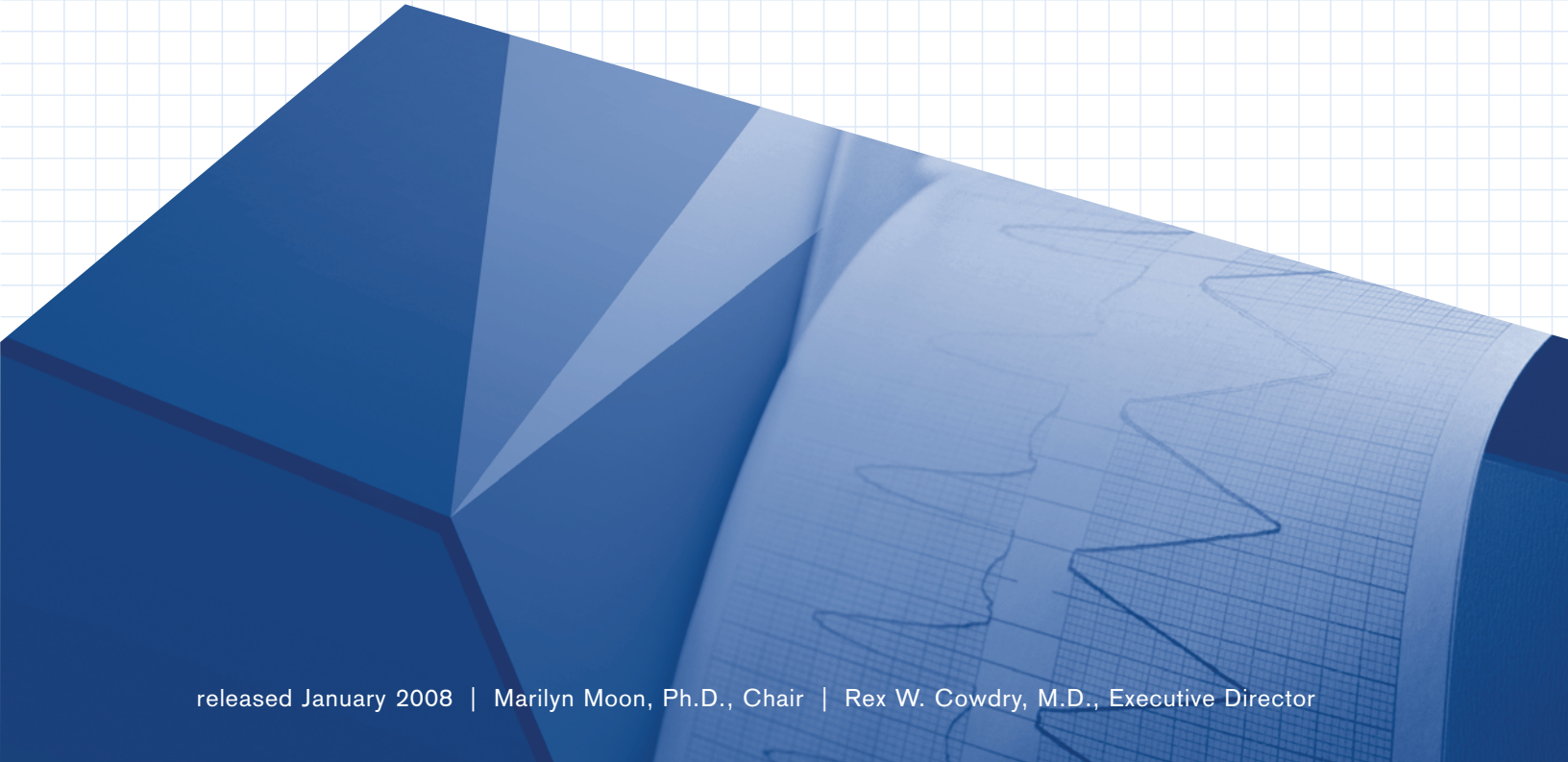
MARYLAND HEALTH CARE COMMISSION

experience from 2006

STATEHEALTHCARE EXPENDITURES



released January 2008 | 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.

Maryland health care spending grew to $32.7 billion in 2006. Per capita expenditures for health care in Maryland ($5,823) continue to be below the U.S. average ($6,062). From 2005 to 2006, per capita health care spending in Maryland grew 7 percent, compared to the longer-term trend of 6 percent per year since 2002. The rate of growth in health care spending continues to surpass the growth in wages and per capita personal income.

The accelerated growth in Maryland's health care spending in 2006 is a departure from the slowing growth observed in the 3 previous years. This uptick is in contrast to the national pattern—confirmed in the recently released National Health Expenditure Accounts—which shows continued slowing in the growth of health care spending in 2006. The state's higher growth in spending may reflect Maryland's stronger economic growth compared to the nation as a whole, but will likely pose increased health care affordability challenges for Maryland families. Premium increases have made the affordability of health insurance a challenge for more Maryland families and contributed to a rise in the number of uninsured Marylanders. The MHCC recently reported that 760,000 Marylanders lacked insurance coverage during 2005-2006, representing 13.6 percent of the population, up from 10.7 percent in 2000-2001.

Recent actions in the 2007 Special Session to increase coverage for employees in small businesses and impoverished childless adults are a good start, but more needs to be done. The Commission looks forward to working with state policymakers, payers, providers, and purchasers to craft creative strategies to control health care costs and insure the uninsured.

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 working closely with Commission staff to complete this study in time for the 2008 Session of the Maryland General Assembly.

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. Tricia Roddy and Patricia Holcomb, Office of Planning, Development and Finance, Maryland Department of Health and Mental Hygiene (DHMH); Jeffrey Gruel, Office of Operations, Eligibility and Pharmacy, DHMH; and Babi Lamba, Center for Health Program Development and Management, University of Maryland-Baltimore County, provided Medicaid expenditure and enrollment information. Jim Johnson and Hank Fitzer, Budget Management Office, DHMH, and Walter Wirsching, Maryland Department of Corrections, supplied information on government spending, while Estelle Apelberg, Vital Statistics, DHMH, provided population statistics.

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 Cheryl Sample at the Centers for Medicare & Medicaid Services (CMS) assisted MHCC with the data use agreements that are necessary before Medicare information can be released. Leroy McKnight in the federal government's Office of Personnel Management supplied information on federal employees' insurance coverage. Richard D. Barnett (TRICARE Management Activity) provided spending information on CHAMPUS/TRICARE programs, and Pat Kane 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. Charlotte Thompson of the Health Services Cost Review Commission provided estimates of hospital spending. Information from the Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS) was used in the estimation of private insurance allocations. Karen Beauregard, John Sommers, and Ray Kuntz at AHRQ provided advice on the use of the MEPS data files.

The development of the state health care expenditure analysis would not have been possible without the significant contributions of our consultants. This project was under the direction of Dr. Deborah Chollet, Mathematica Policy Research (MPR), Thomas Bell of Social & Scientific Systems, Inc. (SSS), and Sophie Nemirovsky of SSS. Dr. Eric Schone of MPR developed the estimation algorithms for private sector spending using the MEPS data, and Dr. Dean Farley of The Lewin Group provided quality assurance services for the methodologies and the final estimates. Adrian Ndikumwami, Shelley Mullins, Sanee Maphungphong, and Po-Lun Chou at SSS provided programming support on the project. Z. Joan Wang and her staff of Avar Consulting, Inc., provided data collection and processing support. Beverly Valdez of SSS, with the assistance of Laura Spofford and Joan Holleman, provided the graphic design and editorial services for the report.

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 2005 to 2006, but a longer trend from 2002 to 2006 is highlighted when the recent and longer-term trends diverge. Spending levels and rates of growth for the United States are compared with Maryland's experience.[1]

HOW MUCH DID MARYLAND SPEND FOR HEALTH CARE?

Health care spending for Maryland residents grew 8 percent to $32.7 billion in 2006, accelerating from 7 percent in 2005. Health care spending accounted for 13 percent of personal income in Maryland in 2006. Health care spending as a share of personal income has been relatively steady since 2002 as a result of slower health care spending growth (which peaked in 2002 at 11 percent) and strong income growth in Maryland. Growth in Maryland's health care spending outpaced growth in the United States as it has for several years. Information just released by the Centers for Medicare & Medicaid Services shows that growth in comparable national spending was about 7 percent.[2] The United States experienced slower spending growth in 2006, continuing the downward trend first observed in 2002. The downward trend in Maryland first observed in 2002 ended with the rebound in 2006. The rebound in the rate of spending could be attributable to a host of demographic and health system factors; however, U.S. spending trends reflect the nation, not one particular area. It is possible that spending growth in the adjacent areas follows the trend observed in Maryland.

Growth has been faster in Maryland, but per capita health care expenditures are lower than in the United States, $5,823 versus $6,062. From 2005 to 2006, per capita health care expenditures in Maryland grew at 7 percent, slightly higher than the 6 percent longer-term annual rate of growth from 2002 to 2006 and slightly higher than the 6 percent annual growth in the United States in 2006.

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 nearly one-third of total health care expenditures in 2006. Total inpatient care accounted for 23 percent of total health care expenditures in 2006; outpatient care (including emergency room visits) accounted for 8 percent of spending. Expenditures for hospital care grew at an average annual rate of about 9 percent from 2002 to 2006—about 1 percent faster than for all health care spending. Growth slowed to 8 percent in 2006, but that increase was still 2 percentage points higher than the growth in United

[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.
[2] Aaron Caitlin et al., "National Health Spending In 2006: A Year Of Change For Prescription Drugs," *Health Affairs*, 27, no. 1 (2008): 14-29.

States hospital spending. Outpatient hospital spending was the fastest growing service category, increasing 10 percent from 2005 to 2006. Over the 5-year period, outpatient spending grew at an average annual rate of 11 percent, faster than all other health care services categories, except home health care services (12 percent).

Increases reported in inpatient and outpatient spending are consistent with Health Services Cost Review Commission (HSCRC) policies from 2003 onward that allowed hospital revenue to increase to support recapitalization of the industry and a large rebuilding program. Recently the HSCRC has taken steps to moderate growth in hospital spending beginning in 2009. As all payers in Maryland pay essentially the same rates for hospital care, higher spending is diffused broadly across all payer sources.

Physician services and other professional services together comprise the next largest category of health care expenditures in Maryland, accounting for nearly 31 percent of total spending. Low payments for practitioners' services have been an issue of significant debate in Maryland over the last several years. Public and private payer fee increases have not kept pace with increases in input costs. Growth in practitioner spending was 6 percent, up 1 percentage point from the 2002 to 2006 trend. The increase in practitioner spending was fueled by higher utilization of services and reinforces the contention by some analysts that higher spending is largely driven by the expanded capabilities of modern medicine.[3] The trend toward expanding types of services covered in an insurance product to include additional practitioner services could be driving the growth in spending for non-physician services. That category increased by 8 percent, compared to a 5 percent increase in physician spending.

Prescription drug spending accounted for 15 percent of total expenditures in 2006, about the same share as in 2005. The introduction of the Medicare Part D program shifted the sources of payment (to Medicare from the private sector and Medicaid), but had less impact on the overall level of retail drug spending. Maryland experienced a 7 percent increase in spending in 2006, the same rate as observed in the long-term trend, but about a percentage point lower than was reported in the United States from 2005 to 2006. The lack of new blockbuster drugs, the patent expiration for several leading drugs, increased use of drug management programs such as step therapy, and the general shift from branded to generic drugs in many therapeutic classes all contributed to slower growth in 2006.

Nursing homes and home health care (11 percent share of spending) grew at 6 percent and 9 percent, respectively. Nursing home spending accounts for roughly 7 percent of total health care spending, absorbing nearly twice as much spending as home health. Nursing home spending was primarily fueled by higher charges; patient volume and length of stay were virtually unchanged from 2005. The growth in home health spending slowed from 2005, but the service was the most rapidly increasing category in 2006 and over the 2002-2006 period. High rates of growth for home health services are driven by the substitution of these services for more expensive institutional nursing care for the elderly and disabled populations.

In 2006, Marylanders spent $2.9 billion for the administration and net cost of private insurance and the administration of public insurance programs. From 2002 to 2006, these expenditures increased at an average annual rate of 13 percent, accelerating to 14 percent growth from 2005 to 2006. Nationally, expenditures for administration and the net cost of insurance grew at an average rate of 11 percent per year from 2002 to

[3] Kenneth E. Thorpe, Curtis S. Florence, David H. Howard, and Peter Joski, "The Rising Prevalence Of Treated Disease: Effects On Private Health Insurance Spending," *Health Affairs* Web Exclusive, June 27, 2005 .

2006, and slowed to 10 percent from 2005 to 2006. In Maryland and nationally, the development of Medicare Part D plans and enrollment in Medicare Advantage plans from fee-for-service Medicare also contributed to the increase in administrative and net costs of insurance.

WHO PAID FOR MARYLAND'S HEALTH CARE?

The shares of the major sources of payment shifted in 2006, primarily due to the implementation of the Medicare Part D program. Spending increased overall for Medicare by 18 percent, Medicaid spending increased modestly by 5 percent, private sector payers saw increases of 8 percent, consistent with their long-term trend (7 percent), and consumer out-of-pocket spending declined owing to introduction of Medicare Part D.

Private insurance and consumer out-of-pocket payments finance most health care expenditures in Maryland. In 2006, private insurance financed 40 percent of all health care expenditures; 16 percent were paid out-of-pocket. Government programs financed the balance—including Medicare (22 percent), Medicaid (17 percent), and other government programs (4 percent). The trend toward greater public financing of health care is progressing quite slowly. Public program expenditures accounted for a slightly larger percentage of all health care expenditures in 2006 (44 percent) than in 2002 (42 percent).

Private insurance accounted for the largest proportion of the increase in total health care spending in Maryland from 2002 to 2006 (38 percent), followed by Medicare (30 percent) as a result of new coverage for prescription drugs. Reflecting greater coverage for prescription drugs among retirees, just 11 percent of the growth in total expenditures was paid out-of-pocket.

From 2005 to 2006, Medicare spending in Maryland increased 18 percent, compared with 22 percent nationally. About 55 percent of Medicare expenditures in Maryland were associated with inpatient hospital care (43 percent) and outpatient care (12 percent). Owing largely to the introduction of Medicare Part D, hospital care accounted for a smaller share of Medicare spending in 2006 (55 percent) than in 2002 (60 percent), as did physician care that accounted for 22 percent in 2002 versus 18 percent in 2006. Prescription drug spending under Part D added more than $600 million to Medicare spending in 2006, but that increase largely offset lower spending for drugs by Medicaid and by patients out-of-pocket. As some critics contended, administrative costs associated with marketing and enrolling beneficiaries were substantial, adding nearly $60 million to the cost of the program. It remains to be seen how much of these costs are associated with program startup.

Medicaid spending growth slowed to approximately 5 percent in 2006, significantly below the 9 percent average growth for the 2002-2006 period. More than one-third of Medicaid expenditures in 2006 were for hospital care—including inpatient care (26 percent) and outpatient care (10 percent). The next largest block of Medicaid expenditures was for long-term care—including nursing home care (19 percent) and home health care (13 percent). The percentage of Medicaid expenditures for prescription drugs declined to 9 percent as Medicare Part D absorbed a portion of spending. Hospital outpatient services and home health services grew the most rapidly in the 2002-2006 period. Institutional care (inpatient and nursing home care) declined significantly; these expenditures accounted for 45 percent of Medicaid spending in 2006 compared with 47 percent in 2002. Physician reimbursement accounted for just 8 percent of the increased spending from 2002. Beginning in 2005, Medicaid has been increasing physician fees to near Medicare levels.

Private insurance expenditures in Maryland grew at an average annual rate of 7 percent per year from 2002 to 2006, nearly the same as the growth in private insurance expenditures nationally over the same period. In 2005 to 2006, spending accelerated in Maryland to 8 percent but declined to 5 percent nationally, the smallest increase in private insurance spending since 1997. On a per capita basis, private insurance expenditures in Maryland remained lower than the national average in 2006. Growth in hospital services accounted for about one-third of the spending increase from 2002. Administration and the net cost of insurance accounted for 28 percent of the overall spending increase. Spending in this category grew 13 percent annually from 2002 to 2006 and increased a percentage point faster in 2006.

Out-of-pocket spending as a percentage of total spending in 2006 was 16 percent, down 2 percentage points from 2002. From 2002 to 2006, out-of-pocket spending in Maryland increased at an average annual rate of 5 percent, compared with the national average of 4 percent. From 2005 to 2006, Maryland had 1 percent growth in out-of-pocket expenditures. Medicare Part D shifted a sizeable portion of elderly prescription drug expenses from out-of-pocket to Medicare beginning in 2006. Prescription drugs accounted for about 25 percent of out-of-pocket spending in 2006, down from nearly 30 percent a year earlier. Consumer spending on retail prescription drugs fell nearly 15 percent from 2005 to 2006. Moderate to strong growth in spending in all other major categories offset the decline in drug spending. About 50 percent of the increase in Marylanders' out-of-pocket expenditures for health care from 2002 to 2006 was attributable to expenditures for health care practitioners.

OUTLOOK FOR 2008 THROUGH 2010

Health care spending in Maryland nudged up in 2006, suggesting that slowing growth in spending has ended for the time being. Health spending increased by about 1 percent despite a slowdown in overall economic activity in Maryland (change in gross domestic product was down by 1 percentage point). Health care costs remain high, and cost growth still exceeds the growth in wages and personal income—even as worker productivity has increased.

Pressure on upward movement of prices seems particularly strong for hospital services. This sector accounts for about one-third of health care spending. Consumers may see continued slowing in prescription drug spending, as few new blockbuster drugs are apparent on the horizon and payers have become more effective in managing utilization. Prescription drugs sometimes offset more expensive forms of care. A recent study by the American Academy of Actuaries found that psychotropic drugs generally accounted for a greater share of spending than all inpatient and outpatient mental health care combined.

There is some positive news. In November 2007, the Maryland Legislature passed the Working Families and Small Business Health Coverage Act, which authorizes Maryland's Medicaid program to expand Medicaid eligibility to as many as 100,000 state residents over the next 5 years. The new law also authorizes up to $30 million in annual subsidies to small businesses with 10 or fewer workers to help offset the cost of providing coverage to their employees. A possible next step will be consideration of proposals to require individuals to carry health insurance, coupled with a health insurance subsidy for lower-income individuals. Although the State's current budget climate is difficult, expanded coverage will likely get serious consideration in 2008.

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 2006, and the distribution of expenditures by type of service and by source of payment. It compares expenditures in 2006 with those in 2005 and in 2002.

This year's report continues the format that was begun last year. 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 2005 to 2006 to the trend since 2002. 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 2002 and 2005 reestimates may differ from those published in earlier reports and should be regarded as improved estimates.

The estimates in this report reflect several important methodological changes. As in previous years, payments from the Medical Expenditure Panel Survey - Household Component (MEPS-HC) are used to calculate the shares of payments from private insurance attributed to different services. However, this year's private payer allocations were adjusted to account for undercounting of nonhospital expenditures in MEPS payment estimates.[4] As a result, the private payer allocations attribute a smaller share of private payments to hospital services, and a larger share to physician and other professional services and prescription drugs.[5]

The methods and data sources for the Maryland and national estimates and the calculation of 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 55.

