accounted for approximately 13 percent. The administrative cost and the net cost of insurance accounted for 9 percent of the total.

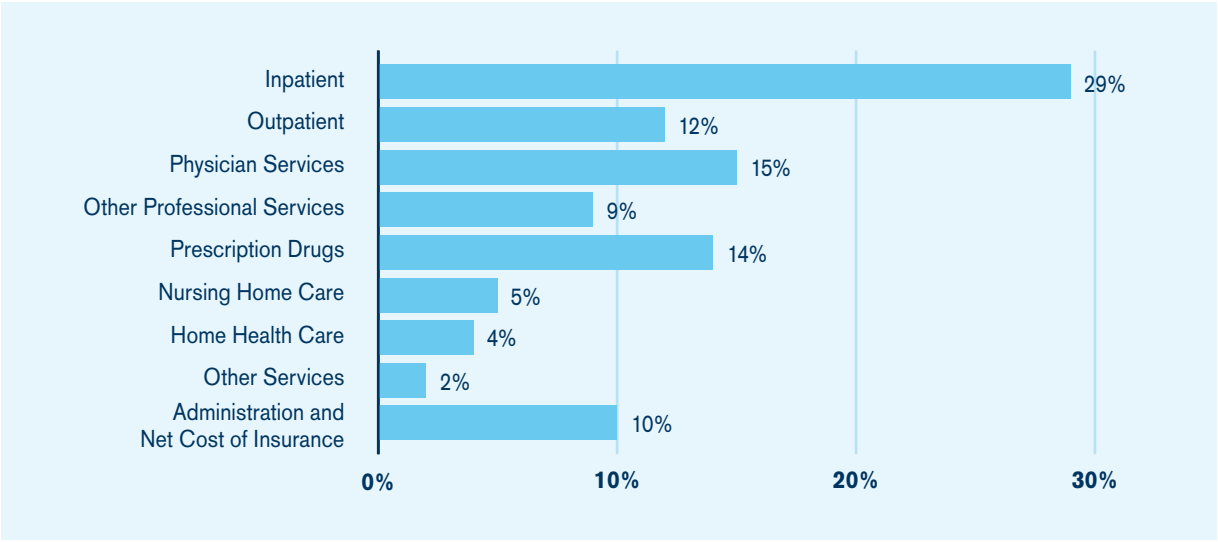
Some longer-term trends in expenditures are apparent. In 2007, Marylanders spent a larger proportion of their health care dollars than in 2003 for both inpatient and outpatient hospital care, and for the administration and net cost of insurance. These categories accounted for 41 percent of expenditures in 2007, compared with 38 percent in 2003. Conversely, Marylanders spent a lower proportion of health care dollars on physician and other professional services in 2007 (30 percent) than in 2003 (32 percent), and also a lower proportion on nursing home care (7 percent versus 8 percent). Prescription drugs (16 percent), home health

[4] Spending on dental services is included in other professional services, unlike the national health care accounts in which dental spending has a separate category.

care (4 percent), and miscellaneous other services (2 percent) accounted for about the same share of total expenditures in 2007 as in 2003.[5]

Because hospital care is the largest single category of expenditures in Maryland, it typically accounts for a large share of the growth in total expenditures. Faster growth of expenditures for hospital care from 2003 to 2007, however, further magnified its role in total expenditure growth. From 2003 to 2007, growth in expenditures for hospital care accounted for approximately 41 percent of total expenditure growth (Figure 3). Inpatient hospital care expenditures accounted for most of this increase, 29 percent of the total increase in expenditures; outpatient hospital expenditure growth accounted for another 12 percent. Expenditures for physician care and other professional services—both large expenditure categories—together accounted for 24 percent of the total growth in expenditures. Growth in expenditures for prescription drugs accounted for 14 percent of the increase in total health care expenditures from 2003 to 2007, while growth in administration and the net cost of insurance accounted for 10 percent.

FIGURE 3: Estimated Share of Increase in Health Care Expenditures by Service Category in Maryland, 2003–2007

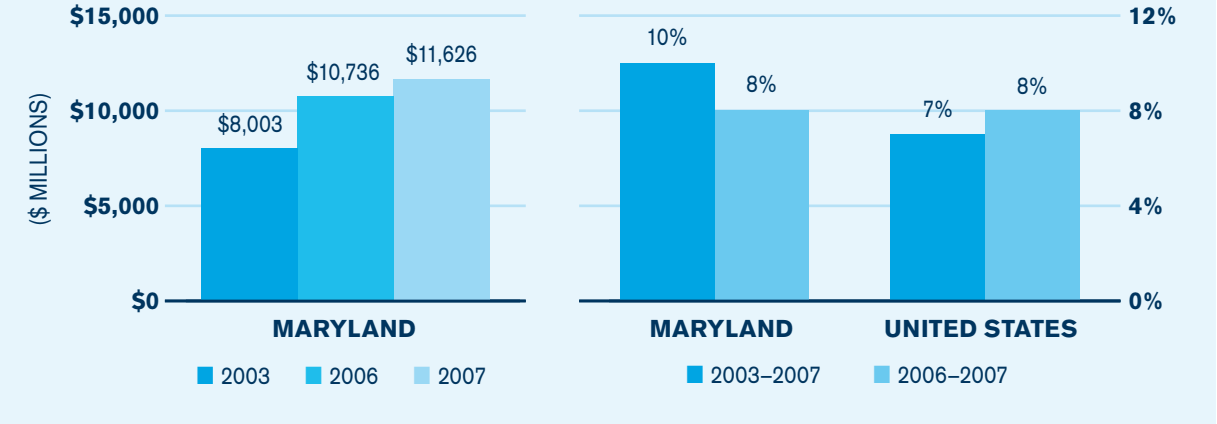


[5] Reported amounts may differ from the apparent sum of expenditures in the figures and tables due to rounding.

EXPENDITURES FOR HOSPITAL CARE

Including both inpatient and outpatient services, Marylanders spent more than $11.6 billion for hospital care in 2007 (Figure 4). Total expenditures for hospital care grew at an average annual rate of 10 percent from 2003 to 2007, slowing to 8 percent growth from 2006 to 2007. Since 2003, hospital expenditures in Maryland have grown much faster than the national average—on average by about 3 percentage points per year. From 2006 to 2007, growth in hospital charges per case and the number of hospital admissions slowed, compared with 2006.[6] Most of the 8 percent increase in expenditures for inpatient hospital care in Maryland was associated with higher charges per case.

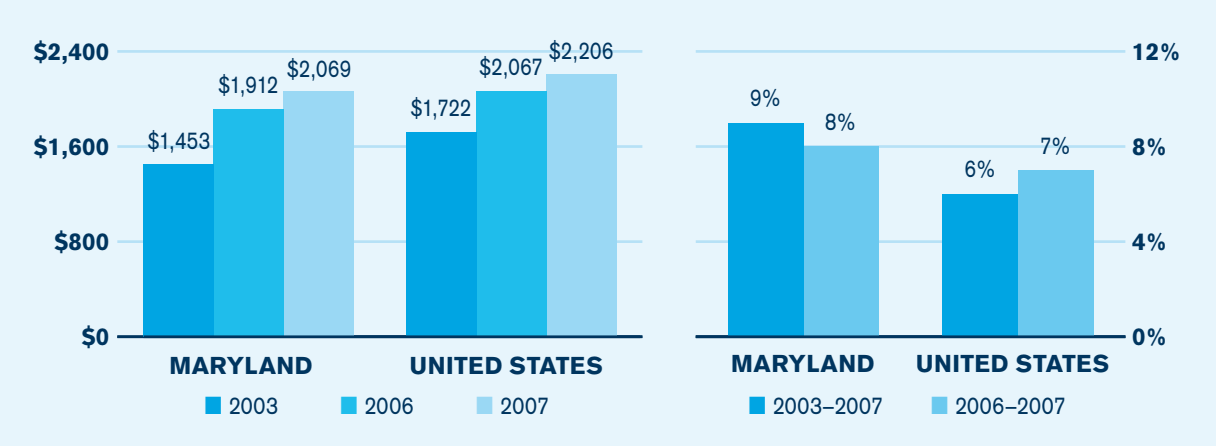
FIGURE 4: Estimated Hospital Services Expenditures and Rate of Growth



Per resident, expenditures for inpatient and outpatient hospital care in Maryland remain below the national average. In 2007, Marylanders spent $2,069 per capita for hospital care, about 6 percent less than the national average ($2,206) (Figure 5). However, expenditures for hospital care in Maryland continue to grow faster than the national average. From 2003 to 2007, per capita spending for hospital care in Maryland grew at an average annual rate of 9 percent, compared with the national average annual growth rate of 6 percent. From 2006 to 2007, per capita spending in Maryland increased 8 percent—again, faster than the national average (7 percent).

[6] Hospital charges per case increased 5.13 percent over the 12-month period ending November 2007, compared with an increase of 6.82 percent over the prior 12-month period. Hospital admissions in Maryland increased 1.27 percent, compared with an increase of 2.01 percent over the prior 12-month period. Maryland Health Services Cost Review Commission (February 2008 and March 2007), *Monitoring Maryland Performance* (http://www.hscrc.state.md.us/financial_data_reports /MonitoringMDPerf.htm, accessed 2/16/09).

FIGURE 5: Estimated Per Capita Hospital Services Expenditures and Rate of Growth, Maryland and U.S.



Maryland's higher long-term growth reflects decisions by state policymakers responsible for administration of the state's all-payer hospital reimbursement system, in two ways. First, following a period of restrictive rate increases from 1999 to 2003, hospitals in Maryland were allowed rate increases from 2004 through 2007 based on forecasted cost growth plus 2 percent. A number of hospitals received additional rate increases to help finance large capital projects.[7] Hospital operating profits in Maryland grew faster than the national average over this period, suggesting that hospital rates in Maryland also grew faster than the national average.[8]

Second, nationally and in Maryland, enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) has grown, while enrollment in private insurance has declined. As a result, Medicaid and SCHIP account for an increasing share of health care services. Because Medicaid and SCHIP reimbursement rates in other states typically are much lower than private insurer reimbursements, growing enrollment in these programs likely has slowed the growth in per capita expenditures nationally when measured as the average across all payers.[9] However, in Maryland, increased Medicaid and SCHIP enrollment has not slowed expenditure growth in the same way because hospital reimbursement rates are the same for all payers.[10]

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[7] Beginning in FY 2004, the Health Services Cost Review Commission (HSCRC) allowed hospitals to file for rate relief associated with anticipated cost increases due to large capital projects. From FY 2004 to FY 2007, 18 hospitals received rate relief from either full or partial rate reviews. This application process (as well as other rate review) was suspended during the transition to use of All Patient Refined (APR) Diagnosis-Related Groups (DRGs) from July 2006 to March 2008.

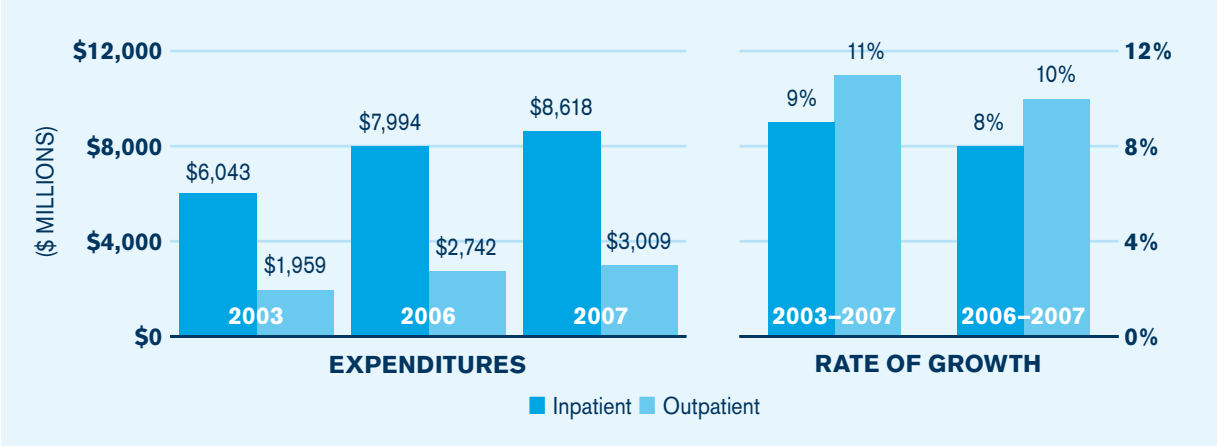
[8] See: HSCRC (July 2, 2008), *Final Staff Report on the Financial Condition of Maryland Hospitals* (http://www.hscrc.state.md.us/finacial_data_reports/AnnualFinancialConditions.htm, accessed February 24, 2009).

[9] From 2002–2003 through 2006–2007, Maryland's nonelderly uninsured rate grew from a two-year average of 14 percent to 15 percent. At the same time, insurance coverage among Maryland's residents shifted out of private coverage into Medicaid. Primarily reflecting the loss of employer-based coverage, the private coverage rate fell from 78 percent in 2002-2003 to 76 percent in 2006-2007, while the Medicaid rate rose from 7 to 9 percent. [See; Maryland Health Care Commission (January 2009), *Health Insurance Coverage in Maryland Through 2007* (http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_thru_2007.pdf)]. Nationally, 13.9 percent of the U.S. population under age 65 was enrolled in Medicaid or SCHIP in 2007, compared with an estimated 12.8 percent in 2003. [See: P. Fronstin (October 2008), *Sources of Health Insurance and Characteristics of the Uninsured*, Washington, DC: Employee Benefit Research Institute (http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf, accessed 2/19/09).

[10] From 2004 to 2008, Medicaid and SCHIP admissions that exceeded DRG-specific day limits were subject to payment reductions. For these admissions, hospitals were required to justify that days beyond the limits were medically necessary. Legislation enacted in 2008 removed these restrictions.

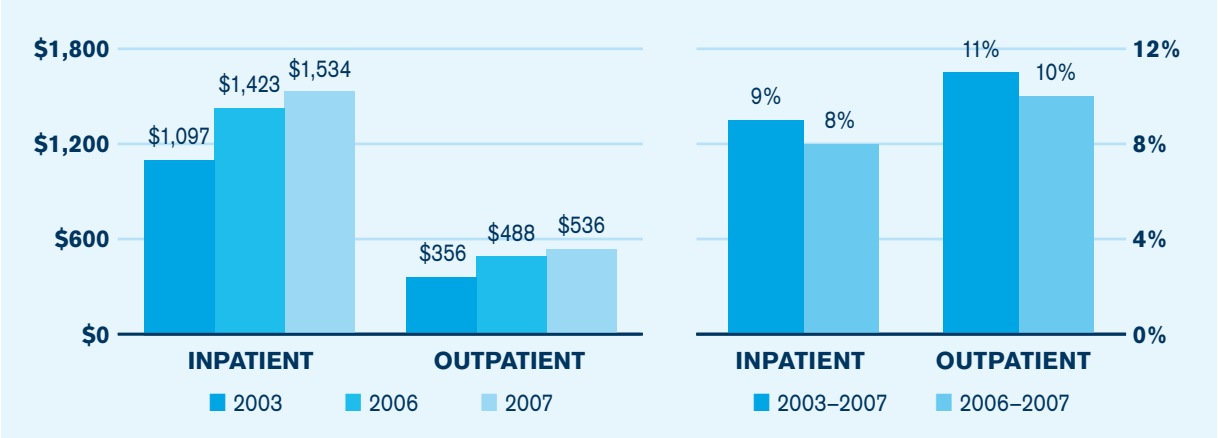
Marylanders spent nearly three times as much for inpatient care as for outpatient care in 2007 ($8.6 billion versus $3.0 billion), but expenditures for outpatient care have grown faster (Figure 6). From 2003 to 2007, expenditures for inpatient care grew at an average annual rate of 9 percent, compared with 11 percent average annual growth in expenditures for outpatient care. From 2006 to 2007, growth in expenditures for both inpatient and outpatient care slowed, to 8 and 10 percent, respectively.

FIGURE 6: Estimated Inpatient and Outpatient Expenditures and Rate of Growth in Maryland



The pattern of expenditures per capita for inpatient and outpatient hospital care is similar to the pattern of total expenditures. That is, Marylanders spent much more per capita for inpatient care in 2007 ($1,534) than for outpatient care ($536), but per capita expenditures for outpatient care have grown faster (Figure 7). Per capita expenditures for outpatient care grew at an average annual rate of 11 percent from 2003 to 2007, and by 10 percent from 2006 to 2007. In contrast, per capita expenditures for inpatient care grew at an average annual rate of 9 percent from 2003 to 2007, and 8 percent from 2006 to 2007.

FIGURE 7: Estimated Per Capita Inpatient and Outpatient Expenditures and Rate of Growth in Maryland



Medicare and private insurance are the largest payers for both inpatient and outpatient hospital care in Maryland. Medicare paid for 40 percent of all inpatient care in 2007, and 32 percent of all outpatient care (Table 2). This was less as a proportion of all payments than in 2003, when Medicare paid for 41 percent of inpatient care and 35 percent of outpatient care. Conversely, private insurance, which paid for 34 percent of inpatient care and 38 percent of outpatient care in 2007, accounted for a larger share of expenditures (by about 1 percentage point) for both than in 2003.

TABLE 2: Estimated Inpatient and Outpatient Expenditures by Source of Payment in Maryland

PAYER CATEGORY	INPATIENT						OUTPATIENT					
	2003		2006		2007		2003		2006		2007	
	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total
TOTALS	**$7,110**	**100%**	**$7,994**	**100%**	**$8,618**	**100%**	**$1,959**	**100%**	**$2,742**	**100%**	**$3,009**	**100%**
Medicare	2,803	41	3,150	39	3,444	40	681	35	894	33	975	32
Medicaid	1,266	19	1,468	18	1,553	18	341	17	470	17	505	17
Other Government	254	5	278	3	316	4	58	3	60	2	91	3
Private Coverage	2,467	33	2,750	34	2,921	34	716	37	1,041	38	1,129	38
Out-of-Pocket	320	2	349	4	383	4	163	8	277	10	308	10

Medicaid (including SCHIP) paid for about 18 percent of inpatient care and 17 percent of outpatient care in 2007. In both service categories, Medicaid's share of total hospital expenditures changed very little from 2003 to 2007—and actually declined slightly as a share of total expenditures for inpatient care, despite rising program enrollment.