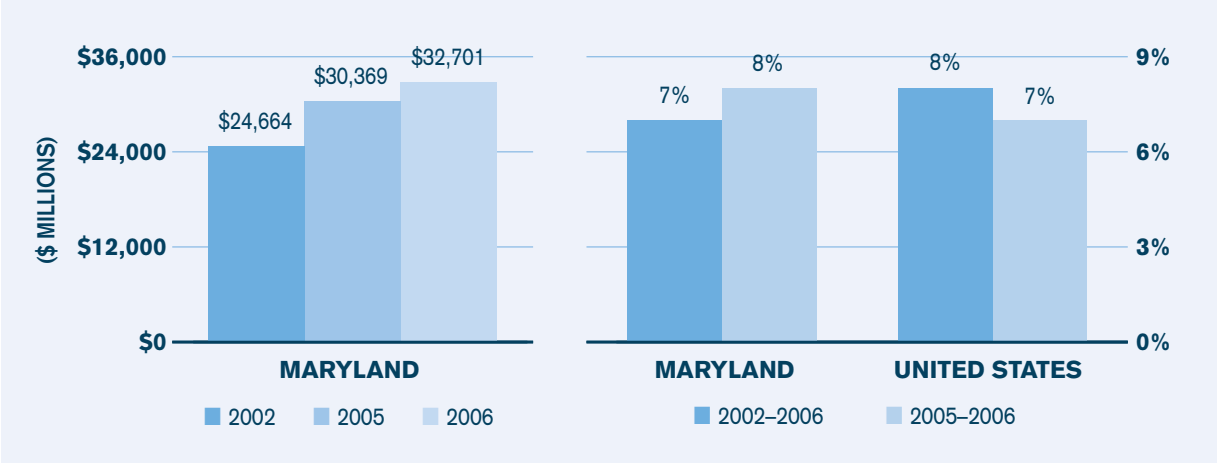
[4] In each service category, the MEPS-estimated per capita private insurance payments were multiplied by the ratio of the adjusted NHEA estimates to the MEPS estimates. Calculation of these ratios was based on: M. Sing et al. (Fall 2006), Reconciling Medical Expenditure Estimates from the MEPS and NHEA, 2002. *Health Care Financing Review* 28(1):25-40.

[5] Because the allocation of hospital payments between inpatient and outpatient services was estimated from Maryland Health Services Cost Review Commission (HSCRC) data, it was not affected by this adjustment.

HOW MUCH DID MARYLAND SPEND FOR HEALTH CARE?

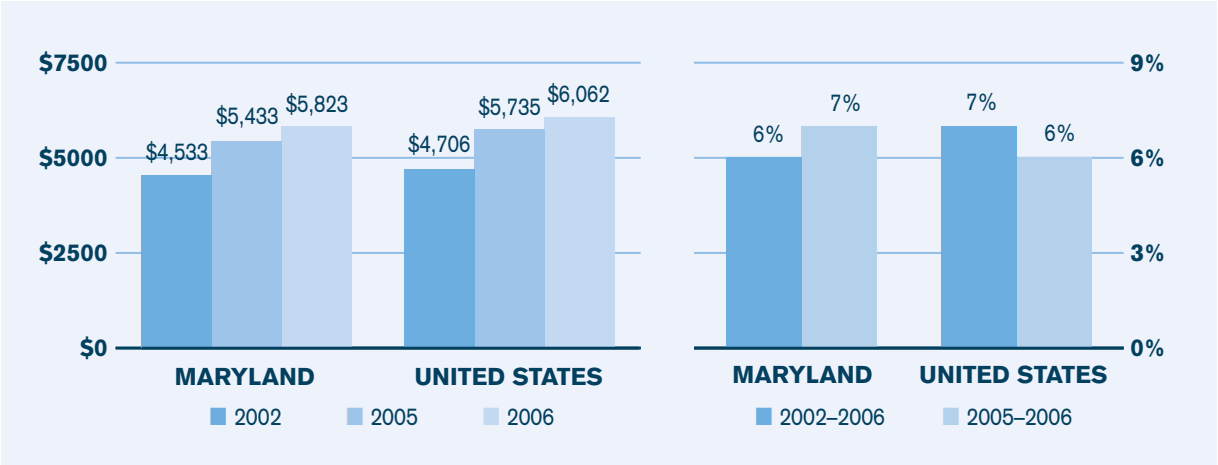
In 2006, Maryland residents spent an estimated $32.7 billion for health care services, compared to $30.4 billion in 2005 and $24.7 billion in 2002 (Figure 1). Health care expenditures in Maryland grew nearly 8 percent from 2005 to 2006, slightly faster than the average rate from 2002 to 2006.

FIGURE 1: Estimated Health Care Expenditures and Rate of Growth



Per resident, health care expenditures in Maryland remain lower than per capita expenditures nationally, although the gap is narrowing.[6] In 2006, Marylanders spent an average of $5,823 per person for health care—approximately 4 percent less than the national average expenditure of $6,062 per person (Figure 2). Per capita expenditures in Maryland grew more slowly than the national average from 2002 to 2006, but accelerated from 2005 to 2006—a departure from slowing growth observed in recent years.[7] From 2005 to 2006, per capita expenditures in Maryland grew at an average rate of 7 percent per year. This uptick contrasts with the national pattern—confirmed in the recently released National Health Expenditure Accounts—of continued slower health care spending growth in 2006.

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



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

[7] As reported in prior years, total and per capita expenditures in Maryland may have been consistently lower than would be estimated based on the improved methods adopted in this report. However, it is not clear that the rate of change would have been substantially different than was reported.

HOW WERE MARYLAND'S HEALTH CARE DOLLARS SPENT?

Hospital inpatient and outpatient care together represent the largest single category of health care expenditures in Maryland, accounting for nearly a third of total health care expenditures in 2006. Inpatient care accounted for 23 percent of total health care expenditures in 2006; 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	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$24,664**	**100%**	**$30,369**	**100%**	**$32,701**	**100%**
Inpatient	5,578	23	7,001	23	7,541	23
Outpatient	1,802	7	2,473	8	2,710	8
Physician Services	4,509	18	5,343	18	5,632	17
Other Professional Services	3,913	16	4,265	14	4,592	14
Prescription Drugs	3,767	15	4,650	15	4,958	15
Nursing Home Care	1,970	8	2,246	7	2,379	7
Home Health Care	808	3	1,172	4	1,279	4
Other Services	508	2	665	2	698	2
Administration and Net Cost of Insurance	1,809	7	2,555	8	2,912	9

Physician services and other professional services together comprise an equally large share of health care expenditures in Maryland, together accounting for 31 percent of total expenditures in 2006. Physician services accounted for 17 percent, compared with 14 percent spent for other professional services.[8]

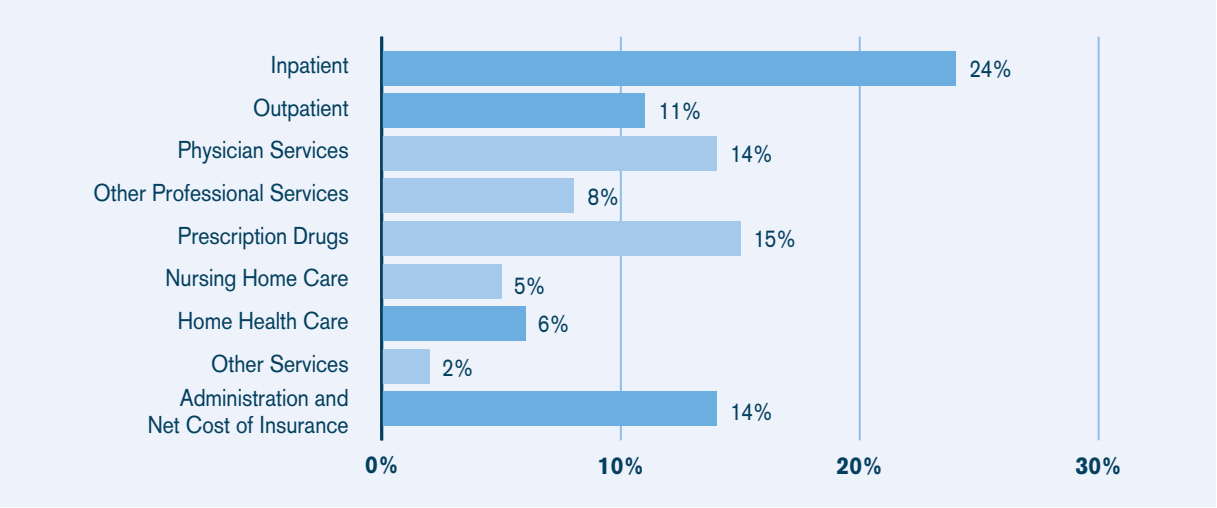
Three categories of expenditures account for nearly all of the balance of health care expenditures in Maryland. Inpatient and outpatient prescription drugs accounted for 15 percent of total expenditures in 2006, while long-term care services—including nursing home care (7 percent) and home health care (4 percent)—accounted for approximately 11 percent. Administrative cost and the net cost of insurance accounted for 9 percent of the total.

Expenditures in three categories—outpatient hospital care, home health care, and administration and the net cost of insurance—accounted for a larger share of Marylanders' total expenditures for health care in 2006 (21 percent) than in 2002 (17 percent). Of these, administration and the net cost of insurance grew the fastest, accounting for 9 percent of total expenditures in 2006 compared with 7 percent in 2002. Conversely, Marylanders spent a lower proportion of health care dollars on physician and other professional services in 2006 (31 percent) than in 2002 (34 percent), and about the same proportion of health care dollars on prescription drugs (15 percent) in both years.

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

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. From 2002 to 2006, growth in inpatient hospital care expenditures accounted for 24 percent of the total increase in expenditures, while outpatient hospital expenditure growth accounted for another 11 percent (Figure 3). Expenditures for physician care and other professional services—both large expenditure categories—together accounted for 22 percent of the total growth in expenditures. Growth in expenditures for prescription drugs accounted for 15 percent of the increase in total health care expenditures from 2002 to 2006, while growth in administration and the net cost of insurance accounted for 14 percent.

FIGURE 3: Estimated Share of Increase in Health Care Expenditures by Service Category in Maryland, 2002–2006

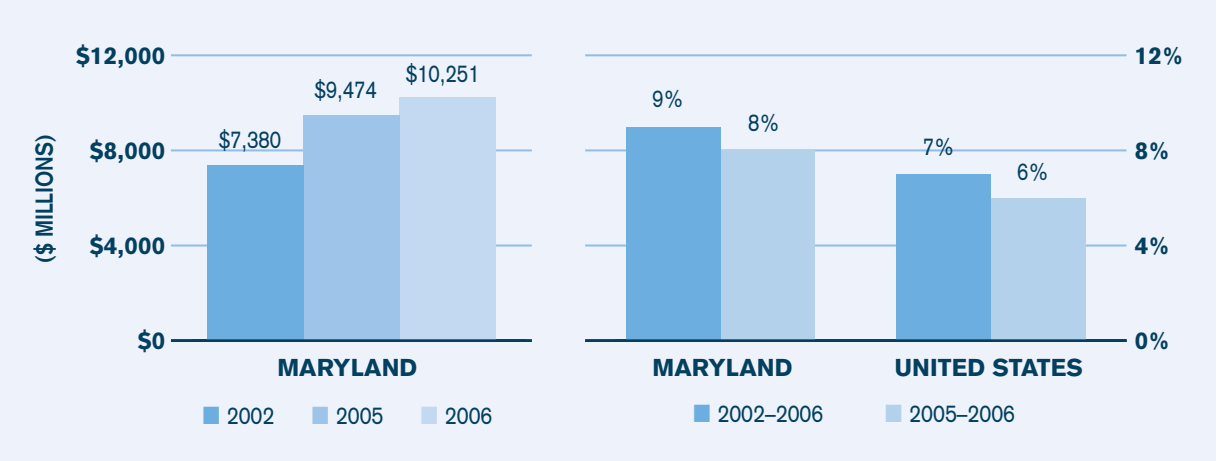


NOTE: Dark shading indicates services that have an increasing share of expenditures in 2006 from 2002. Light shading indicates services that have the same or decreasing share of expenditures in 2006 from 2002. Due to rounding, the increase or decrease in share of expenditures may not be reflected in Table 1 above.

EXPENDITURES FOR HOSPITAL CARE

Including both inpatient and outpatient services, Marylanders spent nearly $10.3 billion for hospital care in 2006 (Figure 4). Total expenditures for hospital care grew at an average annual rate of 9 percent from 2002 to 2006, slowing to 8 percent growth from 2005 to 2006. Since 2002, hospital expenditures in Maryland have grown one-third faster than the national average, exceeding the national average annual growth rate by about 2 percentage points per year. From 2005 to 2006, about three-fourths of the 8 percent increase in expenditures for inpatient hospital care in Maryland was associated with higher charges per case; the balance was due to growth in hospital admissions.[9] [10]

FIGURE 4: Estimated Hospital Services Expenditures and Rate of Growth



On a per capita basis, Marylanders still spend less for hospital care than the national average, but the gap is narrowing. In 2006, Marylanders spent an average of $1,825 per person for inpatient and outpatient hospital care, about 12 percent less than the national average of $2,077 (Figure 5). Still, as the growth in per capita spending for hospital care in Maryland outpaces the national average, the difference between the level of per capita hospital spending in Maryland and the national average gradually has narrowed. From 2002 to 2006, per capita spending for hospital care in Maryland grew at an average annual rate of about 8 percent. In contrast, national expenditures for hospital care rose at an average annual rate of 6 percent from 2002 to 2006, slowing to a 5 percent increase from 2005 to 2006. If per capita expenditures for hospital care in Maryland and the nation continue to grow at the same rates as from 2005 to 2006, Marylanders will spend more per capita for hospital care than the national average by 2011 (data not shown).

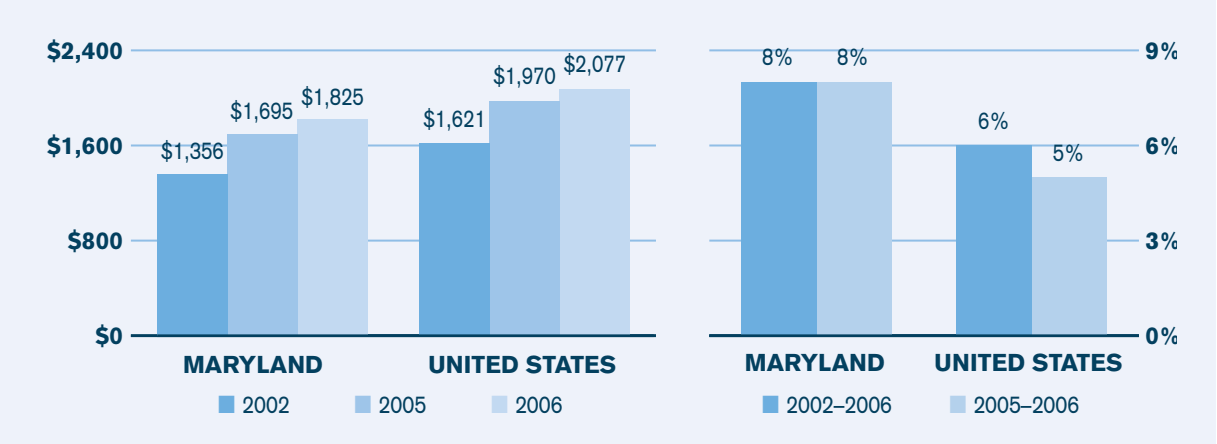
Maryland's recent higher growth in per capita spending for hospital care may in part reflect the state's all-payer regulation of hospital reimbursements. In other states, Medicaid reimbursement for hospital care is typically much lower than private insurer reimbursements. As enrollment in these programs increases, they account for a growing share of health care services, depressing per capita expenditures averaged across all

[9] Since 1971, HSCRC has set the rates that hospitals may charge to any payer. In fiscal 2006 (including the first half of CY 2006), HSCRC increased inpatient rates by 6.0 percent and outpatient rates by 3.9 percent, including adjustments for intensity and inflation. In fiscal 2007 (including the second half of CY 2006), HSCRC increased inpatient and outpatient rates by 5.2 percent and 3.6 percent, respectively.

[10] Hospital admissions in Maryland increased 2.0 percent in CY 2006, compared with CY 2005, while charges per case increased 6.8 percent (from $9,687 to $10,347). Maryland Health Services Cost Review Commission (March 2007), *Monitoring Maryland Performance* (http://www.hscrc.state.md.us/financial_data_reports/MonitoringMDPerf.htm, accessed 12/19/07).

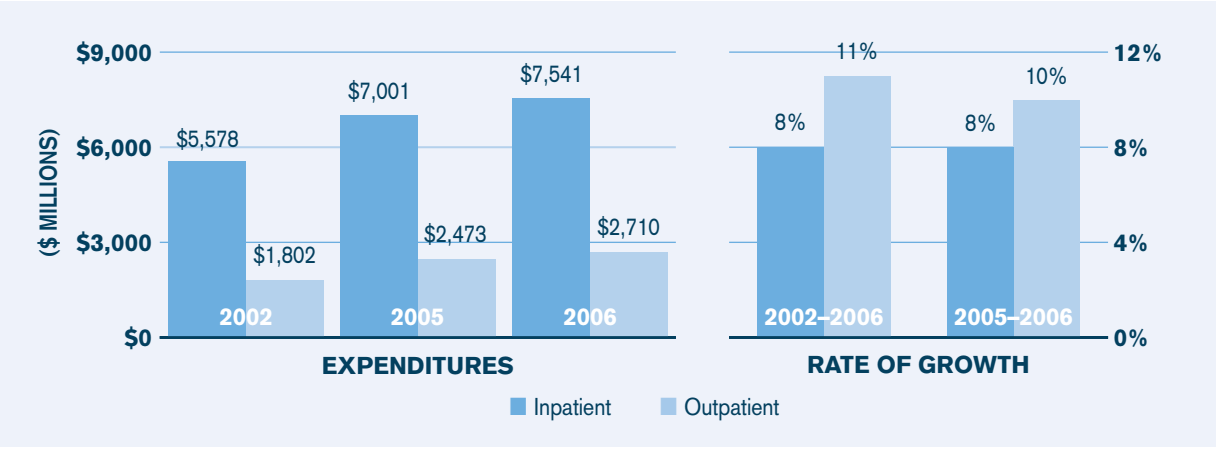
payers.[11] [12] Thus, growth in Medicaid and the State Children's Health Insurance Program (SCHIP) enrollment probably has somewhat reduced the growth in total expenditures for hospital care nationally—but less so in Maryland, where hospital reimbursement rates are the same for all payers.[13]

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



Marylanders spend more than twice as much for inpatient care as for outpatient care (in 2006, $7.5 billion versus $2.7 billion), but expenditures for outpatient care have grown much faster (Figure 6). From 2002 to 2006, expenditures for outpatient care grew at an average annual rate of 11 percent, compared with 8 percent average annual growth in expenditures for inpatient care. From 2005 to 2006, growth in outpatient expenditures dropped to 10 percent, while expenditures for inpatient care continued to grow at about 8 percent.

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



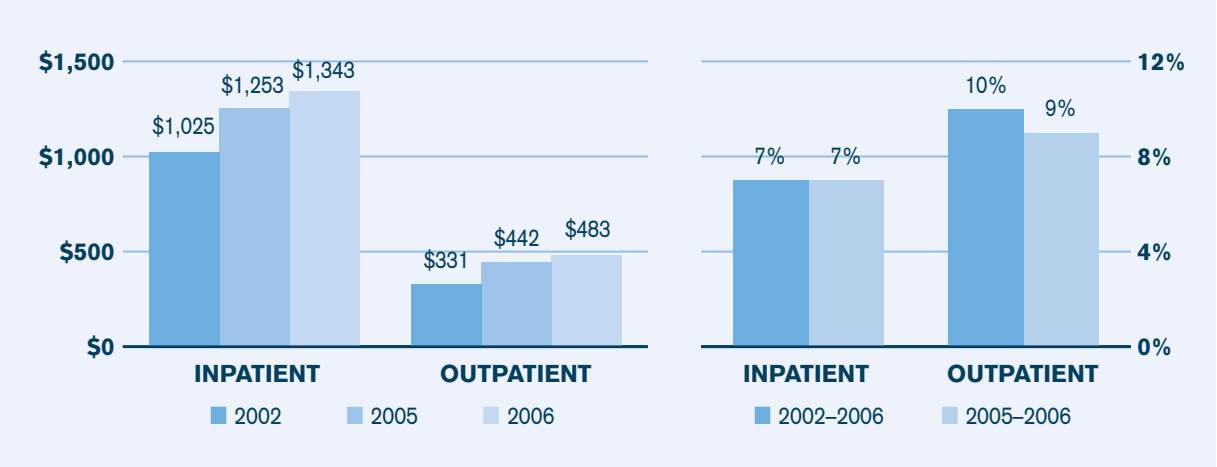
[11] As the proportion of residents with private insurance coverage has continued to decline in Maryland and in other states, enrollment in Medicaid and SCHIP has increased. Maryland Health Care Commission (2007a), *Health Insurance Coverage in Maryland Through 2005* (http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_thru_2005.pdf). Nationally, the percentage of the population under age 65 with health insurance coverage has continued to decline (reaching a post-1994 low of 82.1 percent in 2006), while Medicaid and SCHIP enrollment has risen. In 2006, 13.4 percent of the U.S. population under age 65 were enrolled in Medicaid or SCHIP for at least part of the year, compared with an estimated 11.9 percent in 2002. P. Fronstin (2007), *Sources of Health Insurance and Characteristics of the Uninsured*, Washington, DC: Employee Benefit Research Institute (http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20071.pdf, accessed 12/19/07).

[12] Increases in hospital rates provided through the rate setting system also affect Medicaid expenditures. In Maryland, a 1 percent increase in inpatient hospital rates increases total Medicaid spending by about 0.24 percent, and a 1 percent increase in outpatient rates increases total Medicaid spending about 0.1 percent, all else being equal.

[13] In Maryland, Medicaid limits the number of days that it pays per hospital stay. While all payers pay the same hospital rates in Maryland, hospitals are at risk for Medicaid stays that extend beyond the program's limits on covered days.

The pattern of expenditures per capita for inpatient and outpatient hospital care is similar to the pattern of total expenditures. Marylanders spend substantially more per capita for inpatient care (in 2006, $1,343) than for outpatient care ($483). However, per capita expenditures for outpatient care have grown much faster than for inpatient care (Figure 7). Per capita expenditures for outpatient care grew at an average annual rate of 10 percent from 2002 to 2006, and by 9 percent from 2005 to 2006. In contrast, per capita expenditures for inpatient care grew at an average annual rate of 7 percent from 2002 to 2006, and at about the same rate from 2005 to 2006.

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 41 percent of all inpatient care in 2006 and 33 percent of all outpatient care—about the same proportions as in 2002 (Table 2). Private insurance also financed a substantial share of inpatient care (35 percent) in 2006, and was the largest single source of payment for outpatient care (36 percent). Medicaid (including SCHIP) financed about 20 percent of inpatient and outpatient care, respectively, in 2006. In both service categories, Medicaid's share of expenditures increased 2 to 3 percentage points from 2002 to 2006, consistent with rising program enrollment.

Marylanders pay out-of-pocket a relatively small share of the cost of inpatient care (in 2006, just 1 percent), but a larger share of outpatient expenditures (8 percent). The larger share of outpatient care paid out-of-pocket reflects the typical structure of cost-sharing in private insurance plans and Medicare, as well as the uninsured population's greater use of hospital outpatient departments as a source of primary care.[14]

[14] Maryland Health Care Commission (2007a), *op cit.*

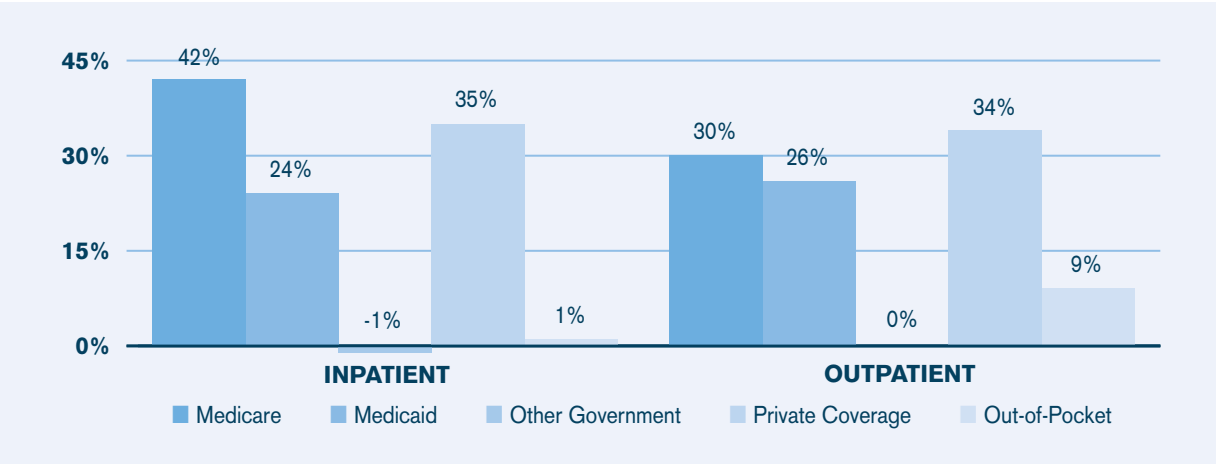
TABLE 2: Estimated Inpatient and Outpatient Expenditures by Source of Payment in Maryland

PAYER CATEGORY	INPATIENT						OUTPATIENT					
	2002		2005		2006		2002		2005		2006	
	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	**$6,223**	**100%**	**$7,001**	**100%**	**$7,541**	**100%**	**$1,802**	**100%**	**$2,473**	**100%**	**$2,710**	**100%**
Medicare	2,477	41	2,892	41	3,109	41	621	34	835	34	893	33
Medicaid	1,178	18	1,329	19	1,491	20	311	17	453	18	551	20
Other Government	282	5	265	4	272	4	55	3	63	3	58	2
Private Coverage	2,231	35	2,457	35	2,607	35	682	38	922	37	987	36
Out-of-Pocket	56	1	57	1	62	1	133	7	199	8	219	8

As the largest payers for hospital care in Maryland, Medicare and private insurance expenditures have accounted for a large share of the growth in expenditures. Medicare and private insurance, respectively, financed 42 percent and 35 percent of the increase in expenditures for inpatient hospital care from 2002 to 2006, and 30 percent and 34 percent of the increase in expenditures for outpatient care (Figure 8).

Medicaid also financed a significant share of the growth in hospital expenditures from 2002 to 2006—24 percent of the increase in inpatient expenditures and 26 percent of the increase in outpatient expenditures. Relative to the proportion of total inpatient and outpatient care that it paid for in 2006 (20 percent), Medicaid accounted for a disproportionate share of the increase in total expenditures for hospital care—largely driven by growth in program enrollment since 2002.

FIGURE 8: Estimated Share of Increase in Inpatient and Outpatient Expenditures by Source of Payment in Maryland, 2002–2006

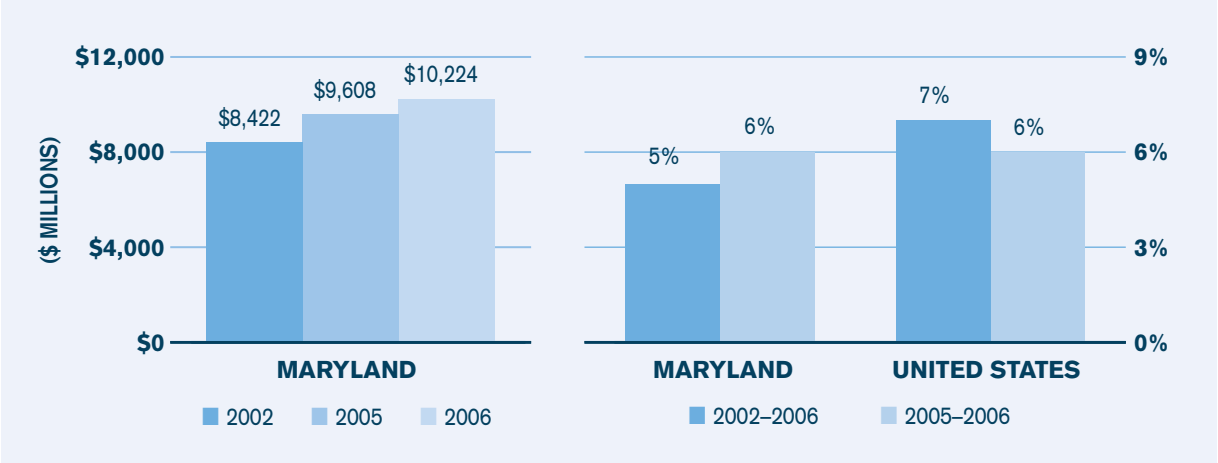


NOTE: 0% indicates < 0.5%.

EXPENDITURES FOR PRACTITIONER SERVICES

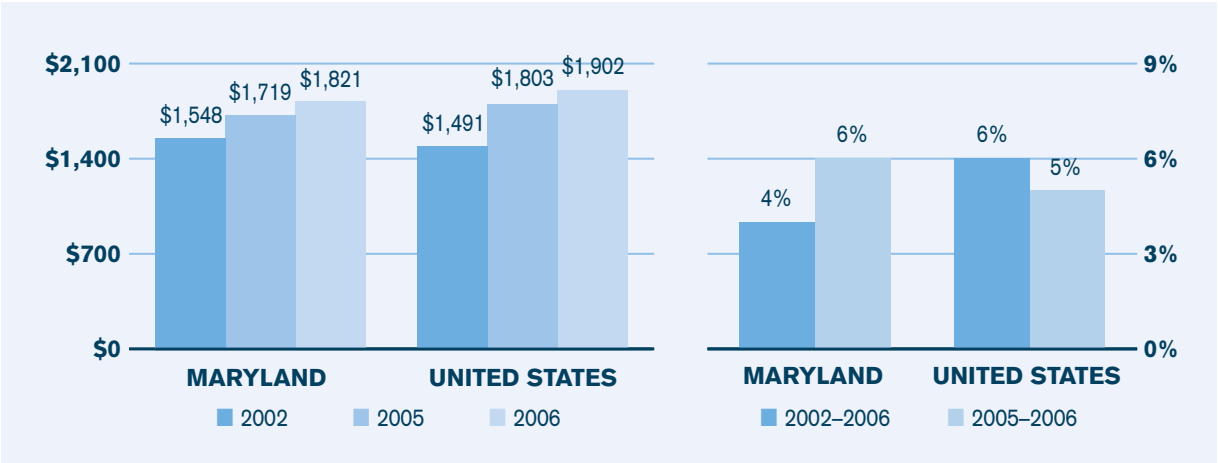
Marylanders spent approximately $10.2 billion for physician and other professional services in 2006—the latter including dental services; nonphysician vision services; occupational, physical, and other therapy services; physician assistant care; nurse practitioner services; and chiropractic care (Figure 9). These providers are permitted under Maryland law to bill patients and insurers directly. In Maryland, total expenditures for practitioner services grew more slowly than the national average from 2002 to 2006 (at an average rate of 5 percent per year, compared with the national average of 7 percent). More recently, from 2005 to 2006, expenditures for practitioner services in Maryland increased by about 6 percent, about equal to the national average rate of growth.

FIGURE 9: Estimated Practitioner Services Expenditures and Rate of Growth



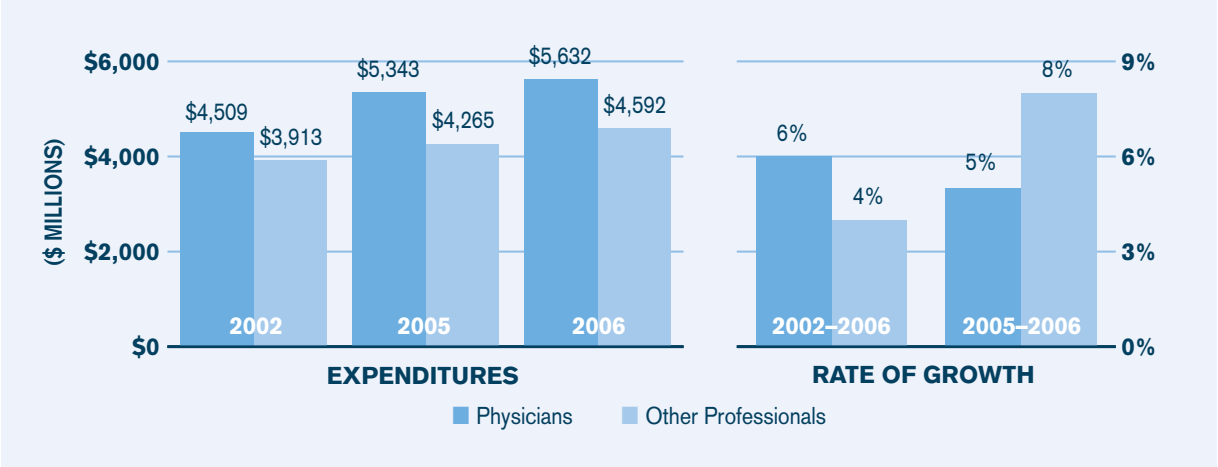
Per capita expenditures for practitioner services remain lower in Maryland ($1,821 in 2006) than the national average ($1,902), and since 2002 they have grown more slowly—increasing at an average annual rate of 4 percent compared with 6 percent nationally. However, from 2005 to 2006, per capita expenditures for practitioner services in Maryland accelerated, growing 6 percent as national expenditures per capita slowed to 5 percent (Figure 10).

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



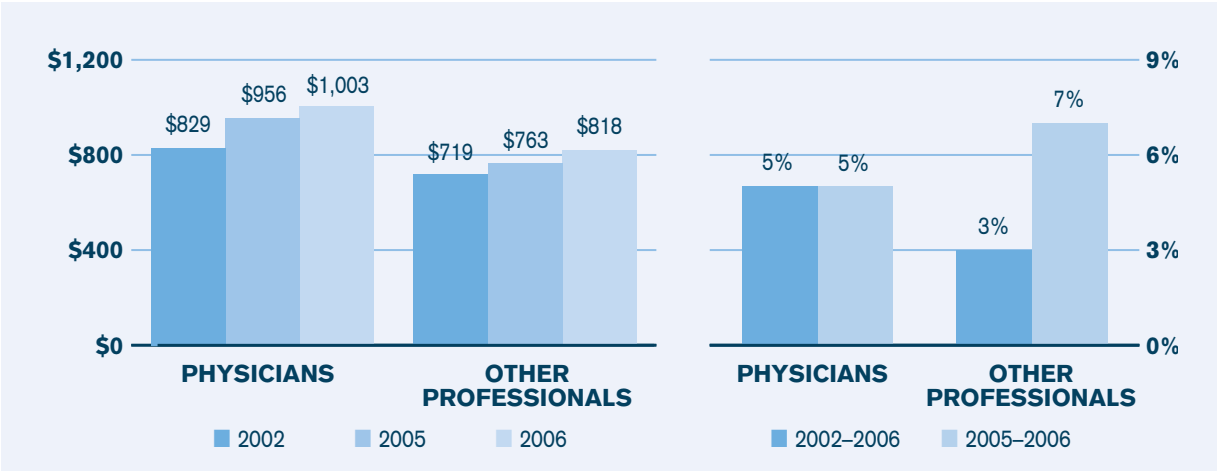
Physician services accounted for more than half of all expenditures for practitioner services in Maryland in 2006—$5.6 billion, versus $4.6 billion for other professional services. From 2002 to 2006, expenditure growth for physician care averaged 6 percent per year, compared with 4 percent for other professional services (Figure 11). However, spending for other professional services in Maryland accelerated from 2005 to 2006, rising by 8 percent as the growth in expenditures for physician services slowed to 5 percent.

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



Marylanders spent $1,003 per capita for physician services in 2006, compared with $818 for other professional services. From 2002 to 2006, 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 3 percent (Figure 12). From 2005 to 2006, per capita spending for physician services continued to grow 5 percent. However, the rate of growth in expenditures for other professional services accelerated to 7 percent, driving much faster growth in expenditures for practitioner services overall in Maryland.

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



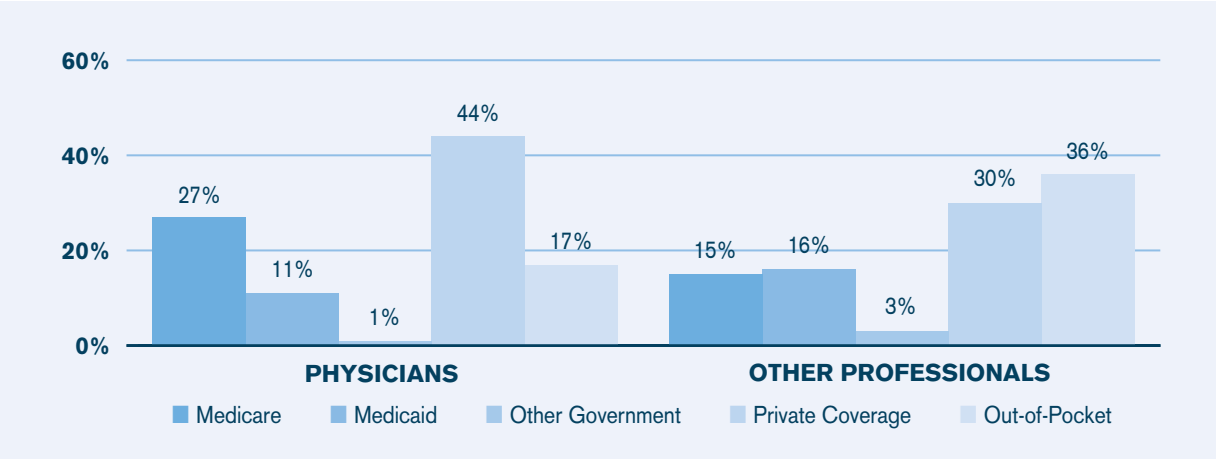
The primary sources of payment for physician care in Maryland differ from those for other professional services (Table 3). Private insurance is the dominant source of payment for physician care, accounting for 53 percent of total expenditures in 2006, followed by Medicare (24 percent). Marylanders financed 13 percent of physician care out-of-pocket in 2006, and Medicaid and other government programs together financed just 10 percent.