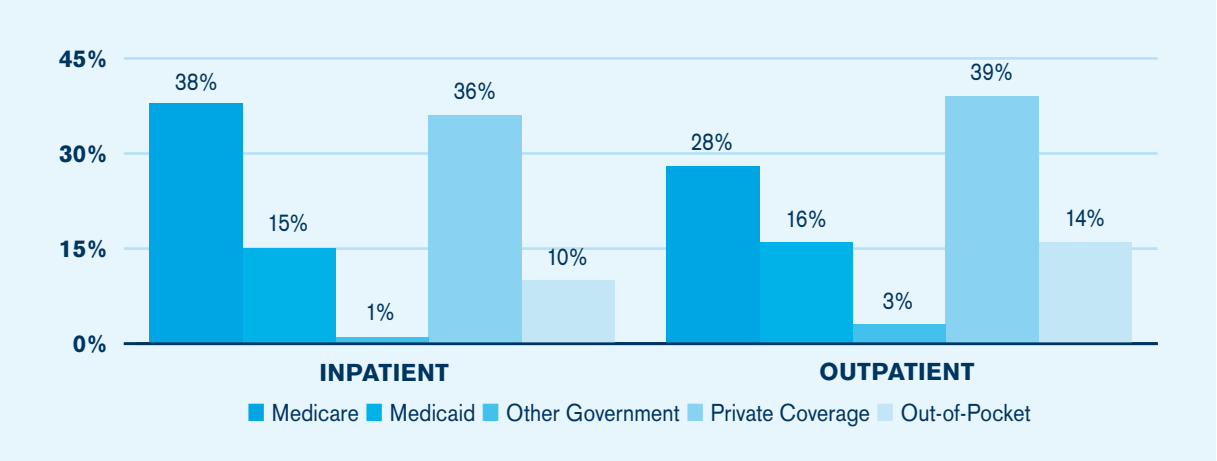
Marylanders continue to pay a relatively low proportion of hospital care out-of-pocket, although both the proportion and amounts they pay out-of-pocket have grown very fast. In 2007, Marylanders paid 4 percent of the cost of inpatient care out-of-pocket, compared with 2 percent in 2003. Similarly, they paid 10 percent of expenditures for outpatient care out-of-pocket in 2007, compared with 8 percent in 2003. In Maryland, out-of-pocket expenditures for both inpatient and outpatient care have increased with higher cost-sharing in private insurance plans, as well as the growing number of Marylanders who rely on hospital outpatient departments for care.[11]

As the largest payers for hospital care in Maryland, Medicare and private insurance expenditures also account for a large share of the growth in expenditures (Figure 8). Private insurance, in particular, accounted for a larger share of the growth in spending for both inpatient and outpatient hospital care—36 percent of the increase in inpatient expenditures from 2003 to 2007 and 39 percent of the increase in outpatient

[11] In Maryland, outpatient visits to community hospitals per 1,000 population increased more than 5.7 percent from 2003 to 2006 (the most recent year for which published data are available), compared with 3.6 percent nationally. However, Marylanders were still less likely to visit a hospital outpatient department (with 1,251 visits per 1,000 population in 2006) than the national average (2,007 per 1,000 population). Community hospitals represent 85 percent of all hospitals; they exclude federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals. See: Kaiser Family Foundation (http://www.statehealthfacts.org/profileind.jsp?cmp=40&cat=8&rgn=22&ind=404&sub=95, accessed 3/15/2009).

expenditures—than its share of total spending in either year. Increased out-of-pocket spending for hospital care (including cost-sharing and payments for uninsured services) accounted for 10 percent of the growth in expenditures for inpatient care from 2003 to 2007, and 14 percent of the growth in expenditures for outpatient care.

FIGURE 8: Estimated Share of Increase in Inpatient and Outpatient Expenditures by Source of Payment in Maryland, 2003–2007

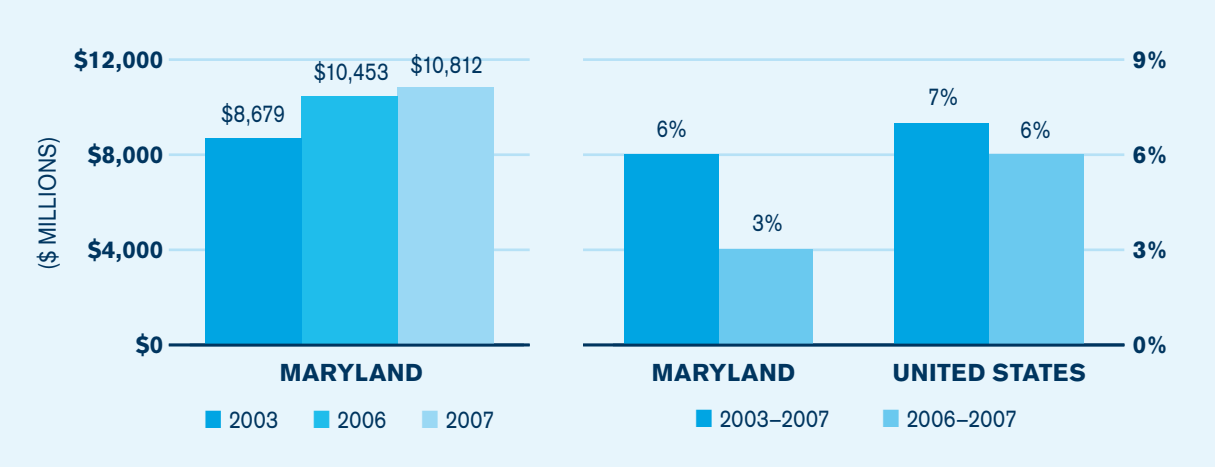


In contrast, Medicare and Medicaid financed smaller shares of the growth in both inpatient and outpatient expenditures than their shares of total expenditures in either year. Medicare accounted for 38 percent of the growth in expenditures for inpatient care and 28 percent of the growth in expenditures for outpatient care from 2003 to 2007. Medicaid accounted for 15 percent of the increase in inpatient expenditures and 16 percent of the increase in outpatient expenditures, despite significant enrollment growth.

EXPENDITURES FOR PRACTITIONER SERVICES

Marylanders spent approximately $10.8 billion for physician and other professional services in 2007—the latter including dental services; nonphysician vision services; occupational, physical, and other therapy services; physician assistant care; nurse practitioner services; and chiropractic care (Figure 9). Under Maryland law, these providers are not subject to rate review like hospitals are, and therefore may bill different payers at different rates.

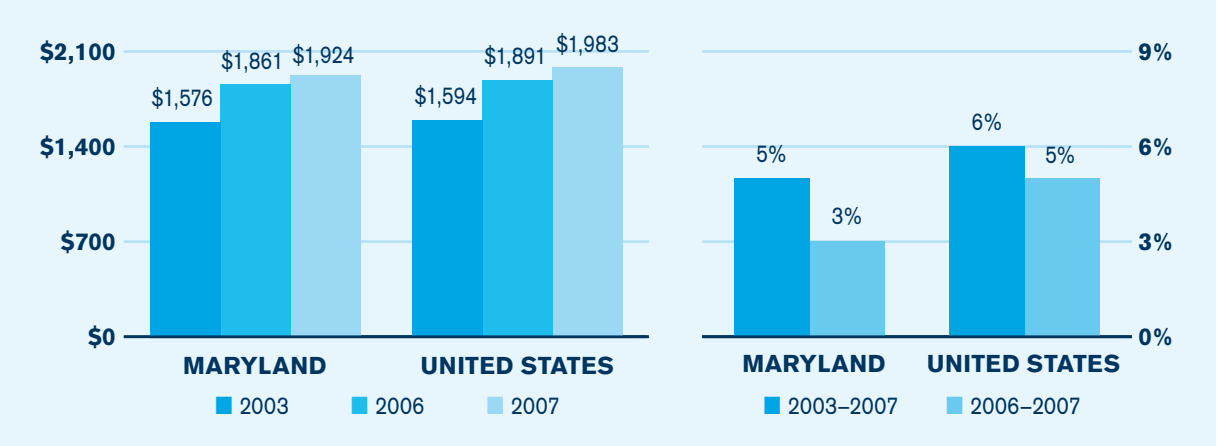
FIGURE 9: Estimated Practitioner Services Expenditures and Rate of Growth



In Maryland, total expenditures for practitioner services grew more slowly than the national average from 2003 to 2007 (at an average rate of 6 percent per year, compared with the national average of 7 percent). From 2006 to 2007, expenditures for practitioner services slowed to half the national average—increasing just 3 percent in Maryland, versus 6 percent nationally.

Per capita expenditures for practitioner services remain slightly lower in Maryland ($1,924 in 2007) than the national average ($1,983), and since 2003 they have grown more slowly—increasing at an average annual rate of 5 percent compared with 6 percent nationally (Figure 10). From 2006 to 2007, per capita expenditures (like total expenditures) for practitioner services grew much more slowly than the national average, 3 percent compared with 5 percent nationally.

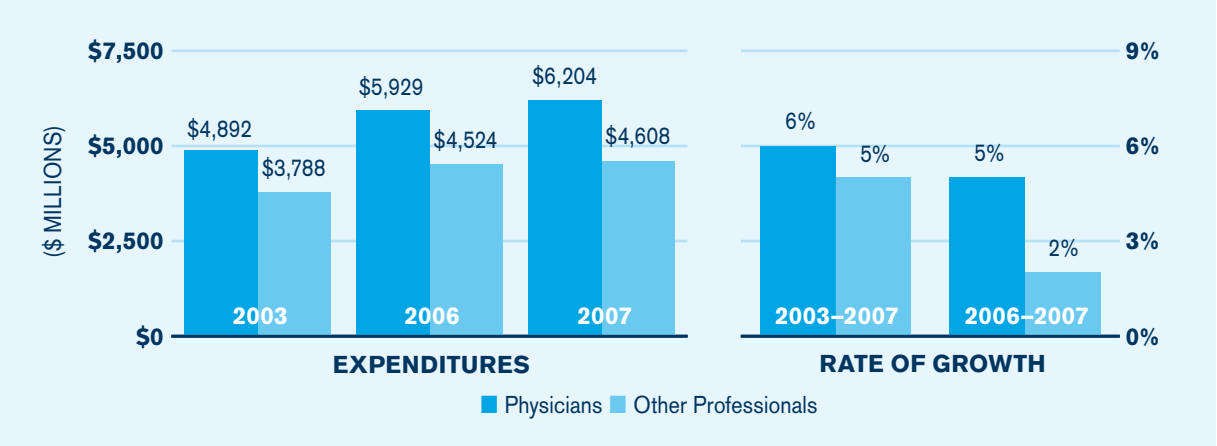
FIGURE 10: Estimated Per Capita Practitioner Services Expenditures and Rate of Growth, Maryland and U.S.



Physician services account for more than half of all expenditures for practitioner services in Maryland—$6.2 billion in 2007, versus $4.6 billion for other professional services. From 2003 to 2007, expenditure growth for physician care averaged 6 percent per year, compared with 5 percent for other professional services (Figure 11).

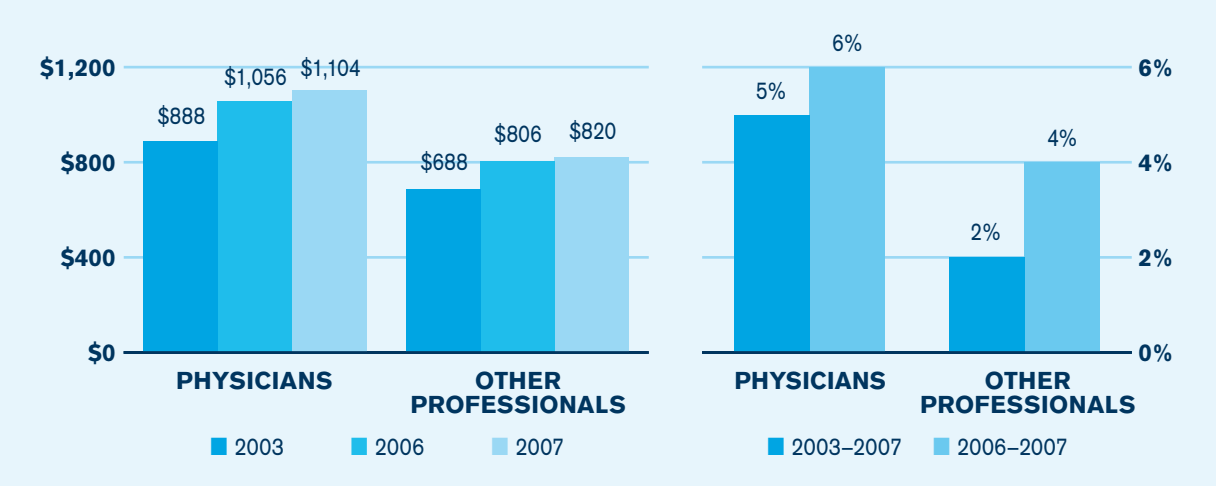
From 2006 to 2007, growth in expenditures for other professional services slowed dramatically, to just 2 percent. Expenditure growth for physician services also slowed, but more moderately, to 5 percent from 2006 to 2007.

FIGURE 11: Estimated Physician and Other Professional Expenditures and Rate of Growth in Maryland



Marylanders spent $1,104 per capita for physician services in 2007, compared with $820 for other professional services. From 2003 to 2007, per capita spending for physician care grew at an average annual rate of 5 percent, while per capita spending for other professional services grew at an average annual rate of 2 percent (Figure 12). From 2006 to 2007, growth in per capita spending for physician services slowed to 6 percent, while growth in per capita spending for other professional services slowed to just 4 percent.

FIGURE 12: Estimated Per Capita Physician and Other Professional Expenditures and Rate of Growth in Maryland



The primary sources of payment for physician care in Maryland differ from those for other professional services (Table 3). Private insurance is the dominant source of payment for physician care, accounting for 54 percent of total expenditures in 2007, followed by Medicare (22 percent). Marylanders financed 15 percent of physician care out-of-pocket in 2007, and Medicaid and other government programs together financed 9 percent.

In contrast, Marylanders paid a relatively large proportion (36 percent in 2007) of expenditures for other professional services out-of-pocket, followed closely by private insurance (34 percent). Medicare financed a relatively small share of other professional services (7 percent), as did Medicaid (11 percent) and other government programs (11 percent)—although any of these programs may finance larger proportions of specific services in this category.

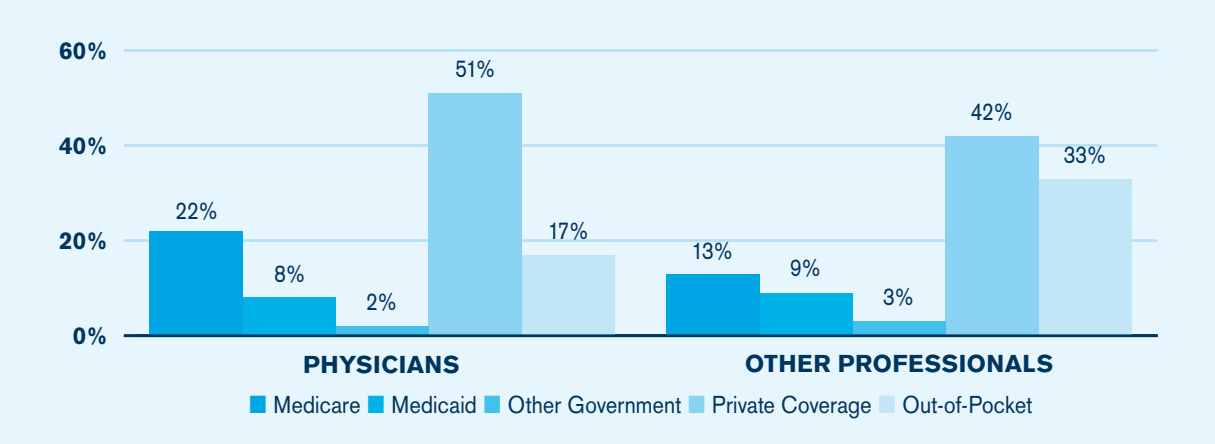
TABLE 3: Estimated Physician and Other Professional Expenditures by Source of Payment in Maryland

PAYER CATEGORY	PHYSICIAN						OTHER PROFESSIONALS					
	2003		2006		2007		2003		2006		2007	
	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total
TOTALS	**$4,892**	**100%**	**$5,929**	**100%**	**$6,204**	**100%**	**$3,788**	**100%**	**$4,524**	**100%**	**$4,608**	**100%**
Medicare	1,109	23	1,333	22	1,392	22	238	6	318	7	343	7
Medicaid	271	6	347	6	375	6	450	12	538	12	526	11
Other Government	142	3	158	3	174	3	497	13	528	12	524	11
Private Coverage	2,652	54	3,198	54	3,324	54	1,202	32	1,498	33	1,544	34
Out-of-Pocket	717	15	893	15	939	15	1,401	37	1,642	36	1,671	36

As the largest purchaser of practitioner services in Maryland, private insurance also accounted for the largest share of the growth in expenditures for these services. Private insurance financed 51 percent of the growth in expenditures for physician services from 2003 to 2007, and 42 percent of the growth in other

professional services (Figure 13). This pattern of growth indicates a slowing of private insurance spending for physician services (where private insurance paid 54 percent of total expenditures in 2007) and faster growth of private insurance spending for other professional services (where it paid 34 percent of total expenditures in 2007).

FIGURE 13: Estimated Share of Increase in Physician and Other Professional Expenditures by Source of Payment in Maryland, 2003–2007



Other payers accounted for a relatively low share of the growth in payments for physician services from 2003 to 2007. Medicare accounted for 22 percent of the increase in spending for physician services, proportionate to its share of total expenditures for these services. In contrast, growth in out-of-pocket spending accounted for 17 percent of the increase in spending for physician services, partly offsetting the slower growth in private insurance spending. Growth in Medicaid and other government program expenditures, respectively, paid 8 percent and 2 percent of the increase in spending for physician services.

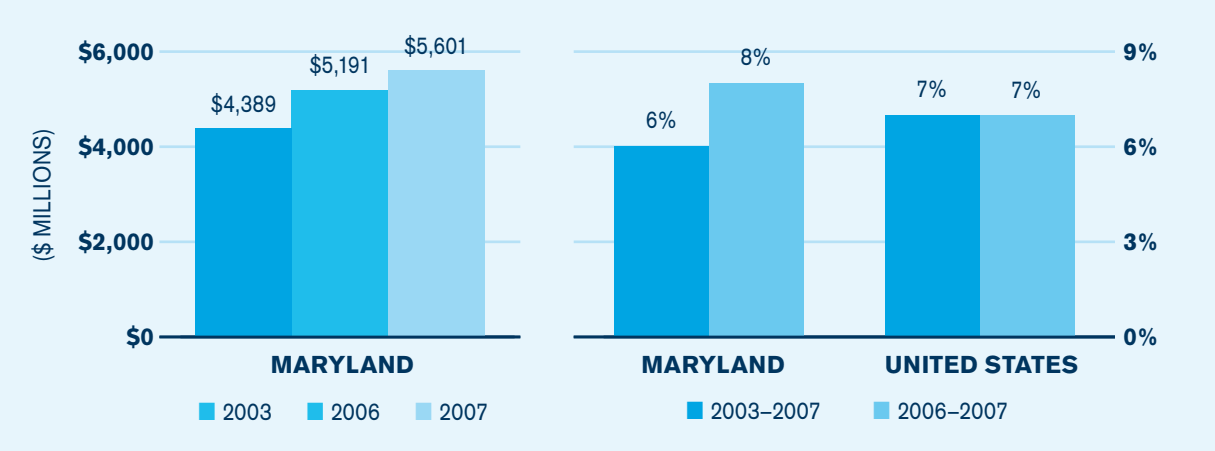
Together, the increase in private insurance expenditures and out-of-pocket spending for other professional services accounted for about 75 percent of the growth in total expenditures for these services from 2003 to 2007. However, while private insurance expenditures accounted for a disproportionately large share of the growth in total expenditures for other professional services (relative to its share of total expenditures), out-of-pocket expenditures grew more slowly—accounting for 33 percent of the growth in total expenditures for other professional services, and slightly reducing the share of total expenditures paid out-of-pocket (from 37 percent in 2003 to 36 percent in 2007; Table 3).