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

PAYER CATEGORY	PHYSICIANS						OTHER PROFESSIONALS					
	2002		2005		2006		2002		2005		2006	
	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	**$4,509**	**100%**	**$5,343**	**100%**	**$5,632**	**100%**	**$3,913**	**100%**	**$4,265**	**100%**	**$4,592**	**100%**
Medicare	1,026	23	1,273	24	1,330	24	214	5	295	7	317	7
Medicaid	261	6	340	6	386	7	423	11	487	11	531	12
Other Government	143	3	146	3	150	3	502	13	525	12	524	11
Private Coverage	2,509	56	2,867	54	3,008	53	1,386	35	1,446	34	1,587	35
Out-of-Pocket	570	13	716	13	757	13	1,389	35	1,513	35	1,633	36

In contrast, Marylanders pay a relatively large proportion (36 percent) of expenditures for other professional services out-of-pocket, followed closely by private insurance (35 percent). Medicaid and other government programs financed 23 percent of other professional services, while Medicare financed just 7 percent—although either program may finance substantially larger proportions of some services in this category. (For example, Medicare is an important purchaser of podiatrist services relative to other sources of payment.)

FIGURE 13: Estimated Share of Increase in Physician and Other Professional Expenditures by Source of Payment in Maryland, 2002–2006



As a purchaser of physician services in Maryland, Medicare's importance has grown steadily. Medicare accounted for more than a quarter of the total increase in spending for physician services from 2002 to 2006 (27 percent), raising Medicare's share of physician services from 23 percent in 2002 to 24 percent in

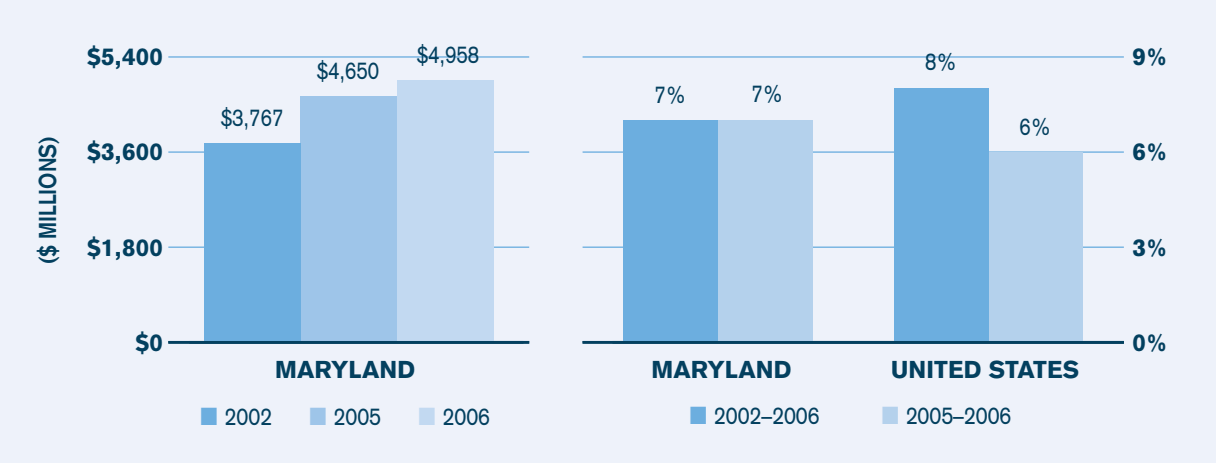
2006 (Figure 13, Table 3). Medicaid also financed a growing share of physician services—accounting for 11 percent of the increase in expenditures for physician services from 2002 to 2006. However, Medicaid's share of all expenditures for physician care remained relatively small, increasing from 6 percent in 2002 to 7 percent in 2006.

In contrast, private insurance paid a lower percentage of all expenditures for physician care in 2006 (53 percent) than in 2002 (56 percent). Nevertheless, reflecting its dominance as a source of physician revenue, private insurance accounted for a larger share of the growth in expenditures for physician care (44 percent) than other payers from 2002 to 2006. The decline in private insurance spending as a proportion of the total may reflect private insurer constraints on physician reimbursement rates, as well as a decline in the percentage of Marylanders with private insurance coverage since 2002. It may also reflect an increase in cost-sharing for physician services in private insurance plans, although this is not reflected in out-of-pocket spending; consumers paid out-of-pocket approximately the same percentage of expenditures for physician care in 2006 (13 percent) as in 2002.

EXPENDITURES FOR PRESCRIPTION DRUGS

In 2006, Marylanders spent nearly $5.0 billion for prescription drugs (Figure 14). Since 2002, expenditures for prescription drugs in Maryland have grown more slowly than the national average, averaging 7 percent per year compared with 8 percent nationally. However, from 2005 to 2006, prescription drug expenditures in Maryland continued to grow by about 7 percent, as expenditure growth nationally slowed to 6 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.[15] It probably also reflects more generous insurance coverage of prescription drugs among retirees in Maryland relative to the national average.

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. However, in Maryland, relatively few Medicare beneficiaries are enrolled in either PDPs or Medicare Advantage plans. Instead, in 2006, an estimated 23 percent of Medicare beneficiaries in Maryland with prescription drug coverage were federal retirees who obtained drug coverage through the Federal Employees Health Benefits Program (FEHBP), compared with about 11 percent nationally. Another 26 percent were enrolled in a private employer-sponsored retiree health plan, compared with 21 percent nationally. Conversely, Medicare beneficiaries in Maryland are much less likely than the national average to be enrolled in a Medicare Advantage plan that would offer coverage at least as generous as that in a PDP.[16]

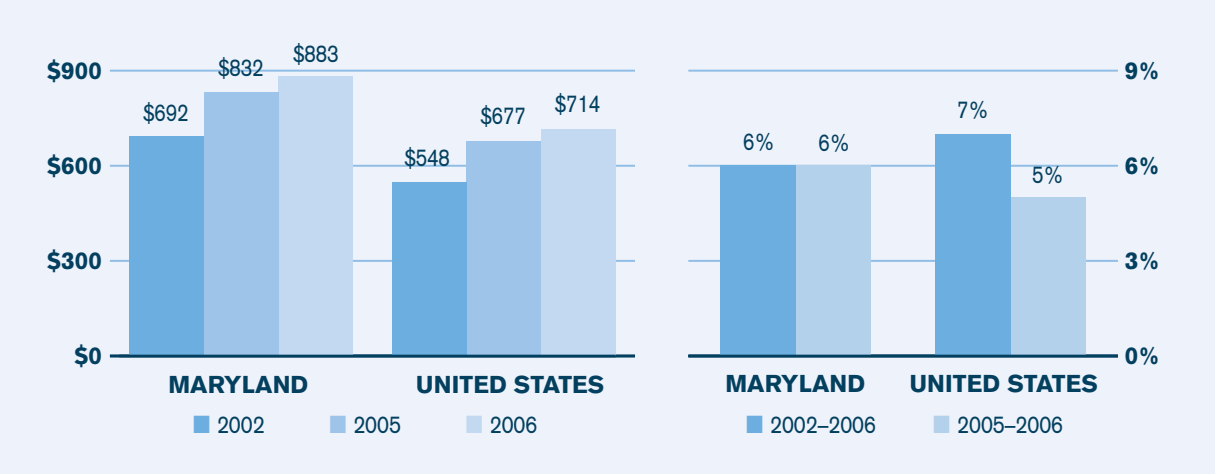
[15] Calculated as 3-year averages, an estimated 13.5 percent of Marylanders (of all ages) were uninsured in 2004-2006, compared with 13.2 percent in 2001-2003. This compares with more than 15 percent of the total population that is uninsured nationally. C. DeNavas-Walt et al., U.S. Census Bureau, Current Population Reports, P60-226, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (Table 9) (http://www.census.gov/prod/2004pubs/p60-226.pdf, accessed 1/4/08); and P60-233, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Table 8) (http://www.census.gov/prod/2007pubs/p60-233.pdf, accessed 1/4/08).

[16] In Maryland, just 6 percent of Medicare beneficiaries were enrolled in a Medicare Advantage plan, compared with 18 percent nationally. Medicare beneficiaries in Maryland with prescription drug coverage were about as likely as the national average to enroll in a PDP (33 percent in Maryland, versus 32 percent nationally). U.S. Department of Health and Human Services (June 14, 2006). News Release: Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage (http://www.hhs.gov/news/press/2006pres/20060614.html, accessed 1/7/08).

Per capita expenditures for prescription drugs in Maryland ($883) substantially exceeded the national average ($714) in 2006, as in earlier years (Figure 15). This discrepancy, which is 24 percent above the national average, probably reflects more generous insurance coverage for prescription drugs in Maryland historically and currently, especially among retirees.

As with total expenditures for prescription drugs in Maryland, per capita spending historically has grown more slowly than the national average, but exceeded the national trend in 2006. In Maryland, per capita expenditures for prescription drugs grew at an average rate of 6 percent per year from 2002 to 2006, compared with 7 percent nationally. From 2005 to 2006, per capita expenditures continued to grow about 6 percent, while growth in per capita expenditures nationally slowed to about 5 percent.

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 2006, private insurance financed 48 percent of all expenditures for prescription drugs, while consumers paid 27 percent out-of-pocket (Table 4).

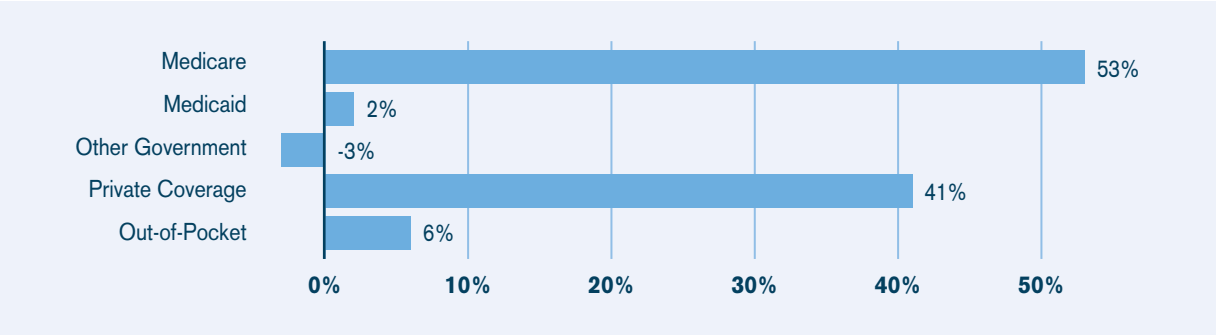
TABLE 4: Estimated Prescription Drug Expenditures by Source of Payment in Maryland

PAYER CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$3,767**	**100%**	**$4,650**	**100%**	**$4,958**	**100%**
Medicare	5	0	8	0	638	13
Medicaid	489	13	727	16	516	10
Other Government	104	3	69	1	74	1
Private Coverage	1,877	50	2,250	48	2,369	48
Out-of-Pocket	1,291	34	1,595	34	1,360	27

NOTE: 0% indicates < 0.5%.

Reflecting new enrollment in Medicare Part D, Medicare expenditures for drugs in Maryland increased from a negligible amount in 2002 and 2005 to an estimated $638 million in 2006. Concurrently, out-of-pocket and private insurance expenditures for prescription drugs increased more slowly and accounted for a lower share of total expenditures in 2006 (27 percent and 48 percent, respectively) than in 2002 (34 percent and 50 percent). Medicaid also paid a lower proportion of total expenditures for prescription drugs in 2006 (10 percent) than in 2002 (13 percent), largely associated with lower drug expenditures for "dual eligibles" in the program—elderly and disabled Medicaid enrollees who are concurrently enrolled in Medicare.[17] As expected, Medicare and private insurance accounted for nearly all of the growth in total expenditures for prescription drugs from 2002 to 2006—53 percent and 41 percent, respectively, reflecting the implementation of Medicare Part D in 2006 (Figure 16).

FIGURE 16: Estimated Share of Increase in Prescription Drug Expenditures by Source of Payment in Maryland, 2002–2006

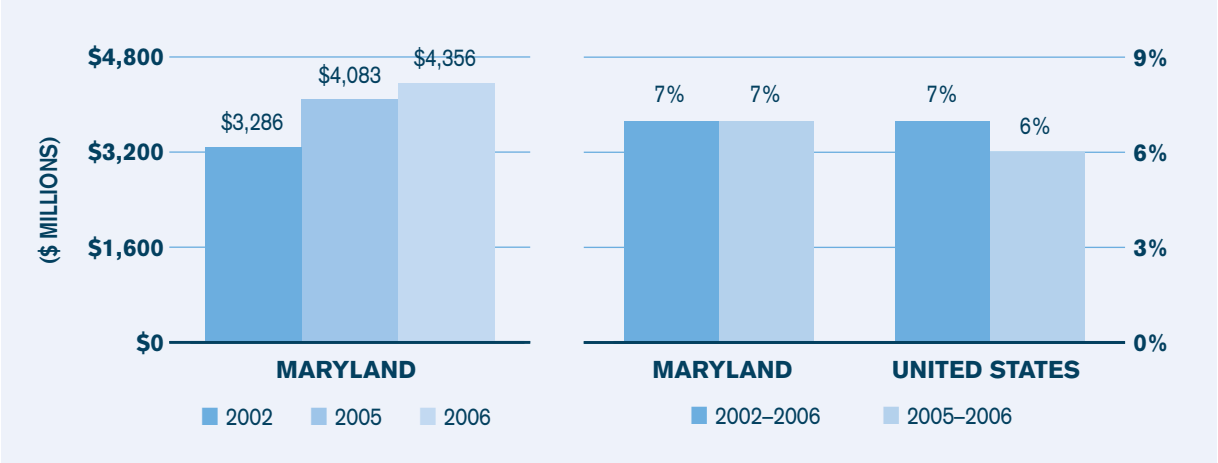


[17] Like all states, Maryland makes a payment to Medicare (popularly termed a "clawback") reflecting the estimated cost of prescription drugs for dual eligibles; these payments are included in Medicare expenditures. The clawback is a monthly payment that each state has made to the federal Medicare program 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 CY 2006, Maryland paid more than $83.3 million in clawback to the federal government. The National Conference of State Legislatures (http://www.ncsl.org/print/health/Clawback.pdf), cited in: The Henry J. Kaiser Family Foundation Commission on Medicaid and the Uninsured (March 2006). *An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit*. Issue Paper (http://www.kff.org/medicaid/upload/7481.pdf, accessed 1/7/08).

EXPENDITURES FOR LONG-TERM CARE AND OTHER SERVICES

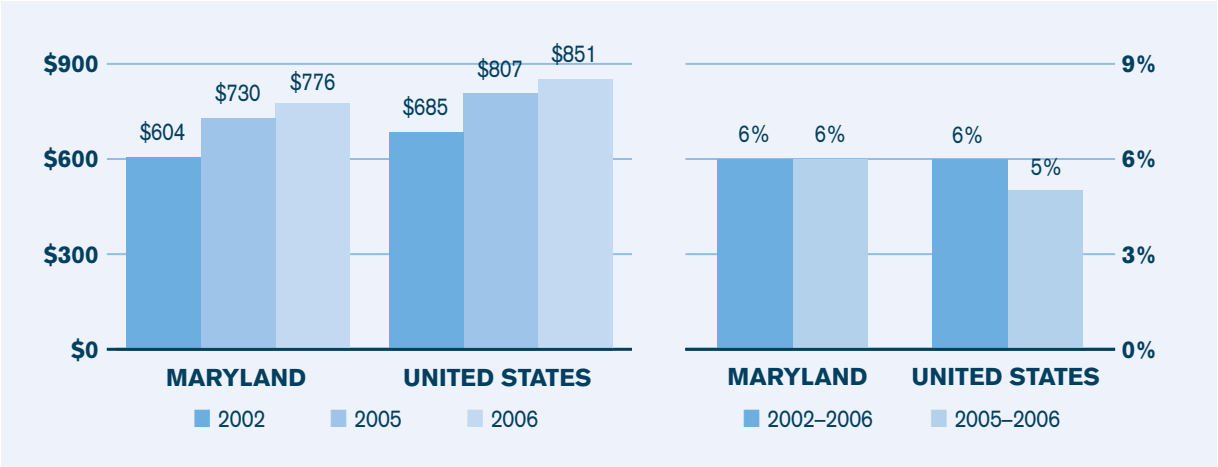
Expenditures for long-term care and other miscellaneous services in Maryland reached $4.4 billion in 2006 (Figure 17). Expenditures for long-term care—including nursing home and home health care expenditures—accounted for approximately two-thirds of these expenditures. Historically, expenditures per capita for long-term care and other miscellaneous services have been lower in Maryland than the national average. Marylanders continued to spend about 9 percent less per capita for these services in 2006 ($776 versus $851)(Figure 18).

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



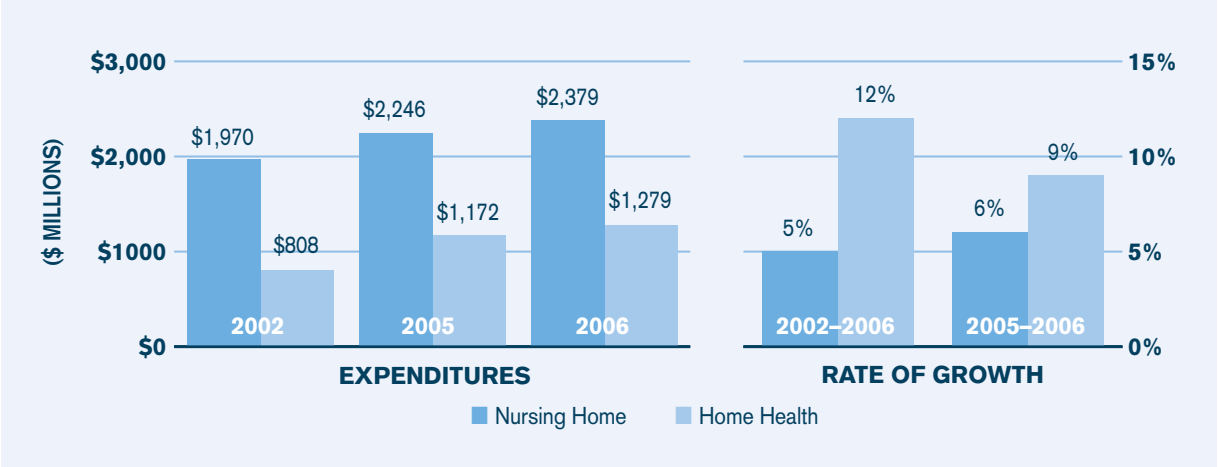
In Maryland and nationally, per capita expenditures for long-term care and other services grew about 6 percent per year from 2002 to 2006. From 2005 to 2006, expenditures for these services continued to rise by about 6 percent in Maryland, while nationally the increase slowed to 5 percent.

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 approximately two-thirds of all expenditures for long-term care in Maryland. In 2006, Marylanders spent nearly $2.4 billion for nursing home care and about $1.3 billion for home health care services (Figure 19). However, expenditures for home health care services have increased much 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.[18] In Maryland, expenditures for home health services grew at an average rate of 12 percent per year from 2002 to 2006, slowing to 9 percent from 2005 to 2006. In comparison, nursing home expenditures grew at an average rate of 5 percent per year from 2002 to 2006, increasing to 6 percent from 2005 to 2006.

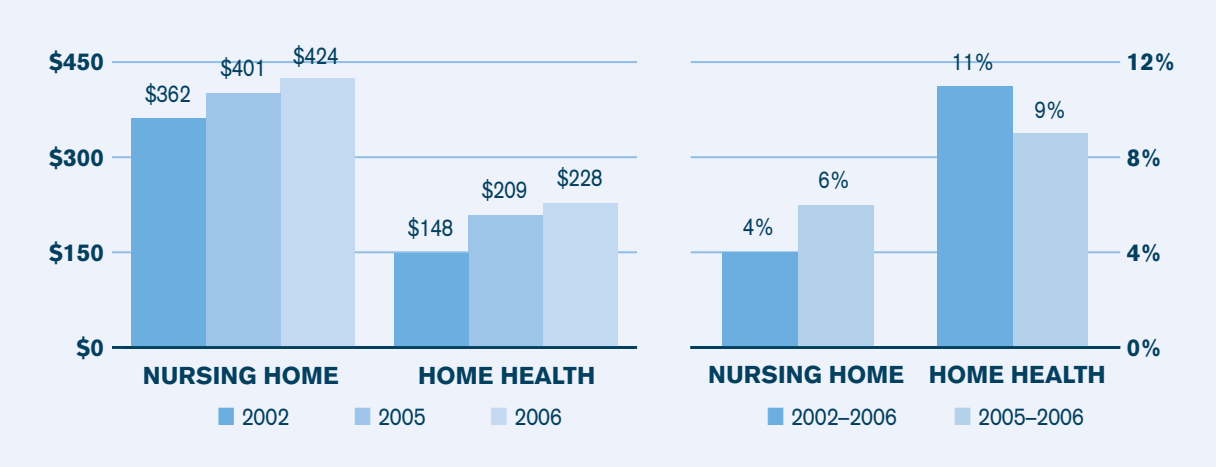
FIGURE 19: Estimated Nursing Home and Home Health Expenditures and Rate of Growth in Maryland



Per capita, Marylanders spent $424 for nursing home care in 2006, compared with $228 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 9 percent per year from 2005 to 2006, compared with an average annual increase of just 6 percent for nursing home care, reflecting the growing care needs of beneficiaries receiving home health care during that period. However, per capita expenditures for home health care increased more slowly from 2005 to 2006 (by 9 percent, compared with 11 percent per year from 2002 to 2006) as per capita expenditures for nursing home care accelerated—growing 6 percent from 2005 to 2006, compared with an average of 4 percent per year since 2002.

[18] Maryland Medicaid funds seven waiver programs for home and community-based services that enable individuals in need of long-term care services to remain in a community setting. In an effort to better promote transitions to the community from institutions, the state applied for and received a federal demonstration grant, called Money Follows the Person, which seeks to transition nearly 2,000 institutionalized residents over the next 4 years to home and community settings. The demonstration provides individuals with additional outreach and resources to assist them with transitioning to community settings. Separately, the state policy (called Money Follows the Individual) ensures that funding is available for those who do transition to receive services through one of the state's 1915(c) home and community-based service (HCBS) waiver programs. 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. These programs served 14,327 people as of January 2006. The total number of waiver slots continues to increase; as of January 2007, there were 16,273 waiver slots. The state continues to apply for new waivers—the New Directions waiver for people with developmental disabilities was implemented in fiscal year 2006, and the Department was just recently approved for the psychiatric residential treatment center (RTC) waiver to target seriously emotionally disturbed teenagers.

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 2006, Medicaid financed 45 percent of all expenditures for nursing home care and 60 percent of expenditures for home health care (Table 5). From 2002 to 2006, Medicaid financed a growing share of home health care services (increasing from 53 percent of total spending for home health care in 2002 to 60 percent in 2006), while its share of total spending for nursing home care declined slightly (from 46 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					
	2002		2005		2006		2002		2005		2006	
	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	**$1,970**	**100%**	**$2,246**	**100%**	**$2,379**	**100%**	**$808**	**100%**	**$1,172**	**100%**	**$1,279**	**100%**
Medicare	284	14	369	16	413	17	131	16	160	14	163	13
Medicaid	912	46	1,040	46	1,072	45	425	53	695	59	765	60
Other Government	39	2	64	3	64	3	6	1	13	1	13	1
Private Coverage	151	8	155	7	166	7	89	11	98	8	107	8
Out-of-Pocket	585	30	618	28	663	28	156	19	206	18	231	18

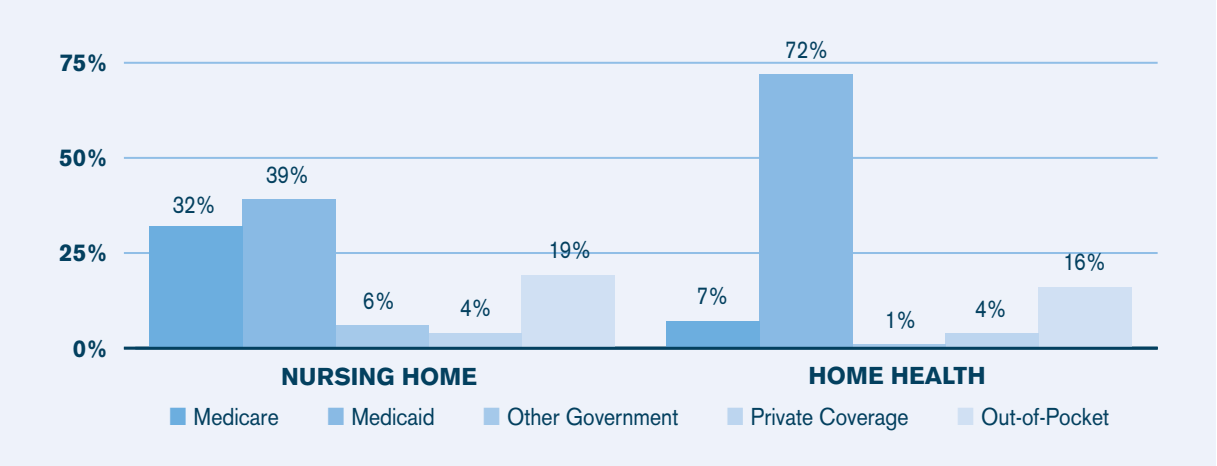
Medicare finances either nursing home or home health care only as it relates to recovery from a hospitalization. As a result, it is a relatively minor payer for these services, despite relatively high need for these services among the elderly and disabled populations that Medicare serves. Nevertheless, Medicare has grown as a proportion of total spending for nursing home care, from 14 percent in 2002 to 17 percent in 2006.

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.[19] In 2006, Marylanders paid 28 percent of nursing home care expenditures and 18 percent of home health care expenditures out-of-pocket.

Out-of-pocket spending for both nursing home care and home health care has grown slowly compared with payments from other sources, such that out-of-pocket spending has declined as a percentage of total expenditures for both service types. Out-of-pocket spending accounted for 19 percent of the growth in expenditures for nursing home care from 2002 to 2006, and 16 percent of the growth in expenditures for home health care (Figure 21). In contrast, Medicaid and Medicare accounted, respectively, for 39 percent and 32 percent of the growth in nursing home expenditures from 2002 to 2006. Medicaid's policy of serving beneficiaries in need of long-term care services in the community when possible is apparent in its share of the growth in home health care expenditures: Medicaid paid 72 percent of the growth in expenditures for home health care from 2002 to 2006. Medicare accounted for just 7 percent of the growth in home health care expenditures over this period.

FIGURE 21: Estimated Share of Increase in Nursing Home and Home Health Expenditures by Source of Payment in Maryland, 2002–2006



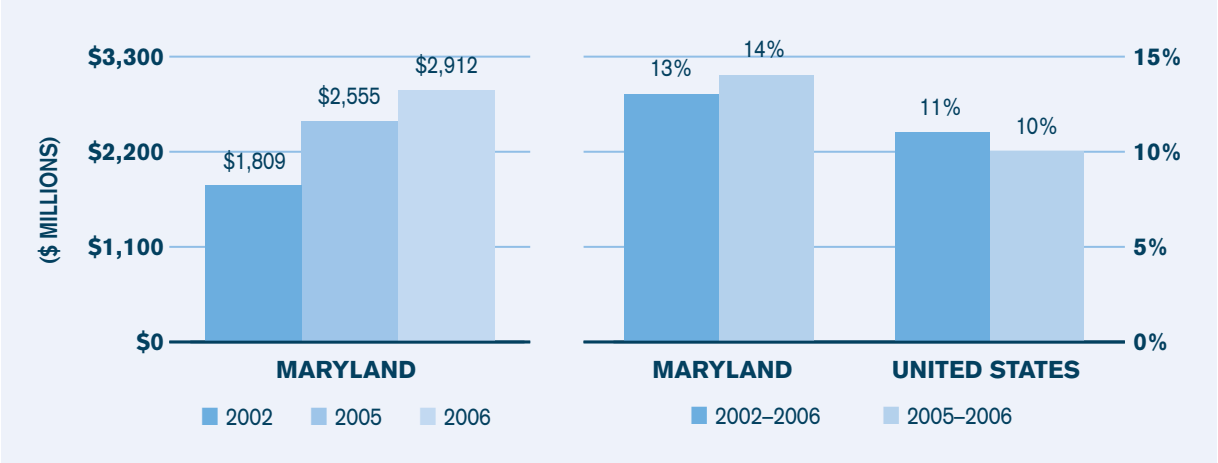
[19] Responding to the magnitude of uninsured long-term care expenditures and the correspondingly high probability that individuals who require long-term care will "spend down" to Medicaid eligibility, the federal Deficit Reduction Act of 2005 (DRA-05) authorized long-term care insurance partnerships 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 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/long-termcare/insurance/fs124_ltc_06.html, accessed 1/4/08).

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. The administrative costs of insurance include the private insurer and public program costs for enrolling and disenrolling participants and processing claims. The net cost of insurance includes private insurers' profits, capital expenditures, additions to surplus, and assessments and taxes.

In 2006, Marylanders spent $2.9 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 than the national average. From 2002 to 2006, these expenditures increased at an average annual rate of 13 percent, accelerating to 14 percent growth from 2005 to 2006. Nationally, expenditures for administration and the net cost of insurance grew at an average rate of 11 percent per year from 2002 to 2006, and slowed to 10 percent from 2005 to 2006. In Maryland and nationally, the development of Medicare Part D plans and enrollment in Medicare Advantage plans from fee-for-service Medicare also contributed to the increase in administrative and net costs of insurance.[20]

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 in 2005 and 2006 may be related to 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 also to increase Medicaid payments.[21] [22] In addition, some of the largest insurers in Maryland added significantly to surplus and profit in 2006, as rate increases exceeded medical cost growth.[23]

[20] In 2007, the administrative costs, sales expenses, and profits of private Part D insurers totaled an estimated $4.3 billion nationally, in addition to $300 million incurred by the Centers for Medicare & Medicaid Services (CMS) to administer the program. In total, these expenditures accounted for an estimated 9.8 percent of the total costs of Medicare Part D. Committee on Oversight and Government Reform, U.S. House of Representatives (http://oversight.house.gov/story.asp?ID=1537, accessed 1/4/08).

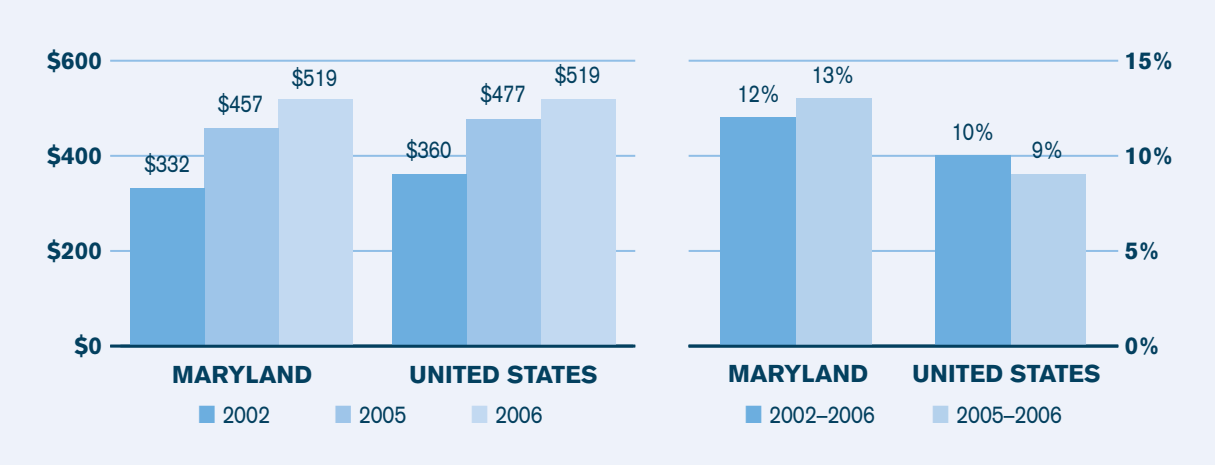
[21] Medicaid started transitioning payment increases by procedure codes in 2005 with codes billed by obstetricians/gynecologists, neurosurgeons, and emergency medicine personnel, who generally face the highest malpractice insurance premiums. It is anticipated that Medicaid rates will equal 80 to 100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

[22] Enacted in 2005, S.B. 831 also capped malpractice insurance rate increases for physicians at 5 percent. 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.

[23] 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).

The faster growth of expenditures for administration and the net cost of insurance in Maryland relative to the national average is apparent in the growing level of expenditures per capita over time. From 2002 to 2006, these expenditures grew much faster in Maryland than the national average—12 percent per year in Maryland, compared with 10 percent per year nationally (Figure 23). From 2005 to 2006, expenditures for administration and the net cost of insurance in Maryland accelerated to 13 percent, as average growth in these expenditures nationally slowed to 9 percent. As a result, while Marylanders historically have paid less for administration and the net cost of insurance than the national average, in 2006 their expenditures per capita equaled the national average—$519 per person.

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



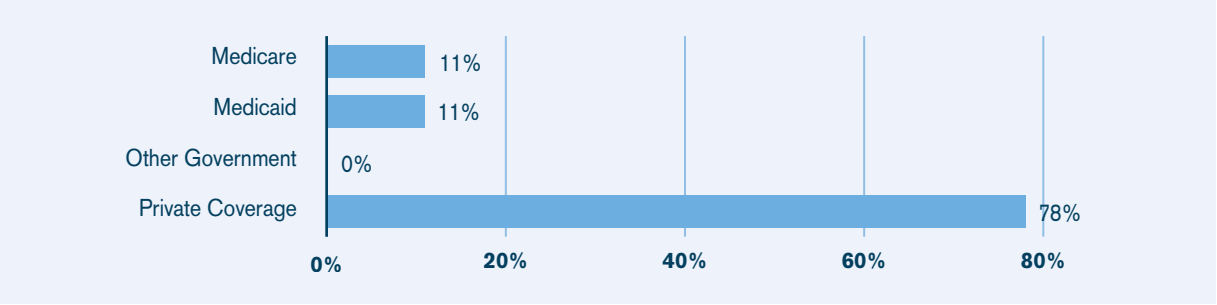
As in 2002 and 2005, private insurance accounted for the vast majority of expenditures for the administration and net cost of insurance in Maryland. In each year, about 75 percent of these expenditures were associated with private insurance plans (Table 6). In 2006, the administrative and net costs of private insurance in Maryland totaled nearly $2.2 billion. Medicaid and Medicare, respectively, accounted for 12 percent and 9 percent of expenditures for administration and the net cost of insurance—about $612 million in 2006.

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

PAYER CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$1,809**	**100%**	**$2,555**	**100%**	**$2,912**	**100%**
Medicare	153	8	211	8	272	9
Medicaid	216	12	319	12	340	12
Other Government	105	6	106	4	105	4
Private Coverage	1,335	74	1,919	75	2,196	75

Consistent with its high share of total expenditures for the administration and net cost of insurance, private insurance accounted for 78 percent of the growth in these expenditures from 2002 to 2006 (Figure 24). Public sector programs accounted for the balance: Medicare and Medicaid each accounted for just 11 percent of the growth in expenditures for the administration and net cost of insurance from 2002 to 2006.

FIGURE 24: Estimated Share of Increase in Administration Expenditures and Net Cost of Insurance by Source of Payment in Maryland, 2002–2006



NOTE: 0% indicates < 0.5%.

WHO PAID FOR MARYLAND'S HEALTH CARE?

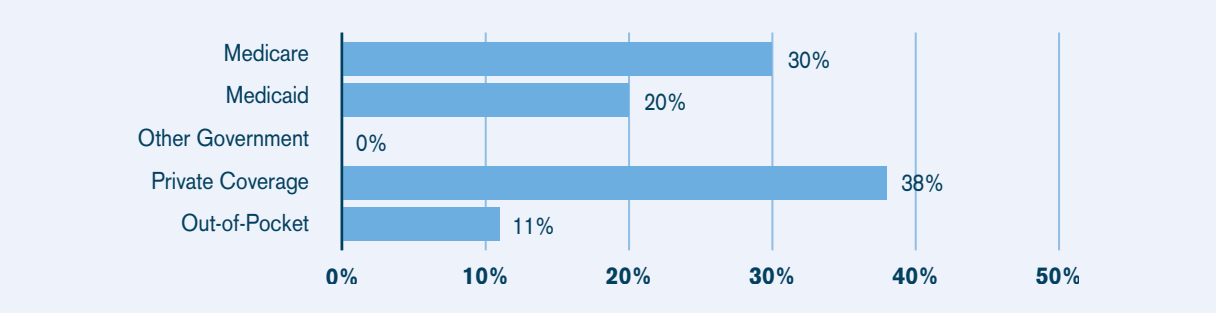
Private payers—either private insurance or consumer out-of-pocket payments—finance more than half of health care expenditures in Maryland. In 2006, private insurance financed 40 percent of all health care expenditures; 16 percent were paid out-of-pocket (Table 7). Government programs financed the balance of expenditures for health care in Maryland—including Medicare (22 percent), Medicaid (17 percent), and other government programs (4 percent). Taken together, public program expenditures accounted for a larger percentage of all health care expenditures in 2006 (44 percent) than in 2002 (41 percent)—associated primarily with the implementation of Medicare coverage for prescription drugs, but also with growing enrollment in Medicaid and SCHIP during the period.

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

PAYER CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$24,664**	**100%**	**$30,369**	**100%**	**$32,701**	**100%**
Medicare	4,832	20	6,181	20	7,283	22
Medicaid	4,076	17	5,431	18	5,695	17
Other Government	1,261	5	1,272	4	1,279	4
Private Coverage	10,002	41	12,163	40	13,079	40
Out-of-Pocket	4,494	18	5,324	18	5,365	16

Private insurance accounted for the largest proportion of the increase in total health care spending in Maryland from 2002 to 2006 (38 percent), followed by Medicare (30 percent) as a result of new coverage for prescription drugs (Figure 25). Reflecting greater coverage for prescription drugs among retirees, just 11 percent of the growth in total expenditures was paid out-of-pocket. Largely due to greater enrollment, Medicaid accounted for 20 percent of expenditure growth from 2002 to 2006.