Faster Medicare spending for other professional services may also have contributed to slower growth in out-of-pocket expenditures for these services. Medicare accounted for 13 percent of the growth in expenditures for other professional services from 2003 to 2007, driving Medicare's share of total expenditures from 6 percent to 7 percent over that period. Medicaid and other government programs accounted for a relatively small share of the growth in spending for other professional services—9 percent and 3 percent, respectively.

EXPENDITURES FOR PRESCRIPTION DRUGS

In 2007, Marylanders spent $5.6 billion for prescription drugs (Figure 14). From 2003 to 2007, total expenditures for prescription drugs in Maryland grew more slowly than the national average, increasing at an average rate of 6 percent per year compared with 7 percent nationally. However, from 2006 to 2007, prescription drug expenditures in Maryland grew faster than the national average—by 8 percent—while total expenditures nationally continued to grow at 7 percent.

FIGURE 14: Estimated Prescription Drug Expenditures and Rate of Growth



The recent, faster growth of expenditures for prescription drugs in Maryland may reflect somewhat greater retention of private and public insurance coverage compared with other states and, therefore, expenditure growth that more closely tracks growth in prescription drug prices.[12] It may also reflect more generous insurance coverage of prescription drugs among retirees in Maryland relative to the national average.

Medicare beneficiaries in Maryland are more likely than the national average to be enrolled in a federal or private retiree health plan that provides coverage for prescription drugs, and about as likely as the national average to be enrolled in Medicare Part D prescription drug plans (PDPs).[13] As of December 2008, 36 percent of Medicare beneficiaries in Maryland were enrolled in PDPs, compared with 38 percent nationally. However, just 7 percent were enrolled in Medicare Advantage plans (which in Maryland typically offer prescription drug coverage), compared with 23 percent nationally.[14]

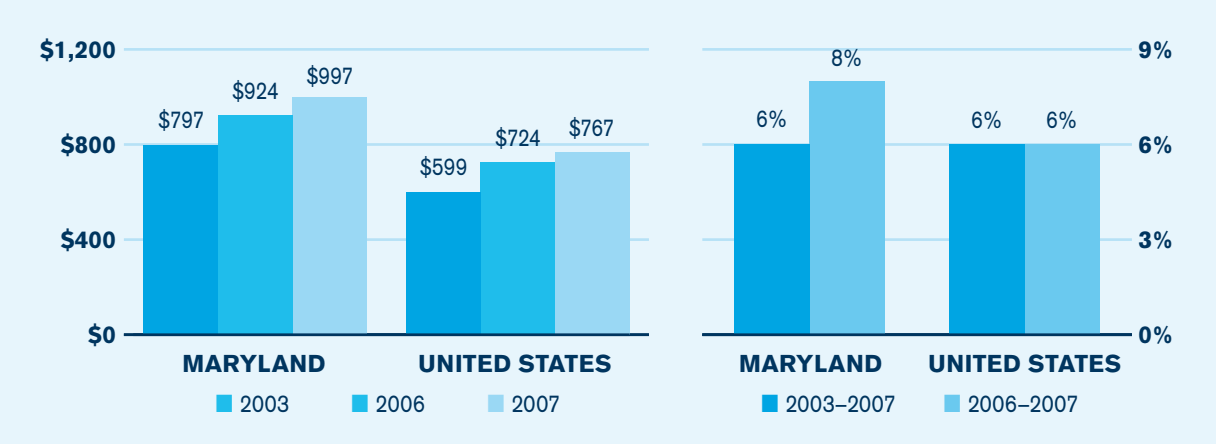
[12] Calculated as 2-year averages, an estimated 13.8 percent of Marylanders (of all ages) were uninsured in 2006-2007, compared with 13.6 percent in 2002-2003, and 14.2 percent in 2003-2004. This compares with more than 15 percent of the total population that is uninsured nationally. See: C. DeNavas-Walt, et al., U.S. Census Bureau, *Current Population Reports*, P60-229, Income, Poverty, and Health Insurance Coverage in the United States: 2004 (Table 9) (http://www.censusbureau.biz/prod/2005pubs/p60-229.pdf, accessed 3/10/09); and P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007 (Table 8) (http://www.census.gov/prod/2008pubs/p60-235.pdf, accessed 3/10/09).

[13] In 2006, Medicare beneficiaries began enrolling in Medicare Part D prescription drug plans (PDPs) as well as in Medicare Advantage plans that uniformly covered a substantial share of beneficiaries' expenditures for prescription drugs. At the same time, coverage for prescription drugs in private Medicare supplement plans was eliminated.

[14] See: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MPDPESCC/list.asp#TopOfPage, accessed 3/11/09).

Per capita spending for prescription drugs in Maryland ($997) substantially exceeded the national average ($767) in 2007, as in earlier years (Figure 15). Per capita spending for prescription drugs in Maryland grew at the same pace as the national average from 2003 to 2007, averaging 6 percent growth per year. However, from 2006 to 2007, per capita spending for prescription drugs accelerated in Maryland—growing 8 percent, compared with 6 percent nationally.

FIGURE 15: Estimated Per Capita Prescription Drug Expenditures and Rate of Growth, Maryland and U.S.



Private insurance is the dominant payer for prescription drugs in Maryland. In 2007, private insurance paid 43 percent of all expenditures for prescription drugs, while consumers paid 35 percent out-of-pocket (Table 4).

TABLE 4: Estimated Prescription Drug Expenditures by Source of Payment in Maryland

PAYER CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$4,389**	**100%**	**$5,191**	**100%**	**$5,601**	**100%**
Medicare	5	0	640	12	746	13
Medicaid	569	13	414	8	443	8
Other Government	103	2	76	1	80	1
Private Coverage	1,937	44	2,254	43	2,385	43
Out-of-Pocket	1,775	40	1,808	35	1,948	35

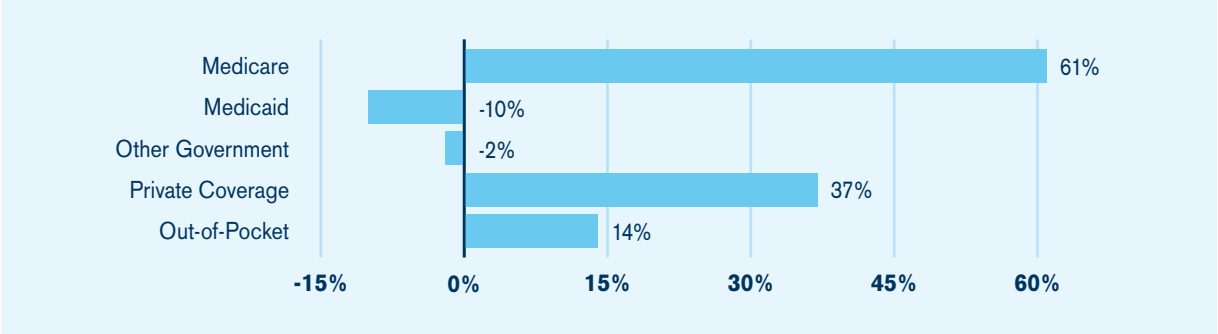
NOTE: 0% indicates < 0.5%.

While privately insured expenditures for prescription drugs increased from $1.9 billion in 2003 to nearly $2.4 billion in 2007, they accounted for about the same share of total spending for prescription drugs in both years.

However, changes in other segments of the prescription drug market have been dramatic. Reflecting new enrollment in Medicare Part D, Medicare expenditures for drugs in Maryland increased from a negligible amount in 2003 to an estimated $640 million in 2006 and $746 million in 2007. Concurrently, out-of-pocket expenditures for prescription drugs increased relatively slowly, accounting for a lower share of total expenditures in 2007 (35 percent) than in 2003 (40 percent). Medicaid also paid less for prescription drugs in 2007 ($443 million, equal to 8 percent of total spending) than in 2003 ($569 million, or 13 percent of total spending), largely associated with lower drug expenditures for "dual eligibles" in the program—elderly and disabled Medicaid enrollees who are concurrently enrolled in Medicare.[15] Similarly, other government programs in Maryland paid less for prescription drugs in 2007 ($80 million) than in 2003 ($103 million).

As expected, Medicare and private insurance accounted for nearly all of the growth in total expenditures for prescription drugs from 2003 to 2007—61 percent and 37 percent, respectively, reflecting the implementation of Medicare Part D in 2006 (Figure 16). Increased out-of-pocket expenditures accounted for 14 percent of the growth in total spending for prescription drugs, while Medicaid (as well as other government program expenditures) declined.

FIGURE 16: Estimated Share of Increase in Prescription Drug Expenditures by Source of Payment in Maryland, 2003–2007

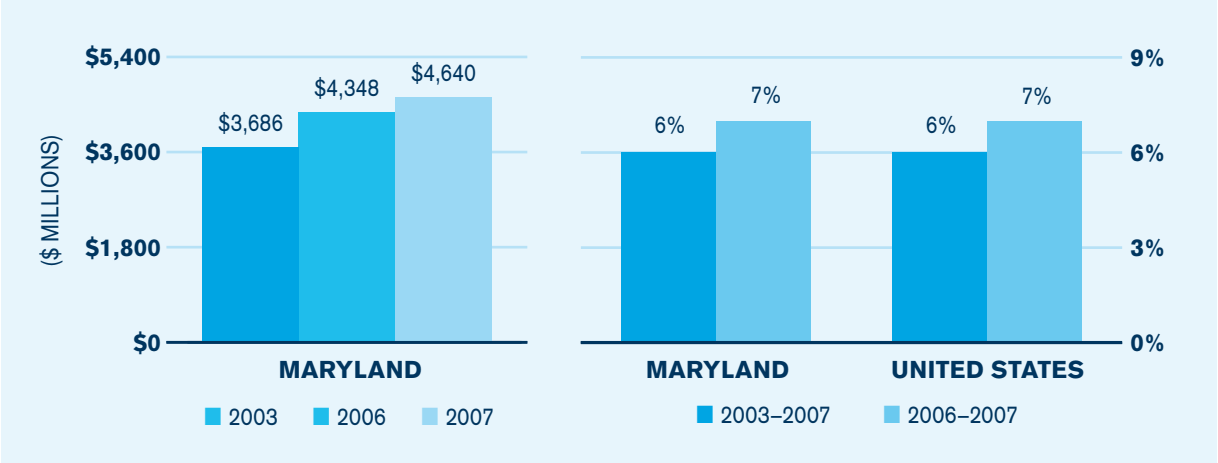


[15] Like all states, Maryland makes a payment to Medicare (popularly termed a "clawback") reflecting the estimated cost of prescription drugs for dual eligibles; these payments are included in Medicare expenditures. The clawback is a monthly payment that each state has made to the federal Medicare program since January 2006. The amount of each state's payment roughly reflects the expenditure of its own funds that the state would have made if it had continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligibles. Nationally, clawback payments substantially exceed the next most significant dollar flow from the states to the federal government for Medicaid, Medicare Part B and Part A premiums on behalf of certain categories of Medicaid beneficiaries. In FY 2008, Maryland paid more than $92.3 million in clawback to the federal government. The Henry J. Kaiser Family Foundation, *State Health Facts* (http://www.statehealthfacts.org/mfs.jsp?rgn=22&rgn=1, accessed 3/11/09).

EXPENDITURES FOR LONG-TERM CARE AND OTHER SERVICES

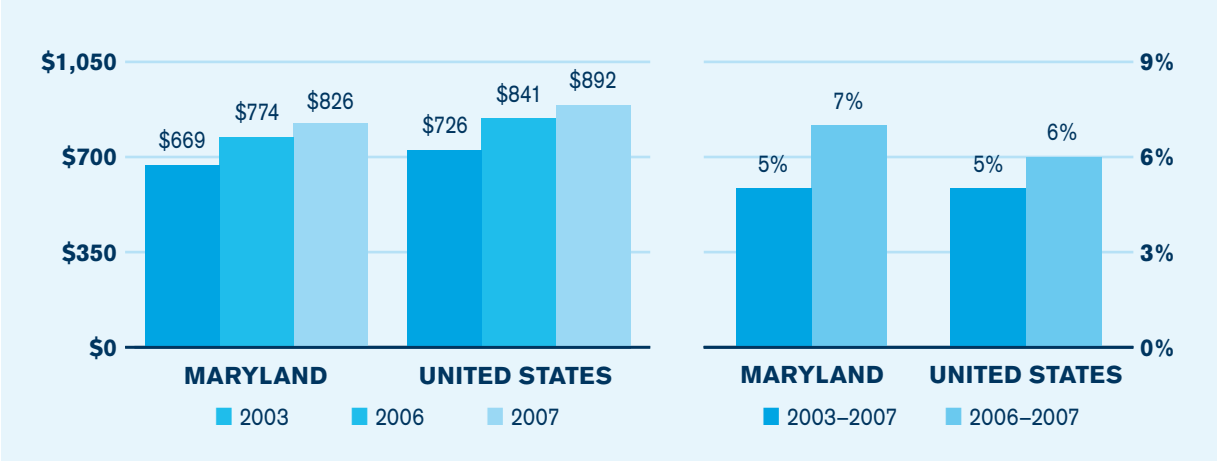
Expenditures for long-term care and other miscellaneous services in Maryland reached $4.6 billion in 2007 (Figure 17). Expenditures for long-term care—including nursing home and home health care expenditures—accounted for 82 percent of these expenditures. Historically, expenditures per capita for long-term care and other miscellaneous services have been lower in Maryland than the national average. Marylanders continued to spend about 7 percent less per capita for these services in 2007 ($826 versus $892; Figure 18).

FIGURE 17: Estimated Long-Term Care and Other Services Expenditures and Rate of Growth



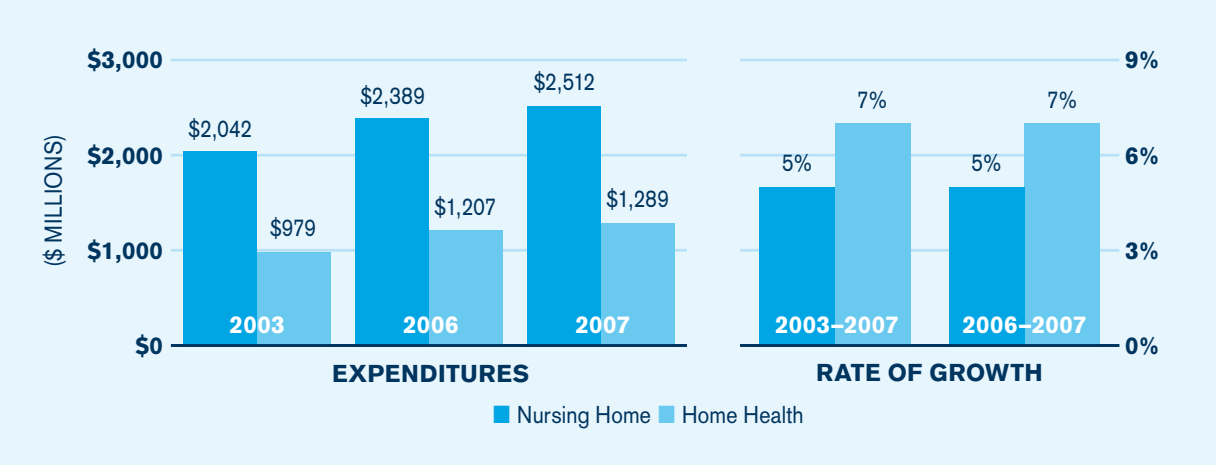
In Maryland and nationally, per capita expenditures for long-term care and other services grew about 5 percent per year from 2003 to 2007. However, from 2006 to 2007, expenditures for these services rose faster than the long-term trend both in Maryland and nationally. In Maryland, per capita expenditures for long-term care and other services rose 7 percent from 2006 to 2007, compared with 6 percent growth nationally.

FIGURE 18: Estimated Per Capita Long-Term Care and Other Services Expenditures and Rate of Growth, Maryland and U.S.



Expenditures for nursing home care account for nearly two-thirds of all expenditures for long-term care in Maryland. In 2007, Marylanders spent $2.5 billion for nursing home care, compared with $1.3 billion for home health care services (Figure 19). However, expenditures for home health care services have increased faster than those for nursing home care as Medicaid—the largest third-party payer for long-term care services—has attempted to help residents in need of long-term care services find them in the community.[16] In Maryland, expenditures for home health services grew at an average rate of 7 percent per year from 2003 to 2007, while, nursing home expenditures grew at an average rate of 5 percent per year. For both service types, expenditure growth from 2006 to 2007 continued the longer-term trends.

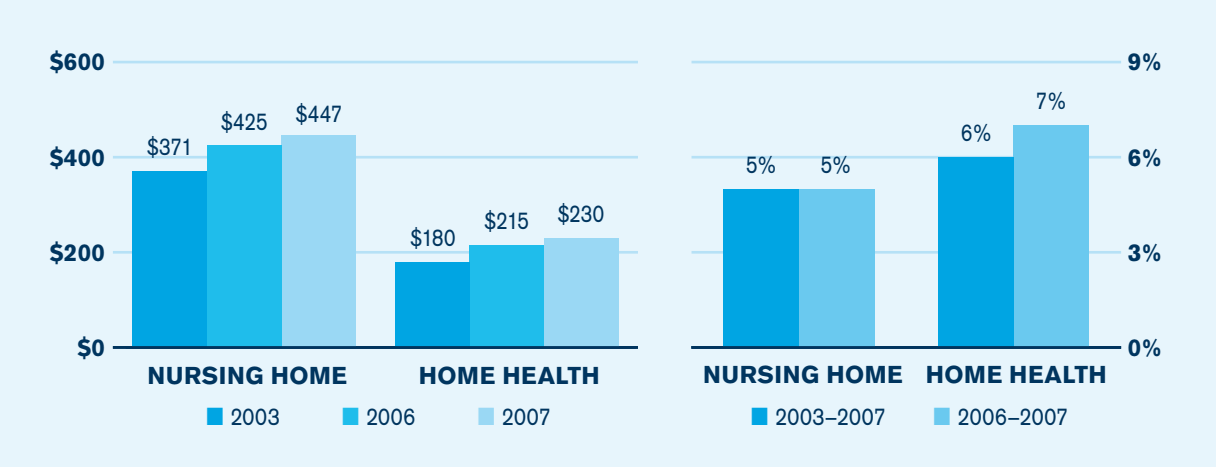
FIGURE 19: Estimated Nursing Home and Home Health Expenditures and Rate of Growth in Maryland



Per capita, Marylanders spent $447 for nursing home care in 2007, compared with $230 for home health care services—a cost difference that in part has motivated Medicaid to attempt to serve beneficiaries in home and community-based settings when possible (Figure 20). Expenditures per capita for home health care increased at an average annual rate of 6 percent per year from 2003 to 2007, compared with an average annual increase of 5 percent for nursing home care, reflecting the growing care needs of beneficiaries receiving home health care during that period. Per capita expenditures for home health care increased faster from 2006 to 2007, by 7 percent, while nursing home expenditures per capita continued to rise at the 5 percent long-term trend rate for those services.