FIGURE 25: Estimated Share of Increase in Health Care Expenditures by Source of Payment in Maryland, 2002–2006

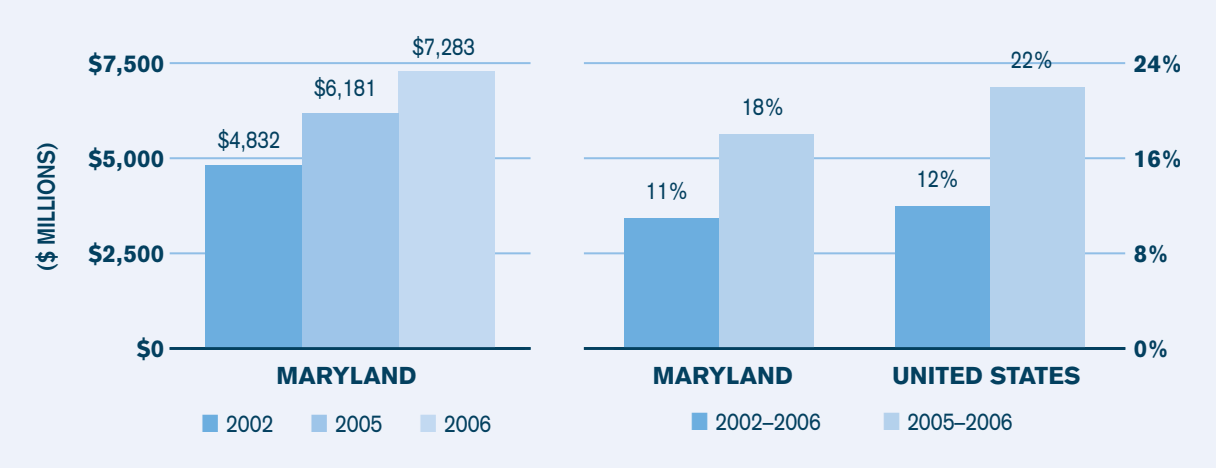


NOTE: 0% indicates < 0.5%.

MEDICARE EXPENDITURES

Medicare expenditures in Maryland reached $7.3 billion in 2006. The implementation of Part D had a smaller impact on total Medicare expenditures in Maryland than nationally, reflecting the relatively high rate of retiree coverage from private employers and FEHBP in Maryland.[24] From 2002 to 2006, Medicare spending in Maryland increased at an average rate of 11 percent per year, compared with an average annual increase of 12 percent nationally. With implementation of Part D, Medicare expenditures in Maryland increased 18 percent from 2005 to 2006, compared with 22 percent nationally (Figure 26).

FIGURE 26: Estimated Medicare Expenditures and Rate of Growth



On a per enrollee basis, Medicare expenditures in Maryland are higher than the national average, but have grown more slowly. In 2006, Medicare spent about 6 percent more per beneficiary in Maryland than the national average—$10,290 compared with a national average of $9,740 (Figure 27). Medicare spending per enrollee in Maryland grew at 9 percent per year from 2002 to 2006, jumping to 16 percent from 2005 to 2006. Nationally, Medicare spending per enrollee grew at an average rate of 10 percent per year from 2002 to 2006, and increased 19 percent from 2005 to 2006. The smaller increase in Medicare expenditures in Maryland from 2005 to 2006 reflects the smaller proportion of beneficiaries in Maryland who gained coverage for prescription drugs with Medicare Part D. This is due to the fact that relatively many beneficiaries in Maryland already were enrolled in employer-sponsored retiree plans and FEHBP in 2005, relatively few gained drug coverage in either Part D or Medicare Advantage plans in 2006.

In 2006, about 55 percent of Medicare expenditures in Maryland were associated with hospital care (Table 8). Again reflecting the impact of Part D coverage for prescription drugs, this was a smaller proportion than in either 2002 or 2005. Nevertheless, inpatient hospital care remains the largest category of expenditures—accounting for 43 percent of Medicare expenditures in Maryland in 2006. Hospital outpatient care and

[24] In 2006, an estimated 23 percent of Medicare beneficiaries in Maryland with prescription drug coverage were federal retirees who obtained drug coverage through the FEHBP, compared with 11 percent nationally. Another 26 percent were enrolled in a private employer-sponsored retiree health plan, compared with 21 percent nationally. Conversely, just 6 percent were enrolled in a Medicare Advantage plan, compared with 18 percent nationally. Medicare beneficiaries in Maryland with prescription drug coverage were about as likely as the national average to enroll in a PDP (33 percent in Maryland, versus 32 percent nationally). U.S. Department of Health and Human Services (June 14, 2006). News Release: Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage (http://www.hhs.gov/news/press/2006pres/20060614.html, accessed 1/7/08).

physician services accounted for 12 percent and 18 percent of total Medicare spending, respectively. While Medicare spending for prescription drugs was negligible in 2002 and 2005, prescription drugs accounted for 9 percent of total Medicare expenditures in Maryland in 2006.

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

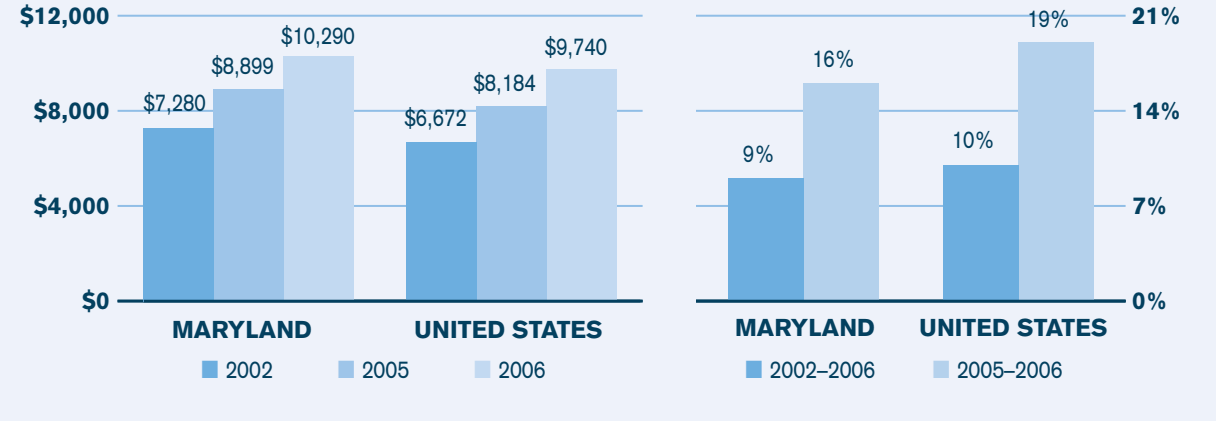


TABLE 8: Estimated Medicare Expenditures by Service Category in Maryland

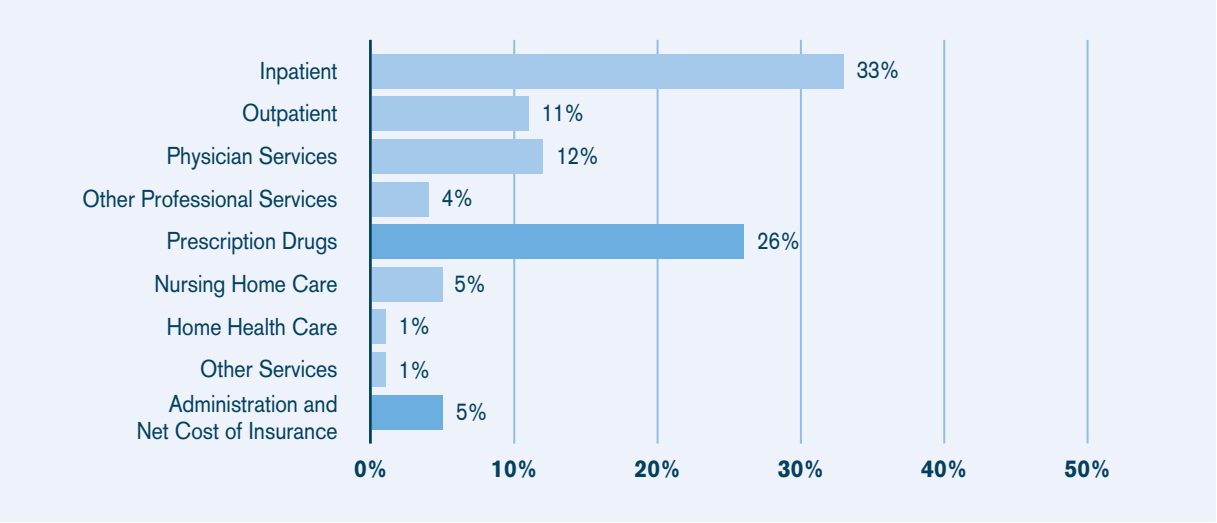
SERVICE CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$4,832**	**100%**	**$6,181**	**100%**	**$7,283**	**100%**
Inpatient	2,288	47	2,892	47	3,109	43
Outpatient	621	13	835	14	893	12
Physician Services	1,026	21	1,273	21	1,330	18
Other Professional Services	214	4	295	5	317	4
Prescription Drugs	5	0	8	0	638	9
Nursing Home Care	284	6	369	6	413	6
Home Health Care	131	3	160	3	163	2
Other Services	110	2	137	2	146	2
Administration and Net Cost of Insurance	153	3	211	3	272	4

NOTE: 0% indicates < 0.5%.

Because inpatient care is the largest single category of Medicare expenditure in Maryland, it also has accounted for a large proportion of the program's expenditure growth since 2002 (Figure 28). Expenditures for inpatient hospital care accounted for 33 percent of the growth in all Medicare expenditures in Maryland from 2002 to 2006, followed by expenditures for prescription drugs (26 percent). Growth in expenditures for physician services and outpatient hospital care accounted for 12 percent and 11 percent, respectively. In 2006 (and again

in 2007), the U.S. Congress postponed implementation of a scheduled 10 percent reduction in Medicare payment rates for physicians intended to further curb growth in expenditures for physician services.[25]

FIGURE 28: Estimated Share of Increase in Medicare Expenditures by Service Category in Maryland, 2002–2006



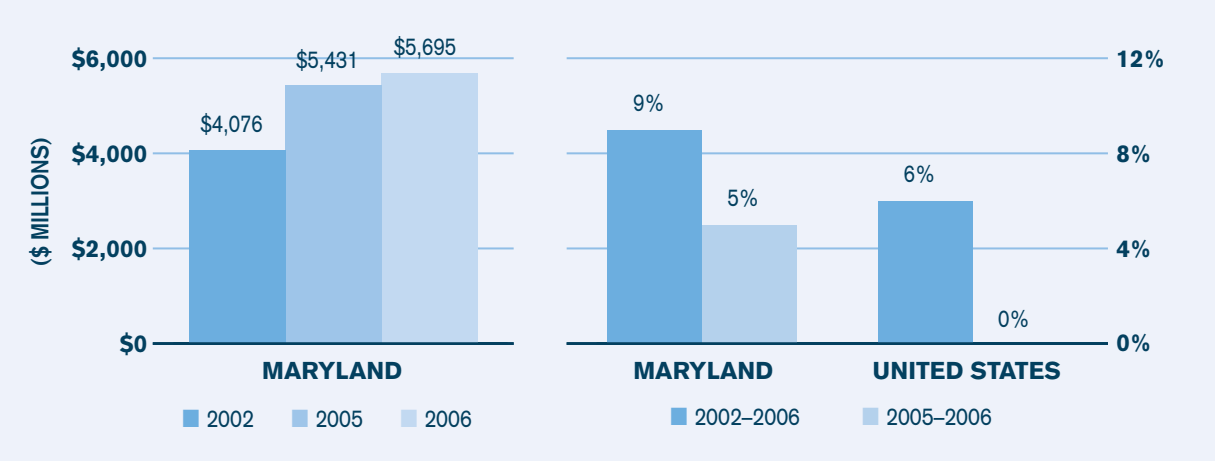
NOTE: Dark shading indicates services that have an increasing share of expenditures in 2006 from 2002. Light shading indicates services that have the same or decreasing share of expenditures in 2006 from 2002. Due to rounding, the increase or decrease in share of expenditures may not be reflected in Table 1 above.

[25] The Medicare Supplemental Medical Insurance (Part B) program uses a fee schedule to pay for covered medical services provided by physicians. In 1998, 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—by FY2007, by $30 billion above the system's cumulative target. However, Congress has postponed reducing physician payments each year, consistent with the SGR targets. Donald M. Marron, Congressional Budget Office (July 25, 2006). Medicare's Physician Payment Rates and the Sustainable Growth Rate. Statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives (http://www.cbo.gov/ftpdocs/74xx/doc7425/07-25-SGR.pdf).

MEDICAID EXPENDITURES

In 2006, Medicaid—financed with both state and federal dollars—spent nearly $5.7 billion for health care services in Maryland (Table 9). Reflecting growth in the enrolled population and increases in Medicaid payment levels, Medicaid spending in Maryland has increased faster than the national average—from 2002 to 2006 at an average rate of 9 percent per year (Figure 29). In contrast, the national spending for Medicaid beneficiaries grew at an average rate of 6 percent per year from 2002 to 2006, reflecting low growth in provider payment rates and rollbacks of eligibility and enrollment during the fiscal crisis that generally extended from 2001 to 2003 in many states.[26] In part reflecting the fact that Maryland's all-payer hospital rate regulation governs the rates that Medicaid pays hospitals in the same way as other payers, Medicaid spending in Maryland continued to rise (by 5 percent) from 2005 to 2006, even as Medicare began paying a large share of prescription drug expenditures for dual eligibles. In contrast, Medicaid spending nationally was nearly flat from 2005 to 2006.

FIGURE 29: Estimated Medicaid Expenditures and Rate of Growth

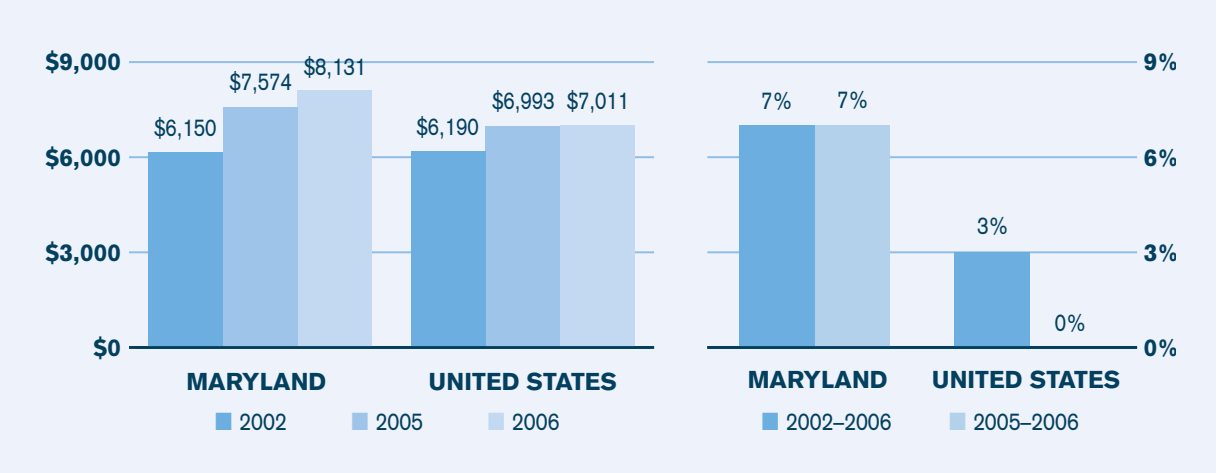


NOTE: 0% indicates < 0.5%.

In Maryland, Medicaid expenditures per enrollee were 16 percent higher than the national average in 2006—$8,131 in Maryland, compared with $7,011 nationally (Figure 30). From 2002 to 2006, per enrollee expenditures grew more than twice as fast in Maryland as the national average—at 7 percent per year, compared with 3 percent nationally. In Maryland, Medicaid expenditures continued to grow at approximately 7 percent from 2005 to 2006, while nationally expenditures per enrollee remained approximately unchanged with implementation of Medicare Part D.

[26] 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: although they faced a combined budget shortfall of nearly $40 billion for fiscal year 2005, that gap was half what they had faced in fiscal 2004. As the fiscal picture continued to improve through 2006 and 2007, some states restored or even expanded Medicaid and SCHIP eligibility and enrollment. AcademyHealth (2005-2007). *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 12/21/07).

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 2006—totaling more than $2.0 billion (Table 9). Inpatient care accounted for most of this amount (26 percent of total expenditures). Reflecting Medicaid's position in Maryland, as in other states, as the largest purchaser of long-term care services, nursing home services and home health care accounted for nearly a third of the program's total expenditure for health care services—in 2006, 32 percent.

TABLE 9: Estimated Medicaid Expenditures by Service Category in Maryland

SERVICE CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$4,076**	**100%**	**$5,431**	**100%**	**$5,695**	**100%**
Inpatient	1,026	25	1,329	24	1,491	26
Outpatient	311	8	453	8	551	10
Physician Services	261	6	340	6	386	7
Other Professional Services	423	10	487	9	531	9
Prescription Drugs	489	12	727	13	516	9
Nursing Home Care	912	22	1,040	19	1,072	19
Home Health Care	425	10	695	13	765	13
Other Services	13	0	41	1	42	1
Administration and Net Cost of Insurance	216	5	319	6	340	6

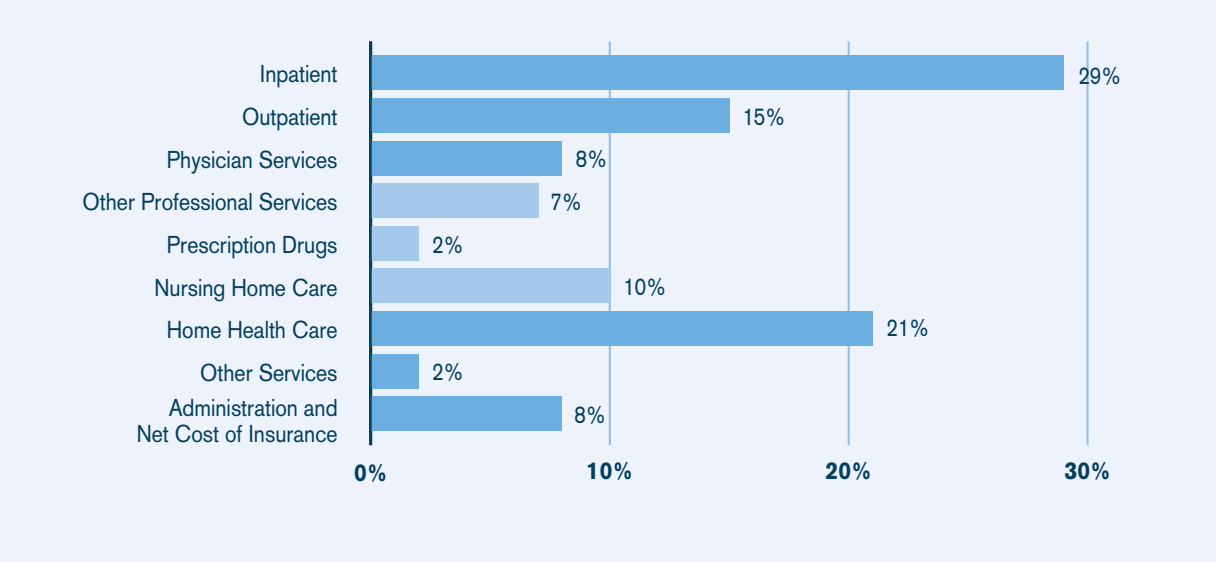
NOTE: 0% indicates < 0.5%.