[16] Maryland Medicaid funds six waiver programs for home and community-based services that enable individuals in need of long-term care services to remain in a community setting, when the level of care they need would otherwise warrant placement in a long-term care facility. In an effort to reduce the rate of growth in nursing home expenditures, the state applied for and received a federal demonstration grant, called *Money Follows the Person*, which seeks to transition many institutionalized residents to home and community settings. State policy (called "Money Follows the Individual") ensures that funding is available for those who transition to receive services through one of the state's 1915(c) home and community-based service (HCBS) waiver programs. Other waiver programs allow Medicaid to provide medical and qualified nonmedical services to medically fragile children, individuals with developmental disabilities, and individuals with traumatic brain injury. Finally, the New Directions waiver for people with developmental disabilities was implemented in fiscal year 2006, bringing the total number of waivers to seven.

FIGURE 20: Estimated Per Capita Nursing Home and Home Health Expenditures and Rate of Growth in Maryland



As in other states, Medicaid is the largest source of payment for both nursing home and home health care in Maryland. In 2007, Medicaid financed 45 percent of all expenditures for nursing home care and 63 percent of expenditures for home health care (Table 5). From 2003 to 2007, Medicaid financed a growing share of home health care services (increasing from 59 percent of total spending for home health care in 2003 to 63 percent in 2007), while its share of total spending for nursing home care has continued to decline (from 47 percent to 45 percent).

TABLE 5: Estimated Nursing Home and Home Health Expenditures by Source of Payment in Maryland

PAYER CATEGORY	NURSING HOME						HOME HEALTH					
	2003		2006		2007		2003		2006		2007	
	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total	Expenditure ($ millions)	Percent of Total
TOTALS	**$2,042**	**100%**	**$2,389**	**100%**	**$2,512**	**100%**	**$979**	**100%**	**$1,207**	**100%**	**$1,289**	**100%**
Medicare	305	15	420	18	479	19	135	14	164	14	177	14
Medicaid	966	47	1,093	46	1,123	45	581	59	765	63	817	63
Other Government	42	2	64	3	63	3	12	1	13	1	17	1
Private Coverage	143	7	159	7	162	6	90	9	103	9	106	8
Out-of-Pocket	586	29	654	27	686	27	162	17	162	13	171	13

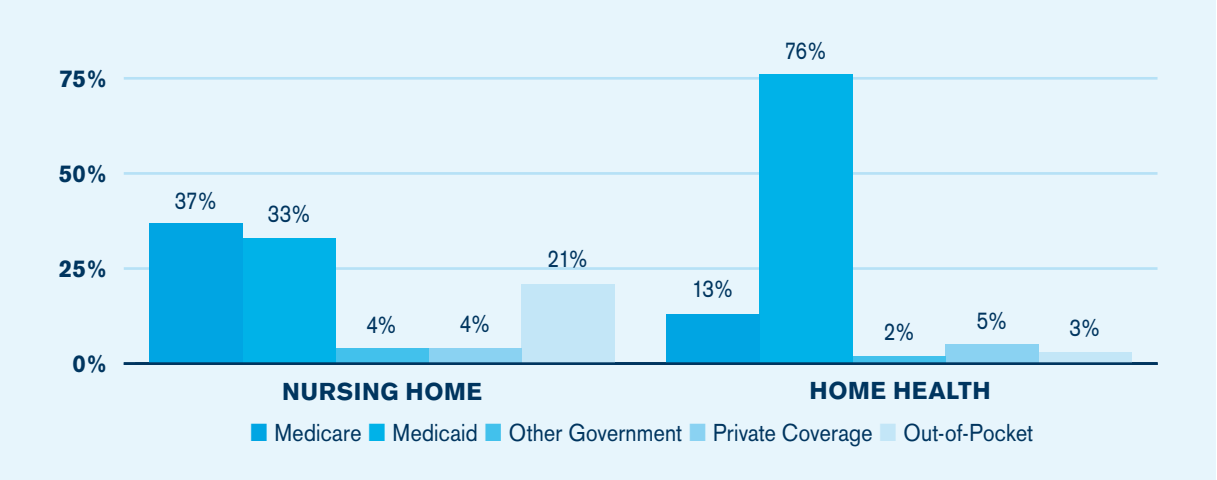
Medicare finances either nursing home or home health care only as it relates to recovery from a hospitalization. As a result, it is a relatively minor payer for these services, despite relatively high need for these services among the elderly and disabled populations that Medicare serves. Nevertheless, Medicare spending for nursing home care has increased as the number of Medicare beneficiaries in Maryland has risen. Medicare accounted for 19 percent of total spending for nursing home care in 2007, compared with 15 percent in 2003.

Reflecting Medicare's limited role in financing either nursing home or home health care, and the fact that private long-term care insurance remains relatively rare, Marylanders finance a significant share of all long-term care expenditures out-of-pocket.[17] In 2007, Marylanders paid 27 percent of nursing home care expenditures and 13 percent of home health care expenditures out-of-pocket.

Together, Medicare and Medicaid accounted for most of the growth in expenditures for both nursing home care and home health care from 2003 to 2007. Medicare accounted for 37 percent of the growth in nursing home expenditures over this period, and 13 percent of the growth in expenditures for home health care (Figure 21). Medicaid also accounted for a large share of the growth in expenditures for nursing home care (33 percent) from 2003 to 2007, and most of the growth in expenditures for home health care (76 percent)—reflecting Medicaid's policy of serving beneficiaries in need of long-term care services in the community when possible.

Out-of-pocket spending for both nursing home care and home health care has grown slowly compared with Medicare and Medicaid expenditures, declining as a percentage of total expenditures for both service types. Out-of-pocket spending accounted for 21 percent of the growth in expenditures for nursing home care from 2003 to 2007, and just 3 percent of the growth in expenditures for home health care.

FIGURE 21: Estimated Share of Increase in Nursing Home and Home Health Expenditures by Source of Payment in Maryland, 2003–2007



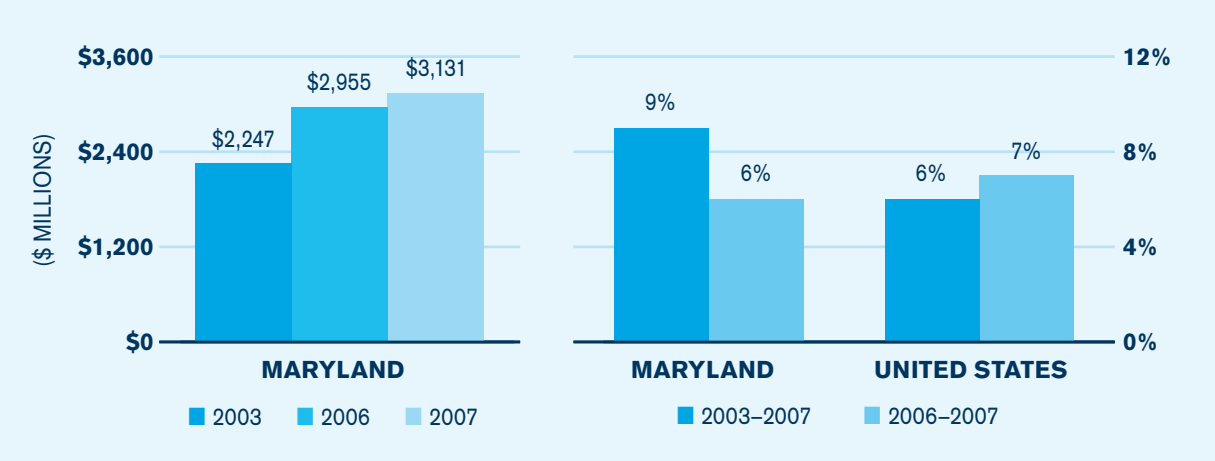
[17] Responding to the magnitude of uninsured long-term care expenditures and the correspondingly high probability that individuals who require long-term care will "spend down" to Medicaid eligibility, the federal Deficit Reduction Act of 2005 (DRA-05) authorized long-term care insurance partnerships that enable individuals who purchase qualifying long-term care insurance policies to retain a specified amount of assets and still qualify for Medicaid, provided they meet other Medicaid eligibility criteria—including income criteria. Maryland is one among at least 21 states that enacted authorizing legislation in anticipation of this change in federal law—although in no state are these provisions likely to substantially affect out-of-pocket spending for long-term care services or spend-down to Medicaid eligibility in the near term. E. Kassner (2006), *Long-Term Care Partnership Programs* (Washington, DC: AARP Public Policy Institute) (http://www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html, accessed 3/4/09).

EXPENDITURES FOR THE ADMINISTRATION AND NET COST OF INSURANCE

Expenditures for administration and the net cost of insurance include all payments for public programs and private insurance net of payments for medical services. For both private insurers and public programs, the administrative costs of insurance include costs for enrolling and disenrolling participants and processing claims. For private insurers, the net cost of insurance also includes profits, capital expenditures, additions to surplus, and assessments and taxes.

In 2007, Marylanders spent $3.1 billion for the administration and net cost of private insurance and the administration of public insurance programs (Figure 22). Expenditures for administration and the net cost of insurance increased much faster in Maryland from 2003 to 2007 than the national average—growing at an average rate of 9 percent per year compared with 6 percent nationally. However, from 2006 to 2007, growth in expenditures for administration and the net cost of insurance in Maryland dropped to 6 percent, while national expenditures increased to 7 percent.

FIGURE 22: Estimated Administration Expenditures and Net Cost of Insurance, and Rate of Growth



Some of Maryland's faster growth in expenditures for administration and the net cost of insurance from 2003 to 2007 may reflect the removal of HMOs' exemption from the 2 percent state tax on premiums that non-HMO insurers pay, as HMOs passed the state tax through to subscribers. The additional revenue gained from the removal of this exemption has been used to help subsidize the cost of medical malpractice premium rates and to increase Medicaid payments.[18, 19] In addition, some of the largest insurers in Maryland added significantly to surplus and profit over this period, as premium increases exceeded medical cost growth.[20] Finally, the development of Medicare Part D plans as well as enrollment in Medicare Advantage

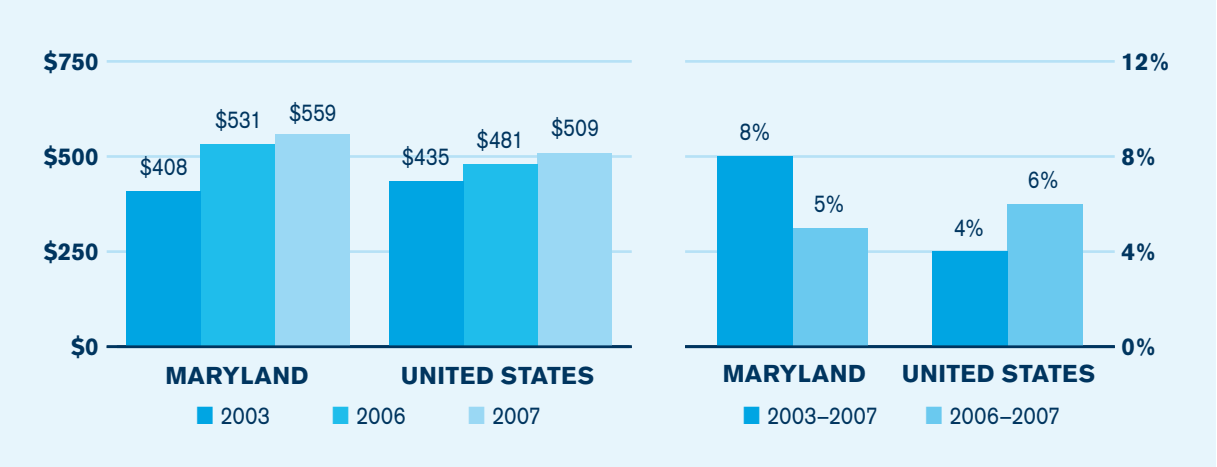
[18] Medicaid started transitioning payment increases by procedure codes in 2005 with codes billed by obstetricians/gynecologists, neurosurgeons, and emergency medicine personnel, who generally face the highest malpractice insurance premiums. Medicaid rates are projected to equal 80 to 100 percent of Medicare fees for all specialties by 2009.

[19] Enacted in 2005, S.B. 831 also capped malpractice insurance rate increases for physicians at 5 percent in 2005. In addition, S.B. 831 capped noneconomic damages at $650,000 in most malpractice lawsuits and at $812,500 in cases that involve patient deaths.

[20] M.W. Salganik (March 21, 2007). Health Insurer '06 Net Up 30%; CareFirst's Income Was $142 Million as Revenue Rose Faster than Costs. *The Baltimore Sun* (http://www.baltimoresun.com/about/bal-searchfront-htmlstory,0,5586988.htmlstory, accessed 1/7/08).

plans have contributed to higher administrative and net costs of insurance in Maryland and nationally.[21] In Maryland, these plans have averaged very low amounts of claims paid per premium dollar, helping to drive per capita expenditures for administration and the net cost of insurance that have risen faster than the national average. From 2003 to 2007, expenditures in this category grew twice as fast in Maryland (8 percent) as the national average (4 percent) (Figure 23). While per capita expenditures for administration and the net cost of insurance grew more slowly in Maryland from 2006 to 2007 (5 percent, as the national growth rate accelerated to 6 percent), Marylanders nevertheless paid nearly 10 percent more per capita for the administration and net cost of insurance in 2007 ($559) than the national average ($509). In 2003, they paid 6 percent less than the national average.

FIGURE 23: Estimated Per Capita Administration Expenditures and Net Cost of Insurance, and Rate of Growth, Maryland and U.S.



Private insurance accounts for the largest share of expenditures for the administration and net cost of insurance in Maryland: in 2007, about 70 percent of total expenditures in this category—nearly $2.2 billion (Table 6). In contrast, Medicaid and Medicare, respectively, accounted for 14 percent and 11 percent of expenditures for administration and the net cost of insurance—totaling about $811 million in 2007. Largely associated with enrollment in Medicare Part D and Medicare Advantage plans, Medicare expenditures for the administration and net cost of insurance more than doubled from 2003 to 2007—increasing from $163 million (7 percent of total expenditures) to $453 million (14 percent of total expenditures).

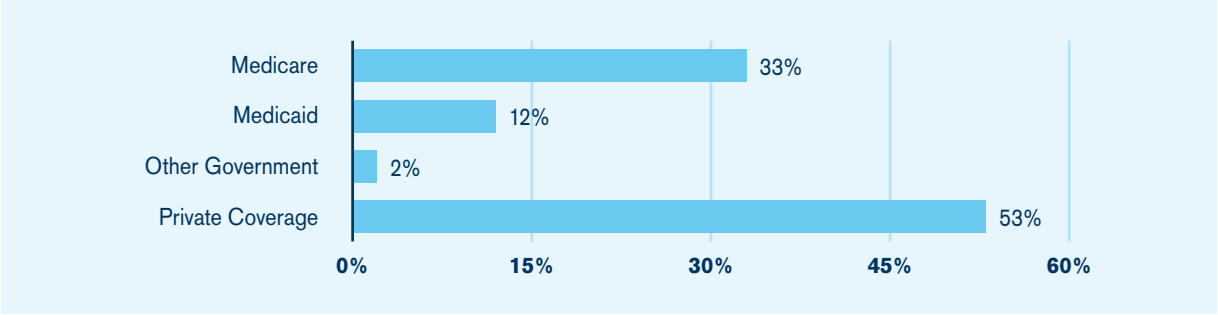
[21] In 2007, the administrative costs, sales expenses, and profits of private Part D insurers averaged $180 per beneficiary. Including $300 million incurred by the Centers for Medicare & Medicaid Services (CMS) to administer the program, total administrative expenses, sales costs, and profits were projected to total $4.6 billion. Of this amount, profits of Part D insurers accounted for an estimated $1 billion. In total, these expenditures accounted for an estimated 9.8 percent of the total costs of Medicare Part D. U.S. House of Representatives, Committee on Oversight and Government Reform, Majority Staff (October 2007), *Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage* (http://oversight.house.gov/documents/20071015093754.pdf, accessed 3/3/09).

TABLE 6: Estimated Administration Expenditures and Net Cost of Insurance by Source of Payment in Maryland

PAYER CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$2,247**	**100%**	**$2,955**	**100%**	**$3,131**	**100%**
Medicare	163	7	409	14	453	14
Medicaid	247	11	386	13	358	11
Other Government	107	5	109	4	121	4
Private Coverage	1,730	77	2,051	69	2,199	70

Consistent with its high share of total expenditures for the administration and net cost of insurance, private insurance accounted for more than half of the growth in these expenditures (53 percent) from 2003 to 2007 (Figure 24). However, this is much less than its share of total expenditures in this category, reflecting the relatively fast growth of Medicare spending for the administration and net cost of insurance. Medicare accounted for 33 percent of the growth in total expenditures for the administration and net cost of insurance from 2003 to 2007, while Medicaid accounted for just 12 percent.

FIGURE 24: Estimated Share of Increase in Administration Expenditures and Net Cost of Insurance by Source of Payment in Maryland, 2003–2007



WHO PAID FOR MARYLAND'S HEALTH CARE?

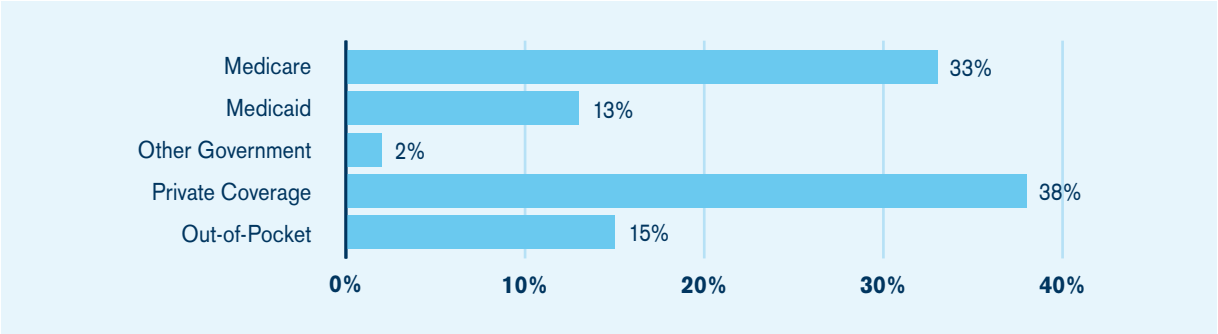
Private payers—either private insurance or consumer out-of-pocket payments—finance more than half of health care expenditures in Maryland. In 2007, private insurance financed 39 percent of all health care expenditures; 19 percent were paid out-of-pocket (Table 7). Government programs financed the balance of expenditures for health care in Maryland—including Medicare (23 percent), Medicaid (16 percent), and other government programs (4 percent). Taken together, public program expenditures accounted for about the same share of all health care expenditures in 2007 (43 percent) as in 2003 (41 percent).

TABLE 7: Estimated Health Care Expenditures by Source of Payment in Maryland

PAYER CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$27,003**	**100%**	**$33,683**	**100%**	**$35,810**	**100%**
Medicare	5,239	19	7,473	22	8,169	23
Medicaid	4,638	17	5,525	16	5,747	16
Other Government	1,266	5	1,307	4	1,419	4
Private Coverage	10,497	39	13,102	39	13,821	39
Out-of-Pocket	5,362	20	6,276	19	6,654	19

Private insurance accounted for the largest proportion of the increase in total health care spending in Maryland from 2003 to 2007 (38 percent), followed by Medicare (33 percent) as a result of new coverage for prescription drugs (Figure 25). Reflecting greater coverage for prescription drugs among retirees, just 15 percent of the growth in total expenditures was paid out-of-pocket. Reflecting greater enrollment, Medicaid accounted for 13 percent of expenditure growth from 2003 to 2007.