Medicaid expenditures for prescription drugs fell from a high point of $727 million in 2005 to $516 million in 2006, as Medicare assumed a large share of the cost of prescription drugs for dual eligibles. However, due to 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.[27]

Most of the growth in Medicaid expenditures in Maryland from 2002 to 2006 was associated with increased expenditure for inpatient hospital care (29 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. It may also reflect changes in rates of hospitalization and length of stay among Medicaid enrollees. Similarly, Medicaid's growing expenditure for home health care also reflects a policy decision to serve beneficiaries in home and community-based settings when possible. Maryland has authority to increase home and community-based care under a federal waiver of Medicaid regulations.[28]

FIGURE 31: Estimated Share of Increase in Medicaid Expenditures by Service Category in Maryland, 2002–2006



NOTE: Dark shading indicates services that have an increasing share of expenditures in 2006 from 2002. Light shading indicates services that have the same or decreasing share of expenditures in 2006 from 2002. Due to rounding, the increase or decrease in share of expenditures may not be reflected in Table 1 above.

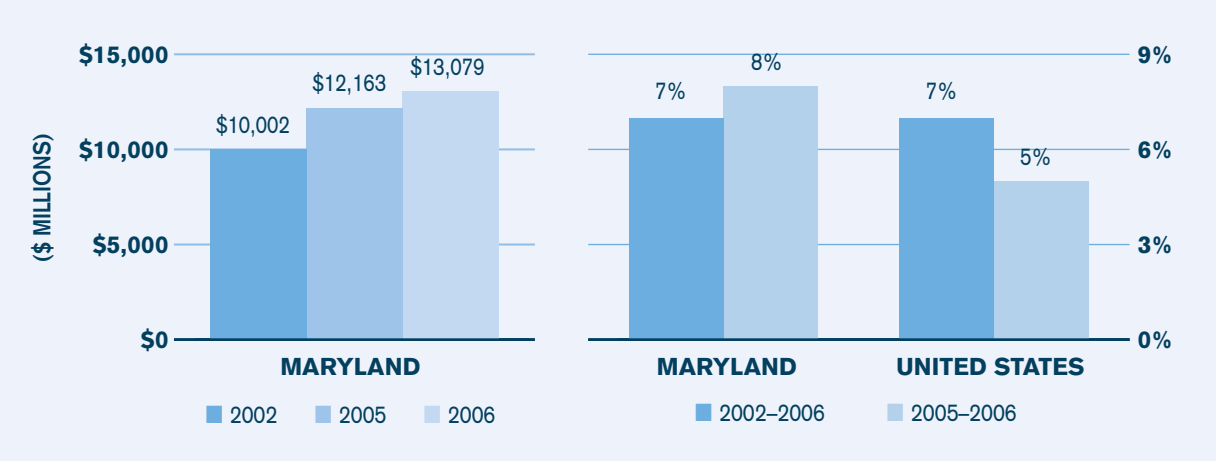
[27] Medicare prescription drug coverage (Part D) is complex: it includes a deductible, a coverage gap (also called the "donut hole"), and catastrophic coverage. Beneficiaries with prescription drug expenses must pay the first $265 out-of-pocket (the deductible), after which the drug plan will pay about 75 percent of costs, until total drug expenses (paid by the plan and the beneficiary) reach $2,400. The beneficiary then pays 100 percent of expenses that exceed $2,400, until the beneficiary's out-of-pocket expense for drugs reaches $3,850. Once total drug costs reach $5,451, the plan then pays as much as 95 percent of additional drug costs for the calendar year. (See: http://www.aarp.org/health/medicare/drug_coverage/what_is_medicare_drug_coverage.html, accessed 1/4/08).

[28] See footnote 18.

PRIVATE INSURANCE EXPENDITURES

Private insurers are the dominant payers for health care in Maryland. In 2006, private insurers in Maryland financed $13.1 billion in expenditures for health care (Figure 32). From 2002 to 2006, private insurance expenditures in Maryland grew at an average annual rate of 7 percent per year, approximately equal to the national average. However, the growth in private insurance expenditures in Maryland accelerated from 2005 to 2006, growing at 8 percent while the national growth in private insurance expenditures slowed to 5 percent. The higher growth of private insurance expenditures in Maryland was in part associated with an increase in the number of Marylanders with private insurance—although the estimated proportion of Marylanders who were uninsured held steady.[29] In contrast, nationally both the number and proportion of Americans who were uninsured—primarily Americans under age 65 and ineligible for Medicare—increased.

FIGURE 32: Estimated Private Insurance Expenditures and Rate of Growth



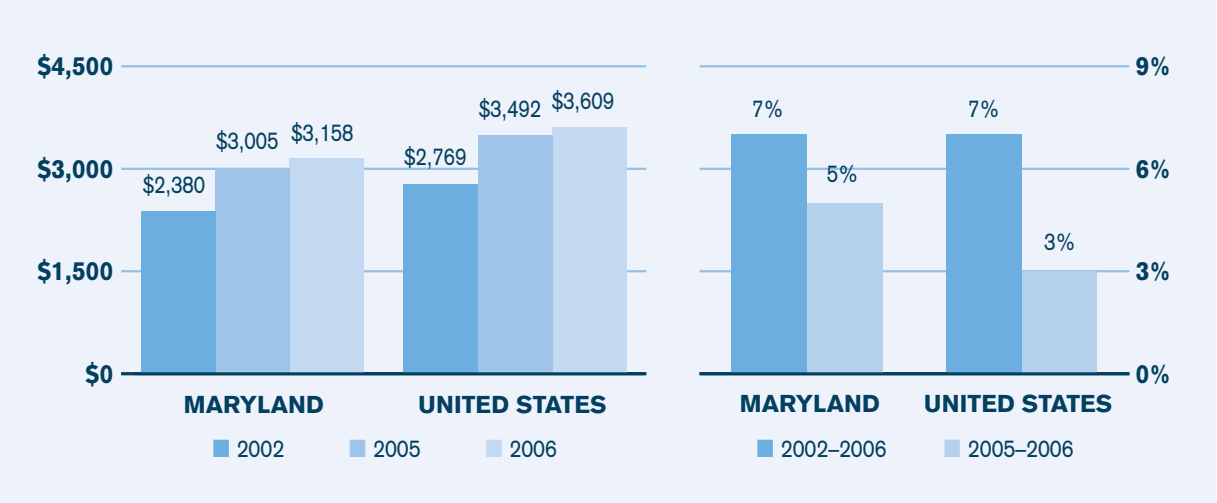
Estimated per privately insured person, insurance expenditures in Maryland were lower than the national average in 2006, as in earlier years (Figure 33). Both Maryland's long-term trend and recent growth in insurance expenditures per capita generally mirrored the national average, increasing at an average rate of 7 percent per year from 2002 to 2006, and slowing from 2005 to 2006. However, nationally, insurance expenditures per capita slowed more sharply—growing just 3 percent from 2005 to 2006, compared with 5 percent in Maryland. Nationally, large and small employers continued to increase cost-sharing in their health plans in 2006, potentially faster than in Maryland where FEHBP is more likely to anchor benefit designs even in the private sector.[30] [31]

[29] An estimated 13.6 percent of Marylanders (of any age) were without health insurance during 2005-2006. This proportion was not statistically different from the rate of 13.1 percent estimated for 2004-2005. Nationally, the rate of uninsured increased from 15.1 percent to 15.5 percent from 2004-2005 to 2005-2006. U.S. Bureau of the Census (http://www.census.gov/hhes/www/hlthins/hlthin06/percent_uninsured_state.xls, accessed 12/21/07).

[30] Nationally, large and small employers increased deductibles by about 3 percent from 2005 to 2006, for both single and family coverage. More recently (from 2006 to 2007), deductibles increased substantially faster, in large firms growing approximately 11 percent. Growth in enrollment in consumer-directed health plans (CDHPs), which have very high cost-sharing, may also have slowed cost increases nationally. The number of employees enrolled in a CDHP (based on either a Health Savings Account or a Health Reimbursement Account) increased from an estimated 1 percent of all covered employees in 2005 to 3 percent in 2006 and 5 percent in 2007. *Mercer's National Survey of Employer-Sponsored Health Plans* (http://www.mercer.com/referencecontent.jhtml?idContent=1287790, accessed 12/21/07).

[31] In Maryland, federal employment is a larger proportion of total employment than the national average. Therefore, a low rate of FEHBP enrollment in consumer-driven or high-deductible health plans has a larger impact on the overall rate of enrollment in these plans—both arithmetically and competitively. In FEHBP, enrollment in high deductible health plans (HDHPs) is "modest." FEHBP HDHP enrollees were generally younger, earned higher federal salaries, and were more likely to select individual rather than family plans than other FEHBP enrollees. Forty-three percent of actively employed HDHP enrollees earned federal salaries of $75,000 or more compared to 14 percent of the other new plan enrollees and 23 percent of all FEHBP plan enrollees. U.S. Government Accountability Office (January 2006). F*ederal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*. GAO-06-271 (http://www.gao.gov/new.items/d06271.pdf, accessed 1/7/08).

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



In 2006, physician services (23 percent) and other professional services (12 percent) together accounted for about a third of private insurance expenditures for health care, followed closely by inpatient and outpatient hospital care (27 percent) (Table 10). Prescription drugs (18 percent) accounted for most other private insurance expenditures. Showing steady growth since 2002, administration and net cost of insurance accounted for 17 percent of private insurance expenditures in 2006. This compared to 13 percent of the total in 2002 and 16 percent in 2005.

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

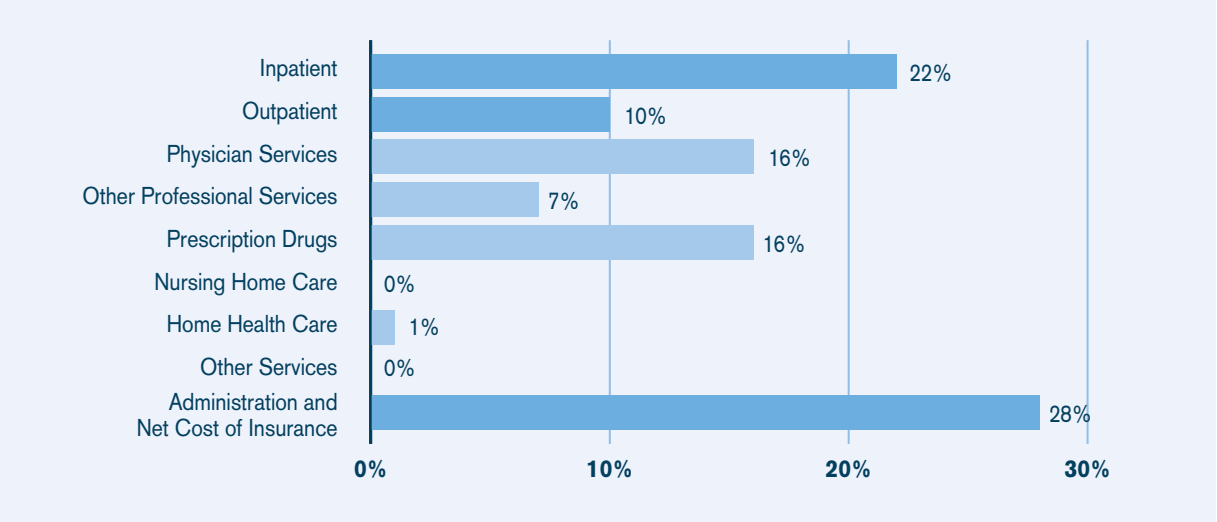
SERVICE CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$10,002**	**100%**	**$12,163**	**100%**	**$13,079**	**100%**
Inpatient	1,928	19	2,457	20	2,607	20
Outpatient	682	7	922	8	987	8
Physician Services	2,509	25	2,867	24	3,008	23
Other Professional Services	1,386	14	1,446	12	1,587	12
Prescription Drugs	1,877	19	2,250	18	2,369	18
Nursing Home Care	151	2	155	1	166	1
Home Health Care	89	1	98	1	107	1
Other Services	45	0	49	0	52	0
Administration and Net Cost of Insurance	1,335	13	1,919	16	2,196	17

NOTE: 0% indicates < 0.5%.

Growth in expenditures for administration and the net cost of insurance was the single largest factor in private insurance expenditure growth from 2002 to 2006, accounting for 28 percent of the $3.1 billion increase in private insurance expenditures during that period (Figure 34). The next largest factors were expenditures

for inpatient hospital care (22 percent of the increase in total expenditures), physician services (16 percent), and prescription drugs (16 percent). Expenditures for other professional services remain a relatively small component of privately insured spending and accounted for just 7 percent of the increase from 2002 to 2006. Nevertheless, privately insured spending for other professional services increased by nearly 10 percent from 2005 to 2006—faster than for any other service category (Table 13A).

FIGURE 34: Estimated Share of Increase in Private Insurance Expenditures by Service Category in Maryland, 2002–2006

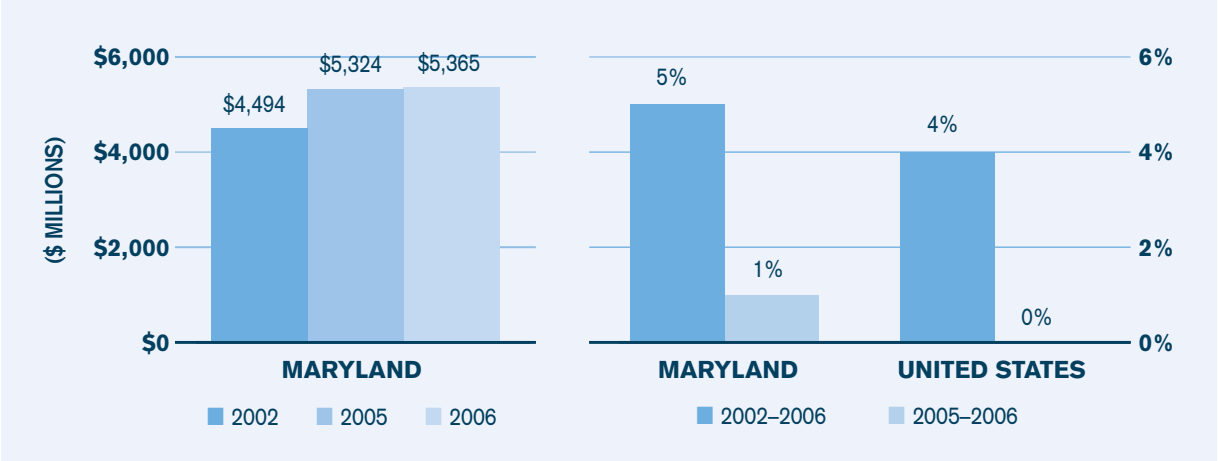


NOTE: Dark shading indicates services that have an increasing share of expenditures in 2006 from 2002. Light shading indicates services that have the same or decreasing share of expenditures in 2006 from 2002. Due to rounding, the increase or decrease in share of expenditures may not be reflected in Table 1 above. 0% indicates < 0.5%.

OUT-OF-POCKET EXPENDITURES

In 2006, Marylanders paid approximately $5.4 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—although in 2006, Marylanders paid a smaller share of each health care dollar due to implementation of Medicare Part D.[32] From 2002 to 2006, out-of-pocket expenditures in Maryland increased at an average rate of 5 percent per year, growing very slowly (just 1 percent) from 2005 to 2006. In contrast, out-of-pocket expenditures nationally grew at an average rate of 4 percent per year from 2002 to 2006, with no change from 2005 to 2006 due to the implementation of Medicare Part D.

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



NOTE: 0% indicates < 0.5%.

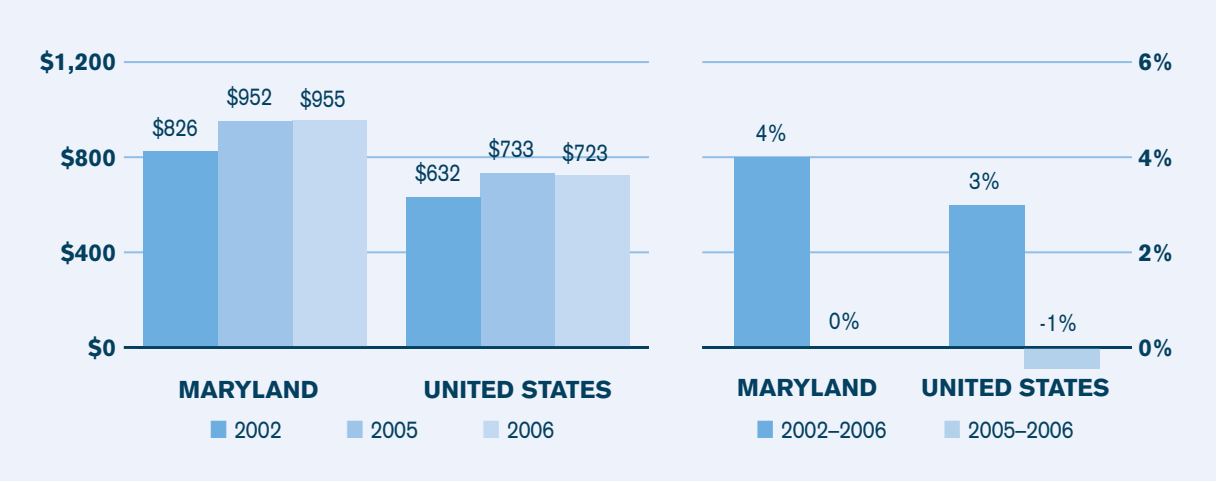
Per capita, Marylanders paid 32 percent more out-of-pocket for health care than the national average in 2006 ($955 versus $723), consistent with both higher average family income in Maryland and higher long-term growth in out-of-pocket expenditures.[33] [34] From 2002 to 2006, out-of-pocket expenditures per capita increased at an average rate of 4 percent per year, compared with 3 percent nationally (Figure 36). From 2005 to 2006, out-of-pocket expenditures per capita in the United States fell by 1 percent, suggesting that lower out-of-pocket spending among public program enrollees (primarily due to implementation of Medicare Part D) more than offset any growth in out-of-pocket spending among the remaining population. However, in Maryland, out-of-pocket expenditures per capita were essentially flat from 2005 to 2006. This is consistent with the fact that relatively many Medicare beneficiaries in Maryland in 2005 already had the benefit of reduced out-of-pocket spending that results from prescription drug coverage (due to their enrollment in employer-sponsored retiree plans and FEHBP). Consequently, the reduction in out-of-pocket spending among Maryland Medicare beneficiaries would be proportionately smaller than the national average, with less of an impact on total out-of-pocket spending.

[32] In 2006, out-of-pocket expenditures accounted for 16 percent of total health care expenditures in Maryland, compared with 18 percent in 2002 and 2005 (Table 7).

[33] In 2005-2006, the median household income in Maryland was 31 percent higher than the national median—$63,082 in Maryland compared with $48,023 nationally. U.S. Census Bureau (http://www.census.gov/hhes/www/income/income06/statemhi2.html, accessed 12/21/07).