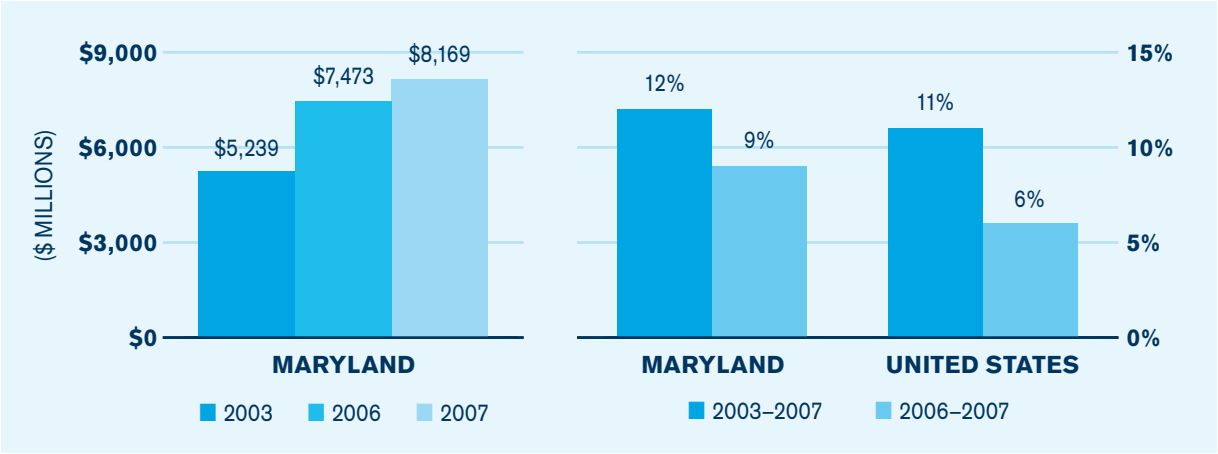
FIGURE 25: Estimated Share of Increase in Health Care Expenditures by Source of Payment in Maryland, 2003–2007



MEDICARE EXPENDITURES

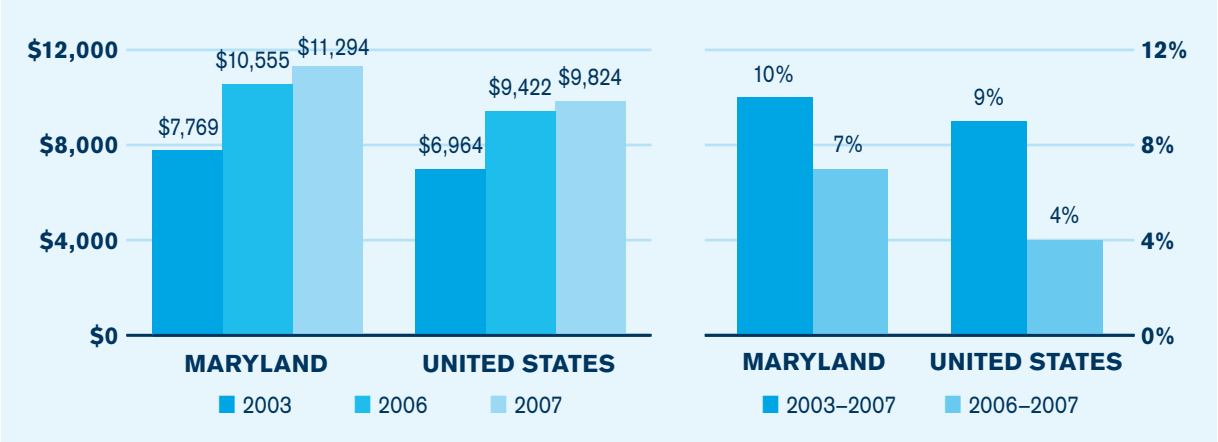
Medicare expenditures in Maryland reached nearly $8.2 billion in 2007—reflecting rapid growth in expenditures from 2003 to 2007. Over that period, Medicare spending in Maryland increased at an average rate of 12 percent per year, compared with an 11 percent average rate nationally (Figure 26). Following the introduction of Part D, Medicare expenditures increased more slowly in Maryland and nationally. Nevertheless, Medicare expenditures in Maryland grew 9 percent from 2006 to 2007, much faster than the national average (6 percent).

FIGURE 26: Estimated Medicare Expenditures and Rate of Growth



On a per enrollee basis, Medicare expenditures in Maryland are much higher than the national average, and they have grown faster. In 2007, Medicare spent nearly 15 percent more per beneficiary in Maryland than the national average—$11,294 compared with a national average of $9,824 (Figure 27). Medicare spending per enrollee in Maryland increased at an average rate of 10 percent per year from 2003 to 2007, slowing to 7 percent from 2006 to 2007, after the introduction of Medicare Part D. Nationally, Medicare spending per enrollee grew at an average rate of 9 percent per year from 2003 to 2007, and increased just 4 percent from 2006 to 2007.

FIGURE 27: Estimated Per Enrollee Medicare Expenditures and Rate of Growth, Maryland and U.S.



In 2007, more than half of Medicare expenditures in Maryland were associated with hospital inpatient care (42 percent) and outpatient care (12 percent), compared with 21 percent for physician and other professional services (Table 8). Nine percent of Medicare expenditures were for prescription drugs, reflecting enrollment in Medicare prescription drug plans (PDPs) that has quickly reached nearly the same penetration in Maryland as nationwide.[22]

TABLE 8: Estimated Medicare Expenditures by Service Category in Maryland

SERVICE CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$5,239**	**100%**	**$7,473**	**100%**	**$8,169**	**100%**
Inpatient	2,477	47	3,150	42	3,444	42
Outpatient	681	13	894	12	975	12
Physician Services	1,109	21	1,333	18	1,392	17
Other Professional Services	238	5	318	4	343	4
Prescription Drugs	5	0	640	9	746	9
Nursing Home Care	305	6	420	6	479	6
Home Health Care	135	3	164	2	177	2
Other Services	127	2	146	2	160	2
Administration and Net Cost of Insurance	163	3	409	5	453	6

NOTE: 0% indicates < 0.5%.

With the introduction of Part D in 2006, Medicare expenditures for prescription drugs increased, as did expenditures for the administration and net cost of insurance. Following implementation of Part D, Medicare expenditures for prescription drugs accounted for about the same share of total Medicare expenditures in both 2006 and 2007. However, expenditures for the administration and net cost accounted for a growing share of Medicare expenditures—6 percent in 2007, compared with 5 percent in 2006 and 3 percent in 2003, before implementation of Part D.[23]

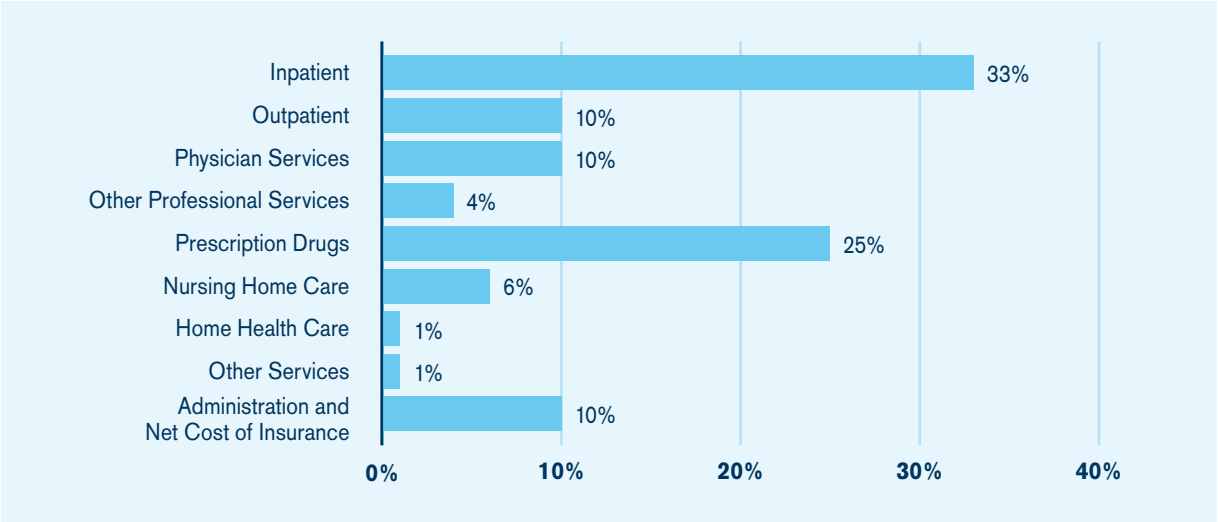
As the largest single category of Medicare expenditure in Maryland, hospital inpatient care accounted for a large proportion of the program's expenditure growth from 2003 to 2007 (Figure 28). Growth in expenditures for inpatient hospital care accounted for 33 percent of the total growth in Medicare expenditures

[22] As of December 2008, 36 percent of Medicare beneficiaries in Maryland were enrolled in PDPs, compared with 38 percent nationally. However, just 7 percent were enrolled in Medicare Advantage plans (which in Maryland typically offer prescription drug coverage), compared with 23 percent nationally. See: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MPDPESCC/list.asp#TopOfPage, accessed 3/11/09). Nationally, about 10.4 percent of Medicare spending for personal health care was for retail prescription drugs in 2006 (the most recent year for which national estimates are available). See: Aaron Catlin et al. (January/February 2008), National Health Spending in 2006: A Year of Change for Prescription Drugs, *Health Affairs* 27, no. 1: 14-29.

[23] Nationally, the administrative costs, sales expenses, and profits of private Part D insurers accounted for 9.8 percent of the total costs of Medicare Part D nationally. In contrast, administrative costs for traditional Medicare average 1.7 percent of total expenditures. U.S. House of Representatives, Committee on Oversight and Government Reform (October 15, 2007), *Private Medicare Drug Plans: Seniors and Taxpayers Hurt by High Expenses, Low Rebates* (http://oversight.house.gov/documents/story.asp?ID=1536, accessed 3/3/09).

in Maryland over this period, while increased spending for prescription drugs accounted for 25 percent. Physician services and outpatient hospital care each accounted for 10 percent of total Medicare expenditure growth—matched by increased spending for the administration and net cost of insurance, which also accounted for 10 percent of the increase in Medicare expenditures from 2003 to 2007.[24]

FIGURE 28: Estimated Share of Increase in Medicare Expenditures by Service Category in Maryland, 2003–2007

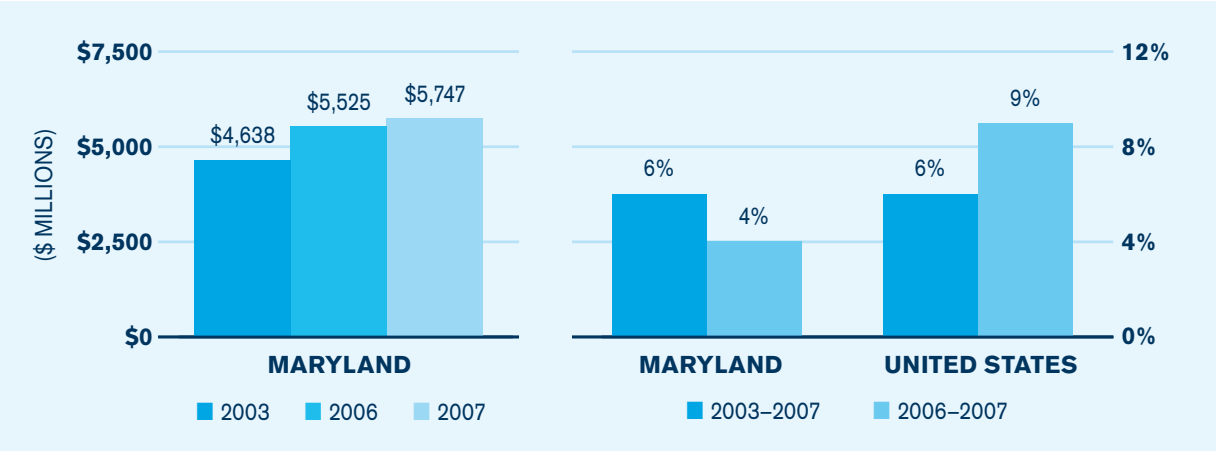


[24] The Supplemental Medical Insurance (Part B) program uses a fee schedule to pay for covered medical services provided by physicians. In 1998, the Congress instructed CMS to update this fee schedule using a Sustainable Growth Rate (SGR) method, intended to control spending on physician services under Part B. Since 2002, Part B expenditures for physician services have consistently exceeded the targets established by the formula. To meet SGR targets in 2009 would require reducing allowed charges for physician services by 4.6 percent. See: *2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (March 25, 2008), Table IV.B1 (http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf).

MEDICAID EXPENDITURES

Maryland's Medicaid program spent approximately $5.7 billion for health care services in 2007, financed with both state and federal dollars (Figure 29). From 2003 to 2007, Medicaid spending in Maryland increased at an average rate of 6 percent per year, equal to the national average. However, from 2006 to 2007, Medicaid expenditures in Maryland grew just 4 percent, more slowly than the long-term trend in Maryland—and also much slower than the 9 percent increase in Medicaid spending nationally, which in many states reflected restoration and even expansion of eligibility for Medicaid and SCHIP.[25]

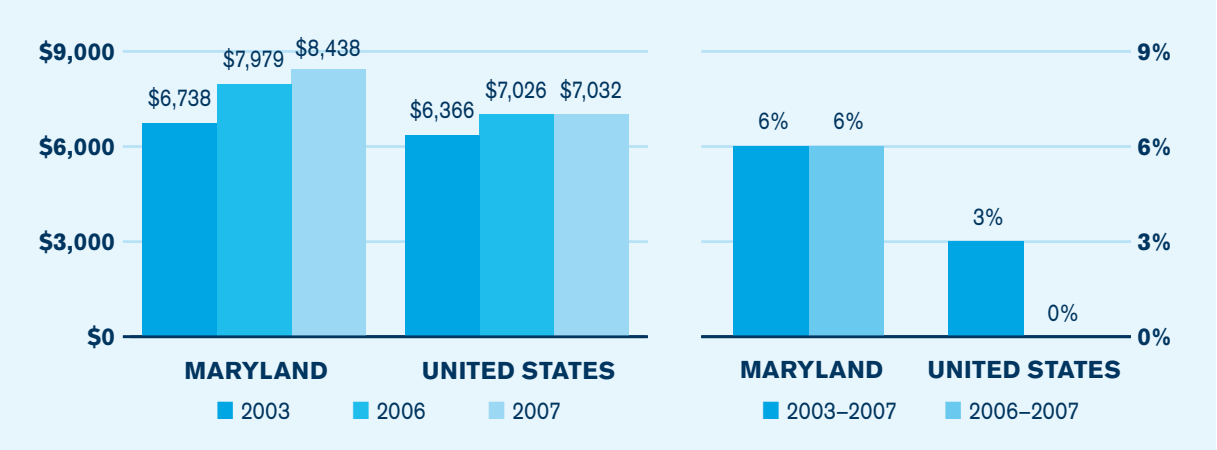
FIGURE 29: Estimated Medicaid Expenditures and Rate of Growth



In 2007, Medicaid expenditures per enrollee in Maryland were nearly 20 percent higher than the national average—$8,438 in Maryland, compared with $7,032 nationally (Figure 30). From 2003 to 2007, per enrollee expenditures grew twice as fast in Maryland as the national average—at 6 percent per year, compared with 3 percent nationally. Medicaid expenditures continued to grow at the same rate (6 percent) from 2006 to 2007, while national expenditures per enrollee did not grow at all.

[25] From 2001 to 2003, many states struggled to balance their budgets in the face of falling revenues. In 2004, financial conditions in many states showed signs of improvement, and by 2006 and 2007, some states had restored or even expanded Medicaid and SCHIP eligibility and enrollment. See: AcademyHealth (2005, 2006, and 2007). *State of the States.* The Robert Wood Johnson Foundation State Coverage Initiatives Program (http://www.statecoverage.net/pdf/stateofstates2005.pdf; http://www.statecoverage.net/pdf/stateofstates2006.pdf; and http://statecoverage.net/pdf/StateofStates2007.pdf, accessed 2/21/08).

FIGURE 30: Estimated Per Enrollee Medicaid Expenditures and Rate of Growth, Maryland and U.S.



NOTE: 0% indicates < 0.5%.

Including inpatient and outpatient care, hospital care accounted for more than one-third of Medicaid expenditures (36 percent) in 2007—totaling nearly $2.1 billion (Table 9). Inpatient care accounted for most of this amount (27 percent of total expenditures). Reflecting Medicaid's position in Maryland, as in other states, the largest purchaser of long-term care services, nursing home services and home health care, accounted for more than a third of the program's total expenditure for health care services—in 2007, 34 percent.

TABLE 9: Estimated Medicaid Expenditures by Service Category in Maryland

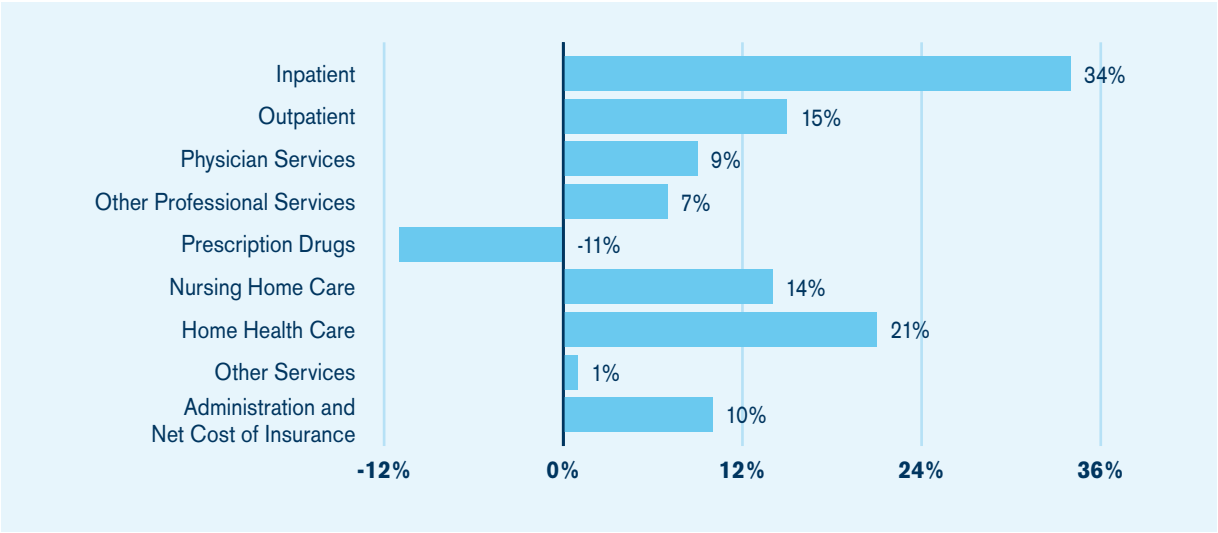
SERVICE CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$4,638**	**100%**	**$5,525**	**100%**	**$5,747**	**100%**
Inpatient	1,178	25	1,468	27	1,553	27
Outpatient	341	7	470	9	505	9
Physician Services	271	6	347	6	375	7
Other Professional Services	450	10	538	10	526	9
Prescription Drugs	569	12	414	7	443	8
Nursing Home Care	966	21	1,093	20	1,123	20
Home Health Care	581	13	765	14	817	14
Other Services	35	1	44	1	48	1
Administration and Net Cost of Insurance	247	5	386	7	358	6

Medicaid expenditures for prescription drugs have declined since 2003, as Medicare has assumed a large share of the cost of prescription drugs for dual eligibles. Nevertheless, reflecting the complex structure of Medicare Part D coverage, Medicaid continues to pay some of these costs—for expenditures below the

Part D deductible, as well as expenditures in the "donut hole" or that exceed the annual limit on Medicare coverage.[26]

Most of the growth in Medicaid expenditures in Maryland from 2003 to 2007 was associated with increased expenditure for inpatient hospital care (34 percent) and for home health care (21 percent) (Figure 31). In general, the growth in Medicaid expenditures for inpatient hospital care reflects increases in the growth of hospital prices set on an all-payer basis, not growth in rates of hospitalization or length of stay among Medicaid enrollees.[27] Similarly, Medicaid's growing expenditure for home health care (with slower growth in expenditures for nursing home care) reflects a policy decision to serve beneficiaries in home and community-based settings when possible, under a federal waiver of Medicaid regulation.[28]

FIGURE 31: Estimated Share of Increase in Medicaid Expenditures by Service Category in Maryland, 2003–2007



[26] Medicare Part D coverage includes a deductible, a coverage gap (called the "donut hole"), and catastrophic coverage. Each year, Medicare establishes "model plan" provisions, including limits on each of these parameters. In 2009, beneficiaries with prescription drug coverage pay (not more than) the first $295 out-of-pocket (the deductible), after which the drug plan pays about 75 percent of costs, until total drug expenses (paid by the plan and the beneficiary) reach as much as $2,700. The beneficiary then pays 100 percent of expenses that exceed $2,700, until the beneficiary's out-of-pocket expense for drugs reaches $4,350. At that point, the plan will pay as much as 95 percent of additional drug costs for the calendar year. Each of these parameters—the deductible, total expenditures up to the "donut hole," and beneficiary expenditures that trigger catastrophic coverage—have increased since 2007. See: http://www.medicare-partd.com/PartD-How-the-MedicarePartD-Plans-Work.php, accessed 3/10/09.

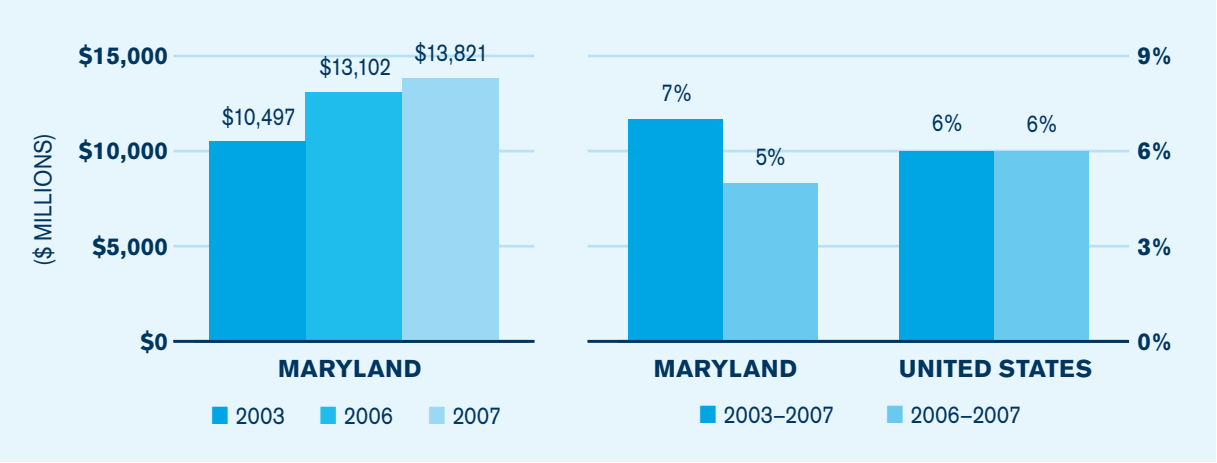
[27] For all payers in Maryland, hospital charges per case increased 5.13 percent over the 12-month period ending November 2007, compared with an increase of 6.8 percent over the prior 12-month period. Hospital admissions in Maryland increased 1.27 percent, compared with an increase of 1.87 percent over the prior 12-month period. See: Maryland Health Services Cost Review Commission (March 2007), *Monitoring Maryland Performance* (http://www.hscrc.state.md.us/financial_data_reports /MonitoringMDPerf.htm, accessed 2/16/09).

[28] Maryland Medicaid funds six waiver programs for home and community-based services that enable individuals in need of long-term care services to remain in a community setting, when the level of care they need would otherwise warrant placement in a long-term care facility. In an effort to reduce the rate of growth in nursing home expenditures, the state applied for and received a federal demonstration grant, called *Money Follows the Person*, which seeks to transition many institutionalized residents to home and community settings. State policy (called "Money Follows the Individual") ensures that funding is available for those who transition to receive services through one of the state's 1915(c) home and community-based service (HCBS) waiver programs. Other waiver programs allow Medicaid to provide medical and qualified nonmedical services to medically fragile children, individuals with developmental disabilities, and individuals with traumatic brain injury. Finally, the New Directions waiver for people with developmental disabilities was implemented in fiscal year 2006, bringing the total number of waivers to seven.

PRIVATE INSURANCE EXPENDITURES

Private insurers are the dominant payers for health care in Maryland, financing $13.8 billion in expenditures for health care in 2007 (Figure 32). From 2003 to 2007, private insurance expenditures in Maryland grew at an average annual rate of 7 percent per year, compared with 6 percent average annual growth in private insurance expenditures nationally. From 2006 to 2007, private insurance expenditures in Maryland grew more slowly—5 percent—while private insurance expenditures nationally continued to grow at 6 percent. Because the number of insured residents did not change significantly from 2003 to 2007 (or from 2006 to 2007), virtually all of the increase in private insurance expenditures in Maryland represented an increase in expenditures per enrollee.[29]

FIGURE 32: Estimated Private Insurance Expenditures and Rate of Growth

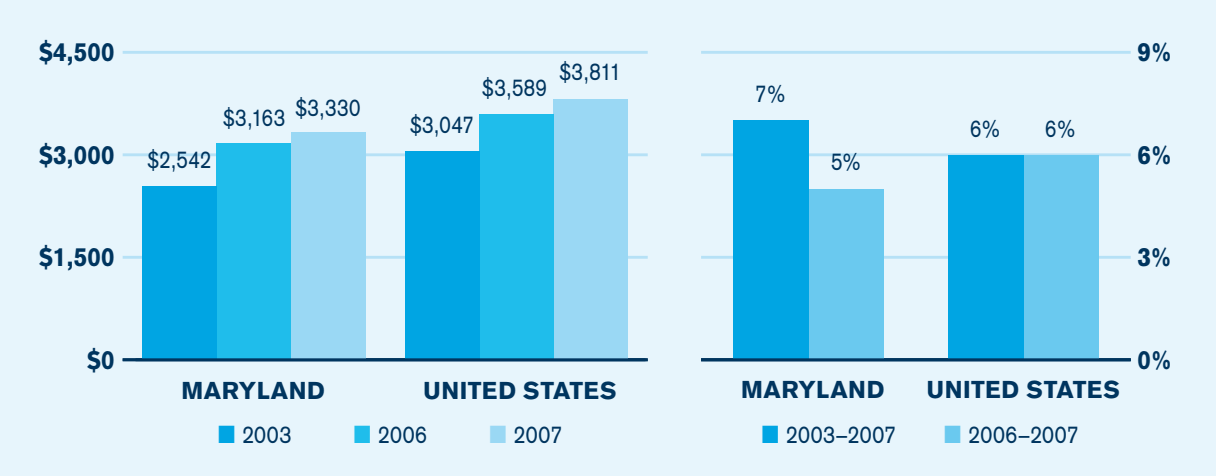


Estimated per privately insured person, insurance expenditures in Maryland were lower than the national average in 2007, as in earlier years (Figure 33).[30] Growth in private insurance expenditures per enrollee mirror the changes in total expenditures: while expenditures per enrollee grew faster than the national average from 2003 to 2007, growth slowed from 2006 to 2007, increasing more slowly than the national average.

[29] Private insurance enrollment in Maryland did not change appreciably from 2003 to 2007. However, primarily reflecting the loss of employer-based coverage, the private coverage rate fell from a 2-year average of 78 percent in 2002-2003 to 76 percent in 2006-2007. Over the same period, Maryland's nonelderly uninsured rate grew from 14 percent to 15 percent. See; Maryland Health Care Commission (January 2009), *Health Insurance Coverage in Maryland Through 2007* (http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_thru_2007.pdf).

[30] It is notable that private insurance expenditures per capita in Maryland are lower than the national average, while Medicare expenditures per capita exceed the national average. Available research suggests that this pattern might be explained by high rates of uninsured under age 65, but this would not explain the pattern in Maryland. See: J. M. McWilliams, et al. (July 12, 2007), Use of Health Services by Previously Uninsured Medicare Beneficiaries, *New England Journal of Medicine* 357(2):143–153.

FIGURE 33: Estimated Per Enrollee Private Insurance Expenditures and Rate of Growth, Maryland and U.S.



In 2007, physician and other professional services together accounted for about a third of private insurance expenditures for health care, followed closely by inpatient and outpatient hospital care (29 percent) (Table 10). Prescription drugs (17 percent) accounted for most other private insurance expenditures. The administration and net cost of insurance accounted for 16 percent of private insurance expenditures in 2007—approximately the same proportion as in 2003.

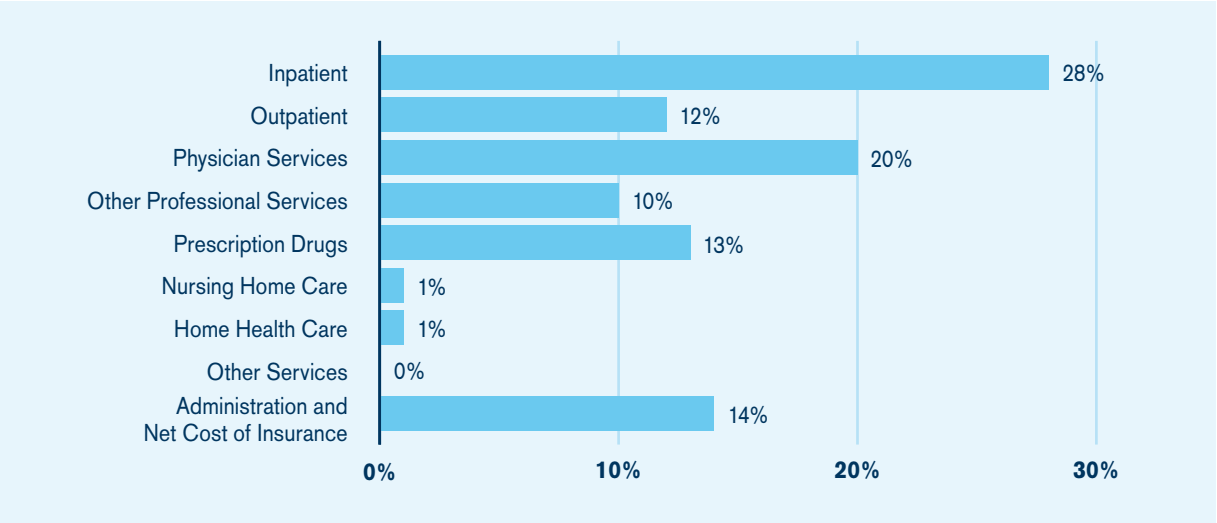
TABLE 10: Estimated Private Insurance Expenditures by Service Category in Maryland

SERVICE CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$10,497**	**100%**	**$13,102**	**100%**	**$13,821**	**100%**
Inpatient	1,982	19	2,750	21	2,921	21
Outpatient	716	7	1,041	8	1,129	8
Physician Services	2,652	25	3,198	24	3,324	24
Other Professional Services	1,202	11	1,498	11	1,544	11
Prescription Drugs	1,937	18	2,254	17	2,385	17
Nursing Home Care	143	1	159	1	162	1
Home Health Care	90	1	103	1	106	1
Other Services	45	0	49	0	50	0
Administration and Net Cost of Insurance	1,730	16	2,051	16	2,199	16

NOTE: 0% indicates < 0.5%.

Growth in expenditures for inpatient care accounted for 28 percent of the growth in private insurance expenditures from 2003 to 2007 (Figure 34)—as for other payers, reflecting the allowed increases in hospital rates over this period (page 17). In contrast, growth in expenditures for physician services accounted for just 20 percent of the growth in private insurance expenditures, followed by expenditures for the administration and net cost of insurance (14 percent) and prescription drugs (13 percent).

FIGURE 34: Estimated Share of Increase in Private Insurance Expenditures by Service Category in Maryland, 2003–2007

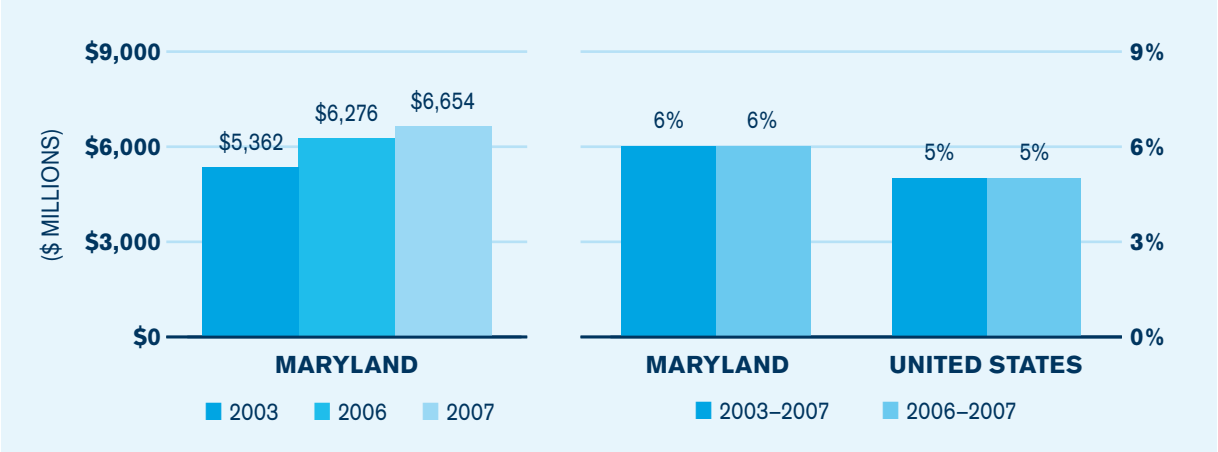


NOTE: 0% indicates < 0.5%.

OUT-OF-POCKET EXPENDITURES

In 2007, Marylanders paid nearly $6.7 billion for health care out-of-pocket (Figure 35). Historically and recently, the growth in out-of-pocket spending in Maryland has exceeded the national average. From 2003 to 2007 (and also from 2006 to 2007), out-of-pocket expenditures in Maryland increased at an average rate of 6 percent per year, compared with 5 percent average annual growth nationally.

FIGURE 35: Estimated Out-of-Pocket Expenditures and Rate of Growth

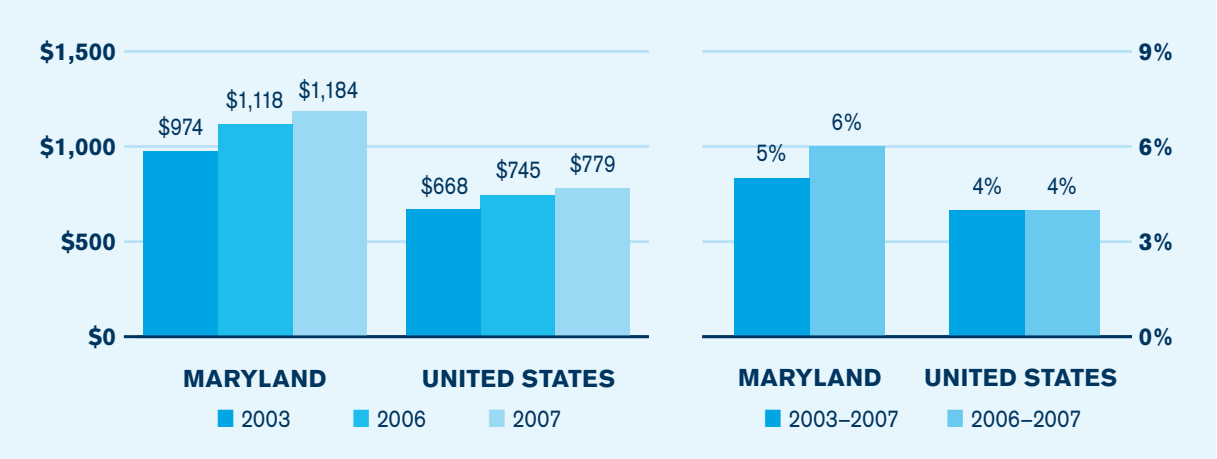


Per capita, Marylanders pay much more out-of-pocket for health care than the national average—in 2007, nearly 52 percent more ($1,184 versus $779). In general, this difference has remained consistent with higher personal income in Maryland, although the higher growth in out-of-pocket spending in Maryland may indicate increasing burden for residents whose incomes have not kept pace with the statewide average.[31, 32] From 2003 to 2007, out-of-pocket expenditures per capita increased at an average rate of 5 percent per year, compared with 4 percent nationally (Figure 36). From 2006 to 2007, out-of-pocket expenditures per capita in Maryland grew still faster, by 6 percent, while expenditures per capita nationally continued to grow at 4 percent.

[31] In 2007, mean household income in Maryland was $82,390, 22 percent higher than the national average. See: U.S. Census Bureau (http://www.census.gov/hhes/www/income/Inequality%20measures%202007.pdf, accessed 3/11/09).

[32] Marylanders on average paid about the same proportion of personal income for all health care services out-of-pocket in 2007 as in 2003—about 2.5 percent. From 2003 to 2007 (and from 2006 to 2007), total personal income in Maryland increased at an average annual rate of 6.5 percent per year, compared with growth in total out-of-pocket expenditures of approximately 5.5 percent. U.S. Department of Commerce, Bureau of Economic Analysis (http://www.bea.gov/regional/spi/drill.cfm, accessed 3/11/09).

FIGURE 36: Estimated Per Capita Out-of-Pocket Expenditures and Rate of Growth, Maryland and U.S.



As in earlier years, expenditures for prescription drugs and other professional services continued to account for most out-of-pocket expenditures in 2007 (Table 11). Prescription drugs accounted for 29 percent of out-of-pocket spending in 2007, while other professional services accounted for 25 percent. While still relatively small individual components of out-of-pocket spending, hospital inpatient and outpatient care and physician services each represented a rising proportion of out-of-pocket expenditures from 2003 to 2007—together accounting for 24 percent of out-of-pocket expenditures in 2007, compared with 19 percent in 2003.

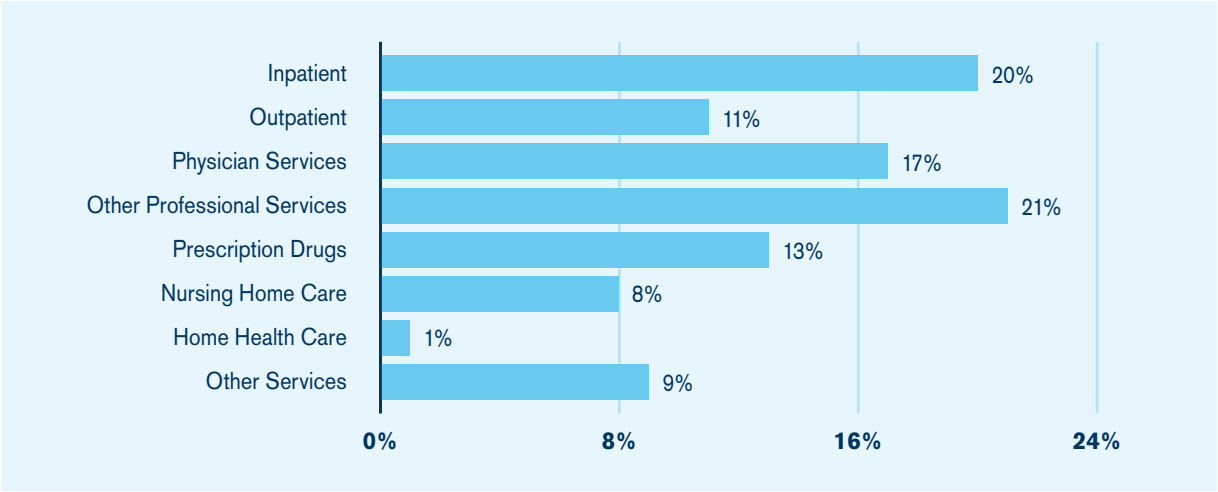
TABLE 11: Estimated Out-of-Pocket Expenditures by Service Category in Maryland

SERVICE CATEGORY	2003 Expenditures ($ millions)	2003 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total	2007 Expenditures ($ millions)	2007 Percent of Total
TOTALS	**$5,362**	**100%**	**$6,276**	**100%**	**$6,654**	**100%**
Inpatient	125	2	349	6	383	6
Outpatient	163	3	277	4	308	5
Physician Services	717	13	893	14	939	14
Other Professional Services	1,401	26	1,642	26	1,671	25
Prescription Drugs	1,775	33	1,808	29	1,948	29
Nursing Home Care	586	11	654	10	686	10
Home Health Care	162	3	162	3	171	3
Other Services	435	8	491	8	549	8

Greater out-of-pocket expenditures for other professional services accounted for 21 percent of the growth in total out-of-pocket expenditures from 2003 to 2007, followed closely by increased spending for inpatient care (20 percent) and physician services (17 percent). Increased spending for prescription drugs accounted for just 13 percent of the growth in total out-of-pocket spending over this period, largely due to the introduction of Medicare Part D, but also to a slowing of the introduction of new drugs and much lower prices for many generics.[33]

[33] In 2006 and 2007, a number of large retailers—including Kmart, Wal-Mart, Target, Giant Food stores, and others—deeply discounted prices for a diverse list of generic prescription drugs. See: National Council of State Legislators, Generic Drug Pricing and States (http://www.ncsl.org/PROGRAMS/HEALTH/generic$.htm, accessed 3/15/2009).

FIGURE 37: Estimated Share of Increase in Out-of-Pocket Expenditures by Service Category in Maryland, 2003–2007



PROSPECTS FOR CHANGE

In 2007, total health care cost growth in Maryland stabilized at the national average. In many ways, this is a signal accomplishment. It occurred in the midst of new initiatives to expand Medicaid and small-employer coverage in Maryland and continued high growth in Medicare expenditures, as economic clouds gathered on the horizon.

However, the high cost of health care in Maryland remains a concern. Per capita health care expenditures in Maryland are now at the national average, and growth in wages, household income, and productivity continues to lag far behind growth in health care costs.

In Washington, President Obama's Administration has linked control of health care costs directly to achieving and sustaining economic recovery and fiscal health. Again, Medicare is contemplating major payment changes, as the program anticipates uncontrolled costs and accelerating enrollment with the baby boomers now retiring. In this new national context of major change, forced by economics and demography, Maryland will be charged with developing new ways to manage health care costs, improve the quality and value of health care services, and ensure access to care for all residents—with near-term and sustainable results.

HOSPITAL SERVICES Nationally, growth in expenditures for hospital care is expected to have peaked in 2007 and 2008. In subsequent years, as Medicare enrollment increases drive faster growth in public spending than in private spending for hospital care, expenditures for hospital care are expected to slow significantly.[34]

In Maryland, regulated all-payer hospital reimbursement may drive a different pattern of hospital expenditure growth. However, as growing enrollment in Medicare drives hospital payments nationally, Maryland's ability to constrain health care costs in pace with the national average may force changes in hospital payments that parallel changes in Medicare payment practices. In the short term, concerns about the impact of deepening economic recession on hospital uncompensated care are driving new attention to how Maryland sets hospital rates.

In 2008 and 2009, the federal Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC, the independent agency charged with advising the Congress on Medicare policy) issued, respectively, rules and recommendations to change payment for hospital care nationally.

Responding to a growing literature documenting the human and economic cost of medical errors, CMS issued rules effective October 2008 expanding the list of selected hospital-acquired conditions that have Medicare and Medicaid payment implications.[35] Specifically, Medicare will no longer pay hospitals the increased costs of care that result when a patient is harmed by one of the listed conditions if it was hospital-

[34] See: Sean Keehan et al. (2008), Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare, *Health Affairs* 27, no. 2: w145-w155.

[35] Reviewing 18 types of medical events, one study concluded that medical errors nationally may account for 2.4 million extra hospital days, $9.3 billion in excess charges (for all payers), and 32,600 deaths. See: Centers for Medicare & Medicaid Services (May 18, 2006), Eliminating Serious, Preventable, and Costly Medical Errors—Never Events (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863, accessed 3/12/2009).

acquired.[36] CMS also issued a letter to State Medicaid Directors outlining the states' authority to deny Medicaid payment for these hospital-acquired conditions.

Beginning in 2009, Maryland will introduce a new value-based purchasing initiative. Under this initiative, Maryland hospitals will not be reimbursed for certain readmissions, hospital-acquired infections, and events that should never occur (called "never-events"), such as wrong-site surgery. Maryland will be the only state to hold hospitals accountable in this way for all admissions, not just those treated under Medicare.

As in past years, MedPAC's March 2009 report to Congress calls for major reform of Medicare's approach to paying hospitals.[37] Reflecting on hospitals' high rate of cost growth from 2001 to 2007 (in excess of increases in the market basket of input prices) that resulted in lower Medicare margins, MedPAC concluded that hospitals with the highest private payments and most robust non-Medicare sources of revenues had lower Medicare margins (-11.7 percent) than hospitals under greater fiscal pressure (4.2 percent). In its March 2009 report, MedPAC recommended a hospital payment update just equal to the projected increase in the market basket of input prices for inpatient and outpatient services—while concurrently implementing quality incentives that would update each hospital's payments (above or below the market basket) based on its performance on selected quality measures. In addition, MedPAC recommended a reduction in indirect medical education (IME) payments to teaching hospitals, with the savings to be used to help fund a quality improvement program.

In Maryland, legislative attention in 2008 turned to hospital uncompensated care, as recession increased the number of uninsured residents who generally rely on hospital outpatient departments for care. The Health Services Cost Review Commission (HSCRC), which oversees all-payer hospital rates in Maryland, implemented a uniform assessment on hospital rates to reflect the aggregate reduction in hospital uncompensated care from the expansion of Medicaid eligibility and coverage.

PRACTITIONER SERVICES Levels of payment for practitioner services in Maryland remain below the national average and have continued to grow more slowly. In 2007, concern about access to and reimbursement of physicians and other health care professionals prompted the General Assembly to establish a state Task Force on Health Care Access and Reimbursement. In its 2008 report, the Task Force made a number of recommendations related to promoting practice formation in Maryland, physician credentialing by health plans and hospitals, and performance measurement.[38]

Subsequently, a number of proposals to address payment imbalances are under consideration. However, the potential for state action is limited by ERISA preemption of state regulation that would affect self-insured employer plans, as well as limited enthusiasm among stakeholders for direct regulation of practitioner fees.

[36] Medicare prohibits the hospital from billing the beneficiary for the difference between the lower and higher payment rates. Medicare will pay for physician and other covered items or services that are needed to treat the hospital-acquired condition, including the costs of post-acute care that would not have been needed for the patient's initial medical problem, but are needed because of the hospital-acquired condition.

[37] See: MedPAC (March 2009), *Report to the Congress: Medicare Payment Policy* (http://www.medpac.gov/documents/Mar09_EntireReport.pdf, accessed 3/12/2009).

[38] Maryland Health Care Commission (December 2008), Task Force on Health Care Access and Reimbursement Established under Senate Bill 107, Final Report and Recommendations (http://mhcc.maryland.gov/legislative/hcar_taskforce_finalrpt.pdf, accessed 3/09/2009).

Nevertheless, the shortage of primary care physicians, in particular, remains a growing concern nationally and in Maryland. In most regions of the state, Maryland lags behind the national average in the numbers of primary and specialty care physicians available to treat patients.[39] Because more than a third of currently practicing physicians are over the age of 55, this shortage is projected to worsen as the health workforce ages.

While there is some disagreement whether the projected shortage of specialty physicians is in fact cause for concern, there is little disagreement Maryland's shortage of primary care physicians is problematic. The number of physicians caring for patients in Maryland grew slightly faster than the population from 1992 to 2006, but none of this growth was among primary care physicians.[40]

Nationally, just one-third of physicians practice in primary care and the proportion is dropping—a trend that is largely attributed to lower rates of reimbursement paid to primary care physicians, who earn about half as much as physicians in specialty care.[41, 42] Equalizing reimbursements between primary care and specialty care physicians may ultimately be needed to avert shortages but, unless payments to specialty care physicians or for other services are constrained, it could also drive greater spending for health care.

In its March 2009 report to Congress, MedPAC recommended updating Medicare payments to physicians in 2010 by just 1.1 percent—the same percentage increase as for 2009.[43] However, it again recommended that payments for primary care services be increased when provided by practitioners who focus on primary care.[44] To constrain total Medicare cost growth, this adjustment would be cost-neutral within Medicare's physician fee schedule—that is, specialty physicians would receive lower cost updates.

Changes to Medicare fee levels have a cascading impact on Medicaid and private payers that directly or indirectly peg their fee schedules to the Medicare Fee Schedule. For example, the Medicaid program in Maryland has raised professional fees, with the goal of reaching 80 to 100 percent of Medicare rates. While the 2009 update was deferred due to a state budget shortfall, in future years realignment of Medicare's payments to physicians could also drive changes in Medicaid spending for physician services.

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[39] Maryland Hospital Association (January 7, 2008), Maryland Physician Workforce Study: Executive Summary (http://www.mdhospitals.org/mha/Health_Policy_Issues/Physician_Workforce_Study/Executive_Summary.pdf, accessed 3/9/2009).

[40] Maryland Health Care Commission (December 2008), *op cit.*

[41] This discrepancy arises because specialists provide more procedures, which generally receive higher reimbursement rates, while primary care physicians provide more evaluation and management services. See: Task Force on Health Care Access and Reimbursement (December 2008), *op cit.*

[42] Historically, the declining number of primary care physicians has been partly offset by an increase in the number of female physicians and international physicians practicing in the United States; both are more likely to practice primary care medicine. However, continuing reimbursement for primary care that continues to lag far behind reimbursements for specialty care may induce more doctors to abandon primary care. See: Ha Tu and Ann O'Malley (June 2007), *Exodus of Male Physicians from Primary Care Drives Shift to Specialty Practice*. Washington, DC: Center for Studying Health Systems Change (http://www.hschange.com/CONTENT/934, accessed 3/9/2009).

[43] MedPAC (March 2009), *op cit.*

[44] This payment adjustment would further adjust payment changes implemented in 2007 to compensate physicians for evaluation and management services. Since 2007, CMS has calculated direct and indirect physician expenses (PE) for services that may or may not involve physician work. Collectively, these changes represented the biggest revision to the methods and data used to calculate PE relative value units (RVUs) since 1999. The new PE methods and data redistribute PE payments across services. When fully implemented in 2010, PE RVUs will have increased 7 percent for evaluation and management services and 3 percent for (nonmajor) procedures and tests. By contrast, PE RVUs will have decreased 8 percent for major procedures and 9 percent for imaging services.

PRESCRIPTION DRUG SPENDING Nationally, growth in real expenditures on prescription drugs fell to the lowest level in 30 years in 2007, significantly contributing to the overall slowdown in medical expenditure growth.[45] In Maryland, per capita expenditures for prescription drugs tracked the national trend from 2003 to 2007, but increased much faster than the national average (8 versus 6 percent) from 2006 to 2007.

Nationally, key factors in constraining prescription drug spending have been the expiring patents on several blockbuster drugs and higher usage of generic drugs. Between 2005 and 2007, generics as a proportion of all drugs dispensed grew from 60 percent to 67 percent. Several more blockbuster drugs are scheduled to lose patent protection over the next 3 years, and fewer new drugs are awaiting FDA approval. Both factors could reduce the growth of prescription drug spending in coming years.[46]

However, in recent years, the balance of prescribing has swung away from drugs that are typically prescribed by primary care physicians toward drugs prescribed by specialists. In general, primary care physicians are more likely to prescribe generic drugs, reducing growth in prescription drugs overall. Nationally, prescription drugs prescribed by specialists accounted for 45 percent of all prescriptions in 2007, as expenditures for drugs prescribed by primary care physicians declined and expenditures for specialist-prescribed drugs increased.[47] It is likely that this transition is also occurring in Maryland. With a growing shortage of primary care physicians, specialists' prescribing behavior might explain the acceleration of prescription drug spending in Maryland in 2007, and may also portend continuing high growth in future years. In Medicare Part D plans, a noticeable trend toward increasing use of preferred, nonpreferred, and specialty tiers in formulary designs for 2009 (with sequentially greater cost-sharing) seems likely to increase beneficiaries' out-of-pocket costs this year.[48]

MEDICARE In Maryland, Medicare expenditures per capita are substantially higher than the national average and also have grown faster. Medicare is a major payer for inpatient hospital care, especially, and updates to the state's all-payer hospital rates have been a major source of increased Medicare expenditures in Maryland. Assuming future updates at more modest levels, Medicare expenditures for hospital care are likely to grow more slowly over the next several years.

However, the impact of the baby boom, just beginning to reach the age of Medicare eligibility, will inevitably make Medicare a more important payer for every service. Medicare beneficiaries in Maryland comprise a lower share of the population (in 2007, 12.9 percent of the population, compared with 14.3 percent nationally), but it will continue to grow, with noticeable impacts on the health care system even over the next several years.

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[45] Micah Hartman et al. (2009), National Health Spending in 2007: Slower Drug Spending Contributes To Lowest Rate of Overall Growth Since 1998, *Health Affairs* 28, no. 1: 246-261.

[46] Drugs losing patent protection over the next 3 years include Flonase, Lipitor, Plavix, and Viagra. See: Murray Aitken et al. (2009), Prescription Drug Spending Trends in the United States: Looking Beyond the Turning Point, *Health Affairs* 28, no. 1: w151-w160.

[47] Murray Aitken et al. (2009), *Ibid.*

[48] Medicare Payment Advisory Commission (March 2009), *op cit.*

MedPAC's *March 2009 Report to the Congress* envisions significant changes in Medicare's payment policies that would bundle services and tighten payment updates, putting "fiscal pressure" on providers to constrain costs. In addition, it recommended various measures to increase provider accountability and the value of care—including use of pay-for-performance incentives, measuring resource use, and comparing the effectiveness of medical treatments. Coming on the heels of a sobering warning from the Medicare Board of Trustees expressing growing concern about inaction on the financial challenges facing Medicare, MedPAC's recommendations seem perhaps more likely to catalyze Congressional action now than in past years.[49]

MedPAC's recommendations extend not only to fee-for-service payments, but also to Medicare Advantage plans. With respect to Medicare Advantage plans, MedPAC recommends setting payment benchmarks equal to Medicare fee-for-service expenditures. Currently, Medicare Advantage plans (specifically, private fee-for-service plans) are estimated to cost the program as much as 18 percent more than standard Medicare fee-for-service.[50] In Maryland, Medicare Advantage enrollment is much lower than the national average—in part related to historically higher rates of federal and private employer retiree coverage. Especially if changes in Medicare payment discourage wider offers of Medicare Advantage plans and narrower benefits, Medicare Advantage enrollment in Maryland seems likely to remain well below that in other states. With respect to Medicare Part D plans, which enroll Marylanders in much greater numbers than Medicare Advantage, MedPAC made no recommendations for immediate change.

MEDICAID and SCHIP In 2008, Maryland implemented modest expansion of its Medicaid program, just as the economy in Maryland and the nation worsened. Related to greater demand for these programs as more Marylanders face unemployment and reduced incomes, as well as new federal legislation expanding federal support for states that maintain Medicaid and SCHIP eligibility, expenditures in these programs likely will increase significantly over the next several years.

Under the Working Families and Small Business Health Coverage Act, Maryland increased Medicaid's income limits for parents and caretaker relatives in July 2008, from about 50 percent to 116 percent of the federal poverty level (FPL), to be phased in over 4 years.[51] In the first year, 25,000 low-income parents and caretakers entered the program under the new eligibility rules—approximately 50 percent more than had been projected and more than had been projected to enroll even by 2013. Greater enrollment and enrollment of older adults than had been expected will result in additional Medicaid expenditures that exceed the identified funding source for the expansion. Still, the magnitude of excess cost is likely to be relatively

[49] Social Security Administration, Office of the Actuary (2008), Summary of the 2008 Annual Reports of the Social Security and Medicare Boards of Trustees (http://www.ssa.gov/OACT/TRSUM/index.html, accessed 3/12/2009).

[50] Private fee-for-service (PFFS) plans, if offered with a sufficiently high deductible to qualify under IRS rules, may be tied to medical savings accounts. These plans typically do not have provider networks. They use Medicare FFS payment rates, but have fewer quality reporting requirements and less ability to coordinate care than other types of Medicare Advantage plans.

[51] Medicaid projected enrollment of 16,600 newly eligible parents or caretakers in the first year, and 20,000 low-income parents by 2013. See: Department of Legislative Services, Office of Policy Analysis (November 26, 2007), SB 6: Summary of Working Families and Small Business Health Coverage Act (http://mlis.state.md.us/other/Fiscal_Briefings_and_Reports/WorkingFamiliesandSmallBusinessHealthCoverageAct.pdf, accessed 3/12/2009).

small and may be covered at least in part by larger assessments on hospitals, if more uncompensated care is averted. [52, 53, 54]

However, the sharp increase in unemployment in the early months of 2009 is likely to increase the number of adults and children who are eligible for Medicaid, at the same time that Maryland's revenues are weakening. Responding to similar situations in every state, the federal American Recovery and Reinvestment Act of 2009 (ARRA) will provide additional federal Medicaid funding (in the form of an increased federal matching percentage, or FMAP) from October 2008 through December 2010, provided that the state does not restrict Medicaid eligibility relative to July 2008 levels. All states will receive an increased FMAP of 6.2 percentage points. Additionally, states with unusually high unemployment may receive additional FMAP of 5.5 to 11.5 percentage points. Under ARRA, Maryland expects to receive an estimated additional $1.63 billion in federal Medicaid funding over 9 quarters, as the state's FMAP rises from 50.0 percent to at least 56.2 percent in October 2008.[55]

Finally, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorized additional federal funding for the CHIP (formerly SCHIP) program, while also modifying how funds are allocated to states.[56] Early estimates from the Congressional Research Service indicate that Maryland's FY 2009 CHIP allotment could increase from $70.2 million to $184.2 million. In addition, Maryland (and other states that had covered children above 150 percent FPL under Medicaid prior to the introduction of SCHIP in 1997) no longer faces limits on spending CHIP funds to cover Medicaid-eligible children above 133 percent of poverty.[57] Since the federal match rate for CHIP is significantly higher than for Medicaid, this change will further increase the available federal funding for Maryland's Medicaid and CHIP programs.

The CHIPRA legislation was accompanied by a rule change regarding the ability of states to enroll somewhat higher-income children in CHIP. Previously, to cover children and their families above 250 percent FPL, states were required to impose strict rules to deter crowd-out and also show that they had already enrolled at

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[52] Expanded eligibility was projected to cost $155,000 in the first year, to be covered by a surplus in the MHIP and by an assessment on hospitals that would recoup some of their savings on uncompensated care. See: Department of Health & Mental Hygiene (January 13, 2009), *Interim Report on Implementation of Medicaid Expansion to Parents and Their Children* (http://www.dhmh.state.md.us/reports/pdf/jan09/MA/124_MA_MedicaidExpansion.pdf, accessed 3/12/2009).

[53] The Working Families and Small Business Health Coverage Act also included a provision to expand a limited Medicaid package to childless adults up to 116 percent of the poverty level starting in July 2009, contingent upon the availability of funds. In the interim, the economic downturn has severely strained state finances. As a result, Governor O'Malley called for a delay to this Medicaid expansion and indicated that newly available federal stimulus funds will not be used to fund coverage of childless adults. See: J. Wagner and R. Helderman (January 22, 2009), O'Malley Suggests Layoffs, Slashing Vacant Positions, *The Washington Post*.

[54] The 4-year phase-in of Medicaid eligibility up to 116 percent FPL for childless adults starting in fiscal year 2010 has been delayed because of Maryland's current budget deficit.

[55] Iris Lav et al. (February 13, 2009), *Recovery Act Provides Much-Needed, Targeted Medicaid Assistance to States*. Washington, DC: Center on Budget and Policy Priorities.

[56] Previously, funding was proportional to the number of low-income uninsured children in the state based on surveys. Under CHIPRA, funding is instead allocated based on the actual level of state spending in the CHIP program in FY 2008 or on planned spending in FY 2009. As a result, states with fewer low-income uninsured children but expansive CHIP programs are projected to receive more federal funding. See: Chris Peterson (January 14, 2009), *Projections of FY 2009 Federal SCHIP Allotments Under CHIPRA 2009*, Congressional Research Service, R40129.

[57] Evelyne Baumrucker, et al. (January 14, 2009), *H.R. 2: The Children's Health Insurance Program Reauthorization Act of 2009*, Congressional Research Service, R41030.

least 95 percent of eligible children below 200 percent FPL.[58] Maryland currently covers children up to 300 percent FPL, and this rule change ensures that the state will be able to continue covering these children.

PRIVATE PAYERS Further weakening of the economy seems likely to increase the number of uninsured in Maryland, due to both job loss and companies cutting health benefits. Even among employers that maintain health insurance benefits, economic stress may force more aggressive measures to control cost—by increasing the cost-sharing that health plans require, if not also increasing employee contributions to premiums. The convergence of these trends—increased numbers of uninsured and increased cost-sharing among those who retain coverage—may increase out-of-pocket spending for health care in 2009 and into 2010, well beyond the current forecast.

In November 2007, Maryland legislators enacted the Working Families and Small Business Health Coverage Act, which is intended to encourage employer-sponsored coverage in Maryland in very small firms. The new law authorized as much as $30 million in annual subsidies to small businesses through a new Health Insurance Partnership, to help offset the cost of providing coverage to their employees. The state projected that the HIP would serve 15,000 previously uninsured adults working in firms of fewer than 10 employees.[59] However, facing a budget shortfall of $300 million in FY 2009, the state cut the program to $15 million and is expecting to cap enrollment at 10,000 workers.[60]

Enrollment in the new Health Insurance Partnership has been slow: 554 workers and dependents in 106 businesses enrolled during the first 6 months of the program.[61] Slow take-up has been attributed to small businesses' uncertainty about market conditions and, therefore, hesitation to offer new benefits until the economy improves.

Nationally and in Maryland, the growing cost of health care and the struggling economy are likely to remain signature issues through 2009 and into 2010. As family incomes fall due to unemployment and worker displacement, reliance on Medicaid and SCHIP is likely to rise, accelerating the growth of public program expenditures with greater federal funding picking up a significant share of the increased fiscal burden. Accounting for a growing share of expenditures for health care, these programs are poised to become even more important drivers of health system change in the coming years, affecting care not only for their enrollees but for privately insured Marylanders as well.

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[58] The anti-crowd-out provisions included requiring a year-long waiting period after losing coverage before these higher-income households became eligible for SCHIP, and cost-sharing requirements that were no more generous than competing private plans. See: Centers for Medicare & Medicaid Services (February 6, 2009; May 7, 2008; and August 17, 2007), State Health Official Letters #09-001, #08-003, and #07-001, (http://www.cms.hhs.gov/SMDL/SHO/list.asp, accessed 3/09/2009).

[59] Department of Legislative Services, Office of Policy Analysis (November 26, 2007), SB 6: Summary of Working Families and Small Business Health Coverage Act (http://mlis.state.md.us/other/Fiscal_Briefings_and_Reports/WorkingFamiliesandSmallBusinessHealthCoverageAct.pdf, accessed 3/12/2006).

[60] Sue Schultz (April 14, 2008), Small-Business Health Plan Slashed by State Lawmakers, *Baltimore Business Journal*.

[61] Maryland Health Care Commission (January 1, 2009), *Health Insurance Partnership: Enrollment Update*. (http://mhcc.maryland.gov/legislative/hlthins_partnership.pdf, accessed 3/09/09).

METHODS

NOTE: Next year, the MHCC will replace this expenditure report with the first in a new series of reports that will appear every 2 years. The first report in this new series will examine Maryland's health care market/system in comparison to the nation and similar state markets using per capita spending measures based on consistent spending information. The report will include comparisons of spending for the privately insured and for Medicare beneficiaries. As the report matures, MHCC expects to examine spending trends overall, for the subpopulations, and for different markets. The second report in the series will focus on spending patterns for the privately insured under-65 population. The focus of this report will be on spending per capita for the market overall and for segments of the market of high interest to policymakers, including the individual market (both medically underwritten and high-risk), small groups, and large groups.

The following section describes the data sources and methods used to produce the Maryland and national estimates provided in this report. This section includes three parts: first, a description of methods and sources for the Maryland expenditures, followed by methods and sources for national expenditures, and finally, the methods and sources used to produce enrollment estimates used in per capita estimates.

MARYLAND EXPENDITURES

MEDICARE Maryland Medicare expenditures are estimated separately for the Original Medicare program and the Medicare Advantage program, and then the two results are aggregated. Expenditures for Original Medicare are estimated from claims data provided by the Centers for Medicare & Medicaid Services (CMS). The claims data include information on expenditures by the type of service (service category). Claims expenditures are aggregated by service category. For the Medicare Advantage program, the Maryland Insurance Administration (MIA) provided total expenditures for Maryland residents by insurer. For a few small insurers, the expenditures are estimated based on their enrollment and the average monthly payment for all Medicare Advantage plans of the same type. Both the enrollment and payment information are available at the CMS Web site. Expenditures by insurer are aggregated and allotted to service categories based on estimates provided by CMS. Administration costs are estimated from the National Health Expenditure Accounts data (for Original Medicare) and from the MIA reports (for Medicare Advantage).

MEDICAID Maryland Medicaid expenditures are estimated from Medicaid Management Information Systems (MMIS) reports by line item provided by the Maryland Department of Health and Mental Hygiene (DHMH). Medicaid HealthChoice premiums are allocated to service categories based on reports produced by DHMH using expenditure reports from the individual insurers. Administrative expenditures are provided by DHMH

for the Medicaid Traditional program and the HealthChoice program. Expenditures for Medicaid inpatient prescription drugs are reported with other inpatient expenditures (not on the "Prescription Drug" row).

OTHER GOVERNMENT Maryland expenditures for Other Government programs (Maryland public programs other than Medicaid, Department of Corrections, Veterans Administration, CHAMPUS/TRICARE) are collected directly from the administrators for the individual programs. Expenditures for Other Government inpatient prescription drugs are reported with other inpatient expenditures (not on the "Prescription Drug" row).

PRIVATE INSURANCE Maryland total expenditures for private insurance (including self-insurance) are produced in four steps:

1. From the MIA annual filings by insurers in Maryland, we estimate the amount of Direct Losses Incurred for Health Care, excluding the Federal Employees Health Benefits Program (FEHBP). This represents the amount of expenditures for insurers reporting to MIA for lives covered in Maryland (not residents of Maryland).
2. For FEHBP, we estimate expenditures from data received from the U.S. Office of Management and Budget.
3. We estimate expenditures of persons in self-insured firms using data from the Maryland Medical Care Data Base (MCDB), which is a claims-based system including a designation of self-insurance.
4. We estimate a NET adjustment that accounts for Maryland residents not covered in steps 1 and 2 because they work outside Maryland, minus non-Maryland residents included in steps 1 and 2. This adjustment is based on the estimates of persons working in Maryland and employed outside the state, and persons from outside Maryland who work in the state, obtained from the Census Bureau's American Community Survey.

Expenditures are allocated to service categories by applying a method for estimating state expenditures developed by the staff at the Agency for Healthcare Research and Quality (AHRQ). This method utilizes the Medical Expenditure Panel Survey—Household Component (MEPS-HC) data. The estimated allocations then are adjusted for undercounting of nonhospital expenditures in MEPS-HC, using an AHRQ-calculated ratio of National Health Expenditure Accounts (NHEA) per capita private payments to MEPS-HC per capita private payments. Hospital expenditures are allocated between inpatient and outpatient services based on payments reported by the Maryland Health Services Cost Review Commission (HSCRC). Finally, the expenditure estimates are updated to the current year using the change in per capita expenditures from three sources: the HSCRC for hospital categories; the MCDB for practitioner categories; and the MCDB prescription drug claims for the prescription drug category. Administration and Net Cost of Insurance is estimated from the MIA annual filings data.

OUT-OF-POCKET Using national MEPS data (2003 MEPS for 2003, and 2006 MEPS for 2006 and 2007), an estimate of out-of-pocket to total expenditures is calculated by service category and insurance coverage/age category. This ratio is then weighted by the actual Maryland population (from the Current Population Survey) to produce a ratio of out-of-pocket expenditures to total expenditures. This ratio is used to develop an estimate of out-of-pocket expenditures among Maryland residents.

NATIONAL EXPENDITURES

Estimates for the nation shown in this report are estimated using the National Health Expenditure (NHE) accounts data estimates and projections by service category and payer. Data for 2003 and 2006 are estimated, and data for 2007 are projected. See http://www.cms.hhs.gov/NationalHealthExpendData/ for more information on the National Health Expenditures projection data. The NHE categories are aggregated by SHEA payer and service category for comparison to Maryland estimates in this report. Because of this aggregation, selected NHE categories/payers are excluded and therefore the totals may differ from total NHE account totals.

ENROLLMENTS/POPULATIONS

Populations for Maryland and the nation are obtained from the Census Bureau's Population Estimates program (http://www.census.gov/popest/estimates.php). Medicare (http://www.cms.hhs.gov/MedicareEnrpts/) and 2003 and 2006 Medicaid (http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/) enrollments are obtained from the CMS Web site. 2007 Medicaid enrollments were estimated using the change in enrollment from the Maryland Department of Health & Mental Hygiene. Private insurance enrollment estimates are 2-year averages estimated from the Current Population Survey.

SUPPORTING TABLES

TABLE 12A: Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2007 ($ thousands)

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR					PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid Total	Medicaid Traditional	Medicaid HealthChoice	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**$8,169,314**	**$5,747,345**	**$3,648,595**	**$2,098,750**	**$1,418,536**	**$13,820,575**	**$6,654,319**	**$35,810,089**
Hospital Services								
Inpatient	3,444,475	1,552,505	798,739	753,766	316,038	2,921,482	383,129	8,617,629
Outpatient	975,428	505,372	182,387	322,985	91,224	1,129,162	307,506	3,008,691
Physician Services	1,392,420	374,902	114,602	260,300	174,141	3,324,278	938,750	6,204,491
Other Professional Services	343,394	525,746	362,618	163,128	523,676	1,543,947	1,671,220	4,607,983
Prescription Drugs	745,751	442,625	233,210	209,415	79,708	2,384,598	1,947,862	5,600,544
Nursing Home Care	478,624	1,122,532	1,035,499	87,033	62,815	162,114	685,606	2,511,691
Home Health Care	177,079	817,353	817,353	n/a	17,163	106,378	171,486	1,289,460
Other Services	159,573	48,447	48,447	n/a	32,464	49,746	548,761	838,992
Administration and Net Cost of Insurance	452,571	357,863	55,741	302,123	121,306	2,198,869	n/a	3,130,609

TABLE 12B: Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2006 ($ thousands)

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR					PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid Total	Medicaid Traditional	Medicaid HealthChoice	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**$7,473,169**	**$5,525,083**	**$3,463,595**	**$2,061,489**	**$1,306,623**	**$13,101,981**	**$6,275,983**	**$33,682,839**
Hospital Services								
Inpatient	3,149,503	1,467,593	739,552	728,041	278,091	2,750,040	348,566	7,993,792
Outpatient	893,729	470,439	166,748	303,690	60,320	1,041,219	276,784	2,742,491
Physician Services	1,333,385	347,161	101,736	245,425	157,808	3,197,686	892,660	5,928,700
Other Professional Services	318,238	538,040	387,160	150,880	527,694	1,497,839	1,642,223	4,524,033
Prescription Drugs	639,750	413,925	201,055	212,870	75,997	2,253,711	1,807,867	5,191,251
Nursing Home Care	419,508	1,092,517	1,002,076	90,441	64,332	158,927	654,071	2,389,354
Home Health Care	163,766	764,911	764,911	n/a	13,044	103,021	162,473	1,207,216
Other Services	146,418	44,222	44,222	n/a	20,122	48,914	491,339	751,014
Administration and Net Cost of Insurance	408,871	386,276	56,134	330,142	109,215	2,050,625	n/a	2,954,987

TABLE 12C: Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2003 ($ thousands)

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR					PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid Total	Medicaid Traditional	Medicaid HealthChoice	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**$5,239,489**	**$4,638,317**	**$3,118,726**	**$1,519,591**	**$1,266,006**	**$10,497,097**	**$5,362,405**	**27,003,314**
Hospital Services								
Inpatient	2,476,746	1,177,719	640,309	537,410	281,567	1,982,425	124,743	6,043,200
Outpatient	681,280	341,412	118,355	223,057	58,179	716,057	162,508	1,959,437
Physician Services	1,108,791	271,440	75,719	195,721	142,399	2,652,176	717,040	4,891,847
Other Professional Services	237,995	449,862	340,648	109,214	497,426	1,201,662	1,400,569	3,787,514
Prescription Drugs	4,799	569,434	396,497	172,937	102,600	1,936,755	1,775,270	4,388,857
Nursing Home Care	304,551	965,736	875,619	90,117	42,338	143,471	586,134	2,042,230
Home Health Care	135,372	580,562	580,562	n/a	11,749	89,644	161,583	978,910
Other Services	127,024	34,756	34,756	n/a	22,943	45,368	434,558	664,649
Administration and Net Cost of Insurance	162,930	247,395	56,261	191,134	106,806	1,729,539	n/a	2,246,671

TABLE 13A: Rate of Growth in Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2006–2007

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR			PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**9.3%**	**4.0%**	**8.6%**	**5.5%**	**6.0%**	**6.3%**
Hospital Services						
Inpatient	9.4	5.8	13.6	6.2	9.9	7.8
Outpatient	9.1	7.4	51.2	8.4	11.1	9.7
Physician Services	4.4	8.0	10.4	4.0	5.2	4.7
Other Professional Services	7.9	-2.3	-0.8	3.1	1.8	1.9
Prescription Drugs	16.6	6.9	4.9	5.8	7.7	7.9
Nursing Home Care	14.1	2.7	-2.4	2.0	4.8	5.1
Home Health Care	8.1	6.9	31.6	3.3	5.5	6.8
Other Services	9.0	9.6	61.3	1.7	11.7	11.7
Administration and Net Cost of Insurance	10.7	-7.4	11.1	7.2	n/a	5.9

TABLE 13B: Rate of Growth in Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2003–2007

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR			PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**11.7%**	**5.5%**	**2.9%**	**7.1%**	**5.5%**	**7.3%**
Hospital Services						
Inpatient	8.6	7.2	2.9	10.2	32.4	9.3
Outpatient	9.4	10.3	11.9	12.1	17.3	11.3
Physician Services	5.9	8.4	5.2	5.8	7.0	6.1
Other Professional Services	9.6	4.0	1.3	6.5	4.5	5.0
Prescription Drugs	253.1	-6.1	-6.1	5.3	2.3	6.3
Nursing Home Care	12.0	3.8	10.4	3.1	4.0	5.3
Home Health Care	6.9	8.9	9.9	4.4	1.5	7.1
Other Services	5.9	8.7	9.1	2.3	6.0	6.0
Administration and Net Cost of Insurance	29.1	9.7	3.2	6.2	n/a	8.6

TABLE 14: Enrollment and Populations, and Rate of Growth, Maryland and U.S., 2003, 2006, 2007

MARYLAND	2003	2006	2007	2003–2007	2006–2007
Population	5,506,684	5,615,727	5,618,344	0.5%	0.0%
Medicare Enrollees	674,448	708,049	723,302	1.8	2.2
Medicaid Enrollees	688,360	692,437	681,094	-0.3	-1.6
Private Insurance Enrollees	4,128,903	4,142,192	4,150,630	0.1	0.2
UNITED STATES	**2003**	**2006**	**2007**	**2003–2007**	**2006–2007**
Population	290,796,023	299,398,484	301,621,157	0.9%	0.7%
Medicare Enrollees	40,172,605	42,355,590	43,259,280	1.9	2.1
Medicaid Enrollees	42,670,575	44,209,365	48,100,000	3.0	8.8
Private Insurance Enrollees	197,842,548	201,566,337	201,896,550	0.5	0.2

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