[34] Marylanders on average paid about the same proportion of personal income for all health care services out-of-pocket in 2006 as in 2002, and a lower proportion than in 2005. From 2002 to 2005, per capita personal income in Maryland increased at an average annual rate of 4.6 percent, compared with per capita growth in out-of-pocket expenditures of approximately 4 percent. From 2005 to 2006, per capita personal income in Maryland increased 5.3 percent, while out-of-pocket expenditures were flat. U.S. Department of Commerce, Bureau of Economic Analysis, Annual State Personal Income. (http://www.bea.gov/bea/regional/spi/default.cfm?satable=SA04, accessed 12/21/07).

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



NOTE: 0% indicates < 0.5%.

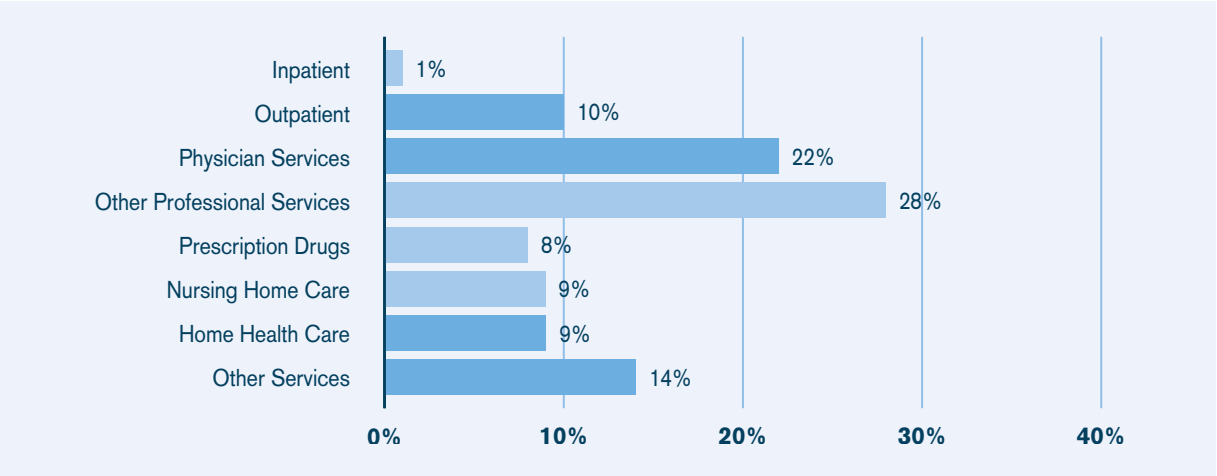
As in earlier years, expenditures for other professional services and prescription drugs continued to account for more than half of all out-of-pocket expenditures in 2006 (Table 11). Other professional services accounted for 30 percent of total out-of-pocket spending in Maryland, while prescription drugs accounted for 25 percent. While still relatively small individual components of out-of-pocket spending, outpatient care, physician services, home health care, and other services all represented a rising proportion of out-of-pocket expenditures from 2002 to 2006—together accounting for 31 percent of out-of-pocket expenditures in 2006, compared with 26 percent in 2002.

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

SERVICE CATEGORY	2002 Expenditures ($ millions)	2002 Percent of Total	2005 Expenditures ($ millions)	2005 Percent of Total	2006 Expenditures ($ millions)	2006 Percent of Total
TOTALS	**$4,494**	**100%**	**$5,324**	**100%**	**$5,365**	**100%**
Inpatient	50	1	57	1	62	1
Outpatient	133	3	199	4	219	4
Physician Services	570	13	716	13	757	14
Other Professional Services	1,389	31	1,513	28	1,633	30
Prescription Drugs	1,291	29	1,595	30	1,360	25
Nursing Home Care	585	13	618	12	663	12
Home Health Care	156	3	206	4	231	4
Other Services	320	7	419	8	440	8

Greater out-of-pocket expenditures for physician services and other professional services accounted for 50 percent of the growth in total out-of-pocket expenditures from 2002 to 2006 (Figure 37). Increased expenditures for long-term care—including both nursing home and home health care—accounted for 18 percent of the total increase in out-of-pocket expenditures over that period.

FIGURE 37: Estimated Share of Increase in Out-of-Pocket Expenditures by Service Category in Maryland, 2002–2006



NOTE: Dark shading indicates services that have an increasing share of expenditures in 2006 from 2002. Light shading indicates services that have the same or decreasing share of expenditures in 2006 from 2002. Due to rounding, the increase or decrease in share of expenditures may not be reflected in Table 1 above.

PROSPECTS FOR CHANGE

The fourth consecutive year of slower growth in health care costs nationally and in Maryland is good news. However, the high cost of health care remains a concern, as growth in wages, household incomes, and gross domestic product continues to lag far behind annual increases in health care costs.

Ongoing concern about high health care costs has surfaced as growing interest in reform of private and public payer reimbursement practices, if not also greater health care reform to expand coverage and improve the efficiency of care. In Maryland, these initiatives are playing out as further adjustments to the state's regulation of hospital reimbursements and continuing debate regarding appropriate fee levels for physicians and other professionals. The large public payers (particularly Medicare) are moving forward with plans to base a portion of professional reimbursement on individual providers' having met performance and quality thresholds. In addition, Medicare beneficiaries in Maryland and nationally are likely to face ongoing change in both the drug coverage and premiums offered by Part D plans.

HOSPITAL SERVICES Nationally, growth in expenditures for hospital care is expected to accelerate in the next several years.[35] However, in Maryland, regulated all-payer hospital reimbursement drives a different pattern of hospital expenditure growth than the national average. While total hospital expenditures in Maryland have grown faster than the national average, hospital expenditures per capita remain lower than the national average.[36] Several major factors are likely to drive the trend in hospital expenditures over the next several years, including past and current payment policies, population health and aging, and the adoption of new technology.

Recent changes in hospital rates and capital expansion by Maryland hospitals seem likely to drive relatively significant growth in expenditures for hospital care.[37] However, in 2007, HSCRC reduced the 2008 update on inpatient and outpatient rates to 4 percent and reestablished rate incentives (effective in 2009) that are intended to moderate further volume increases.[38] [39]

Despite payment practices intended to curb unnecessary use of hospital care, trends in population health and medical technology will continue to drive hospital costs in Maryland and nationally. For example, the sharp increase in the number of hospitalizations for chronic obstructive pulmonary disease (COPD) since

[35] While growth in expenditures for hospital services nationally slowed from 2005 to 2006, the factors that drove slower growth—largely state Medicaid cost-containment efforts—are expected to loosen over the next few years, driving faster national growth in hospital expenditures. J.A. Poisal et al. (2007), "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs*, 26, no. 2: w242-w253.

[36] From 1997 to 2005, expenditures for inpatient hospital care nationally rose 89 percent in real (2005) dollars: from $462 billion to $875 billion. Most of this increase was due to growing costs per admission (from 1997 to 2005, the annual rate of hospital admissions increased just 13 percent). Researchers estimate that, if hospital inpatient expenditures continue to grow at the current trend, the annual national inpatient bill may reach $1 trillion by 2008. R.M. Andrews and A. Elixhauser, *The National Hospital Bill: Growth Trends and 2005 Update on the Most Expensive Conditions by Payer*. Agency for Healthcare Research and Quality, HCUP, Statistical Brief #42 (December 2007).

[37] Beginning in 2003, HSCRC pursued a conscious policy of increasing the update factors on rates to enable hospitals to increase operating margins, set aside cash reserves for expansions, and improve access to capital markets. By 2007, major capital expansions were underway in many Maryland hospitals, with some hospitals indicating that their capital investment programs will require continued favorable rate increases. MHCC (October 2007), *Spotlight on Hospital Spending* (http://mhcc.maryland.gov/spotlight/hospitalspending1007.pdf, accessed 12/22/07).

[38] At its June 2007 meeting, HSCRC adopted an ambulatory surgery guaranteed revenue system to provide an incentive for hospitals to organize and deliver care more appropriately, and reduced the 2008 update accordingly. These changes are expected to reduce projected hospital revenue by about 0.5 percent.

[39] In October 2007, HSCRC reestablished an 85 percent variable cost volume adjustment on hospital rates as of 2009, intended to reduce the financial rewards to hospitals for volume increases. Volume increases accounted for 23 percent of hospital spending growth from 2001 to 2005.

1997 may be characteristic of the increases in health services use that will accompany the aging of the baby boom generation, even before age 65.[40] And while the adoption of new technologies—such as the use of nuclear particle accelerators to treat tumors—may improve health outcomes for some, it can add significant cost to the health care system overall.[41]

PRACTITIONER SERVICES Growth in expenditures for practitioner services could surface as a major driver of total health care spending. In 2002 through 2006, spending for physician services grew relatively slowly, but accelerated from 2005 to 2006. In contrast, the national rate of growth in expenditures for physician services fell from 2005 to 2006, driven by a dip in price growth for physician services to just 1.8 percent.

In Maryland and in other states, the Centers for Medicare & Medicaid Services (CMS) has proposed a Medicare price update in 2008 that, combined with the effect of past legislation, would reduce payments for physician services by nearly 10 percent—although other Medicare payment practices phased in from 2007 to 2010 are expected to raise the base against which this reduction would apply for some types of physician services.[42] [43]

Responding to continued growth in expenditures on physician services and increased spending associated with Congressional overrides to avert payment cuts for physician services, the Medicare Payment Advisory Commission (MedPAC) has advised such cuts since 2002, based on CMS's sustainable growth rate (SGR) formula.[44] [45] MedPAC also has conveyed concern about the growing cost of Medicare Part B and about the SGR formula (which contains no incentives for physicians to curb either volume growth overall or the delivery of unnecessary services in particular) and has prominently raised the issue of restructuring Medicare payments to physicians to reward quality and efficiency and improve payment equity. Such a restructuring seems likely to include pay-for-performance programs for quality, improving payment accuracy, and/or

[40] The number of people admitted to hospitals suffering from chronic pulmonary heart disease increased more than 50 percent from 1997 to 2005, according to the Agency for Healthcare Research and Quality, climbing from 301,400 to 456,500 over 8 years. Pulmonary heart disease is a lung blood vessel disorder often linked to cigarette smoking; most people suffering from the disease also have another heart or lung disorder. About 20,000 people died of chronic pulmonary heart disease in hospitals in 2005, a figure two times higher than the overall death rate at hospitals. These hospitalizations cost $5.6 billion in 2005, with an average stay for a patient costing $12,400. The average overall hospital stay costs about $8,100. Agency for Healthcare Research and Quality (December 2007) (http://www.ahrq.gov/data/hcup/hcupref.htm, accessed 12/26/07).

[41] Nuclear particle accelerators accelerate protons to nearly the speed of light and shoot them into tumors. Proton beams are more precise than the X-rays now typically used for radiation therapy, minimizing side effects from stray radiation and, possibly, increasing the cure rate. A nuclear particle accelerator can cost more than $100 million—making it, in the words of one equipment vendor, "the world's most expensive and complex medical device." Until 2000, the United States had only one hospital-based proton therapy center. Now there are five, with more than a dozen others announced, and still more under consideration. A. Pollack (December 26, 2007). Hospitals Look to Nuclear Tool to Fight Cancer. *New York Times* (http://query.nytimes.com/gst/fullpage.html?res=9B04E1DF173BF935A15751C1A9619C8B63, accessed 12/26/07).

[42] In 2007, CMS proposed a 2008 update factor of -5.1 percent. When combined with the effect of the Tax Relief and Health Care Act of 2006 (TRHCA), CMS estimated the net change to the conversion factor from 2007 to 2008 to be -9.9 percent. MedPAC, *Report to the Congress: Promoting Greater Efficiency in Medicare* (June 2007) (http://www.medpac.gov/documents/Jun07_EntireReport.pdf, accessed 12/20/07).

[43] In 2007, CMS began using new methods to calculate direct and indirect physician expenses (PE) for services that may or may not involve physician work. Collectively, these changes represent 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 service. When fully implemented in 2010, PE RVUs will increase by 7 percent for evaluation and management services and 3 percent for (nonmajor) procedures and tests. By contrast, PE RVUs will decrease by 8 percent for major procedures and by 9 percent for imaging services.

[44] MedPAC is an independent agency that advises Congress on Medicare policy.

[45] Section 1848 of the Social Security Act requires the Secretary of Health and Human Services to make available to the Medicare Payment Advisory Commission (MedPAC) and the public, by March 1 of each year, an estimated sustainable growth rate (SGR) and estimated conversion factor applicable to Medicare payments for physicians' services for the following year and the data underlying these estimates. See: http://www.cms.hhs.gov/SustainableGRatesConFact/, accessed 12/21/07.

bundling payments to reduce overutilization.[46] In December 2007, Congress again suspended application of the SRG formula that would have cut physician payments until July 2008.

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. The Medicaid program in Maryland is continuing to raise professional fees, with the goal of reaching 80 percent to 100 percent of Medicare rates by 2009. As a result, growth in Medicare's physician payments adds upward pressure on Medicaid spending for physician services.

PRESCRIPTION DRUG SPENDING January 2006 ushered in a significant change in how drug expenditures are financed for Medicare beneficiaries, in particular. With the implementation of Part D, Medicare accounted for 13 percent of all drug expenditures in Maryland in 2006, compared with its negligible role as a purchaser of drugs in earlier years. However, private insurance continues to be the largest purchaser—accounting for nearly half of all drug expenditures in Maryland. Consequently, private insurance initiatives to improve the efficiency of these expenditures are likely to be the driving force of expenditure trends in future years.

Incentives to further manage the use and cost of prescription drugs are implicit in Maryland's statistics. On average, Marylanders spend per capita 25 percent more on prescription drugs than the national average, probably related to greater insurance coverage of prescription drugs in Maryland as well as the state's higher per capita income. However, this higher cost is cause for concern among employers and workers in Maryland, who compete in a national and global market. Nationally, large employers significantly increased deductibles in their health insurance plans in 2007, and enrollment in consumer-driven health plans—while still low—edged up to an estimated 5 percent of covered employees.[47] Both trends suggest that increased cost-sharing for prescription drugs may be employers' principal strategy for curbing utilization and cost in the next several years.[48]

MEDICARE Medicare spending trends in the next few years will be driven by modest growth in prescription drug spending and, potentially, changes in the physician payment formula. Of course, further increases in hospital costs also will drive Medicare spending in Maryland, reflecting Medicare's position as major purchaser of hospital care nationally and in every state.

While rising enrollment in Medicare Advantage (MA) seems likely also to drive spending trends nationally, it is unlikely to be as major a factor in Maryland, where higher rates of public and private retiree coverage appear to largely displace the higher levels of beneficiary enrollment observed in other states. By 2007, an estimated 5 percent of Medicare beneficiaries in Maryland had enrolled in Medicare Advantage plans, slightly more than in 2006, but still well below the national rate (20 percent), despite greater availability of Medicare Advantage plans in Maryland than in many states.[49]

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[46] MedPAC (June 2007), *op cit.*

[47] See footnote 30.

[48] In Maryland, MHCC has identified one policy that could have modest impacts on the growth in prescription drug spending: Maryland law prohibits insurers and HMOs from offering enrollees incentives to use mail-order pharmacies. However, while pharmacy benefit managers that operate mail-order pharmacies claim significant savings over retail store pharmacies, such savings may be overstated as the retail store and mail-order segments of the prescription drug market become increasingly integrated. MHCC, *2005 Prescription Drug Use and Expenditures: Trends Among Privately Insured Patients* (http://mhcc.maryland.gov/health_care_expenditures/drug/drug0207.pdf, accessed 1/4/08).

[49] Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker (www.kff.org), based on Mathematica Policy Research, Inc. analysis of CMS MA Enrollment by State County Contract file. Data on the total number of Medicare eligibles from December 2005 were used to calculate plan penetration for 2007.

However, Medicare beneficiaries in Maryland are about as likely as the national average to be enrolled in stand-alone Part D prescription drug plans (PDPs). Nationally, enrollees in these plans may see an average increase in premiums for these plans of 17 percent.[50] Changes in enrollment, as beneficiaries seek lower-cost coverage of the drugs that they need, seem likely to moderate the actual increase in premiums that they pay. Nevertheless, the ongoing cost to PDPs associated with enrolling and disenrolling large numbers of beneficiaries could offset any administrative cost savings that they might otherwise realize.

Nationally, Medicare spending growth is expected to slow to 6.5 percent in 2007 (reflecting adjustments to Medicare Advantage plan payments and a scheduled reduction to the physician payment update), but then to increase to an average 7.6 percent per year from 2008 onward.[51] However, in December 2007, the Congress again delayed Medicare physician payments cuts of up to 10 percent, suggesting that a dip in Medicare spending growth is unlikely to materialize in 2008 or even in 2009.

MEDICAID Enacted in November 2007, the Working Families and Small Business Health Coverage Act authorized Maryland's Medicaid program to expand Medicaid eligibility to as many as 100,000 state residents over the next 5 years. The law increased Medicaid eligibility for adults from less than 40 percent of the federal poverty level to 116 percent—but still well below income levels at which private insurance is likely to be affordable. If implemented, this change would increase Medicaid spending in the coming years by approximately $700 million per year, including both federal and state funds.[52]

In addition, Medicaid spending for long-term care services is expected to climb as Maryland's population continues to age and the need for long-term care grows. Much of the growth in Medicaid spending will occur as payments for community-based services; through the Money Follows the Person Rebalancing Demonstration, Maryland's Medicaid program is attempting to transition nearly 2,000 institutionalized residents over the next 4 years to home and community-based settings.[53] This effort to rebalance spending from institutional to community-based long-term care settings is estimated to increase community-based spending by up to 9 percent each year from 2007 to 2011. In addition, there have been several efforts to evaluate and modify the level-of-care criteria used to assess medical eligibility for the home and community-based waiver programs. In particular, a December 2007 ruling by the Maryland Court of Special Appeals could have a substantial impact on the standards used to assess medical eligibility for the Older Adult Waiver Program.[54]

PRIVATE PAYERS Nationally, employer premiums paid for family coverage increased more than 6 percent from the spring of 2006 to the spring of 2007—much less than in some previous years.[55] While the slower premium growth rate is welcome, it is unclear whether or how such relatively slow growth will continue. In

[50] J. Hoadley et al. (November 2007), *Medicare Part D 2008 Data Spotlight: Premiums*. The Henry J. Kaiser Family Foundation (http://www.kff.org/medicare/upload/7706.pdf, accessed 1/4/08).

[51] J. Poisal et al. (2007). Ibid.

[52] Implementation of the program depends on voter approval of a constitutional amendment in November 2008 that would legalize slot machines. The expanded coverage would be funded by revenue from slot machines, a $1 per pack increase in the cigarette tax, and increases to personal and corporate income taxes enacted as part of an overhaul of the state's tax system.

[53] See footnote 18.

[54] A. Green. "Elder Care in the Balance: Maryland Court Rulings Could Allow Government Aid for Thousands of Seniors," *Baltimore Sun*, December 10, 2007.

[55] G. Claxton et al. (2007). Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrolment Remain Stable," *Health Affairs*, 26(5): 1407-1416.

a national survey of employers, a significant percentage of employers stated they were very likely to increase deductibles, copays or cost-sharing for prescription drugs and office visits, and the amount that employees contribute toward premiums—and indeed at least one subsequent national survey has observed this trend. Thus, nationally and in Maryland, any further slowing of insurance spending in the near term seems likely to come at the cost of increased out-of-pocket spending.

Further erosion of private insurance in Maryland could also force increases in out-of-pocket spending. However, in November 2007, Maryland legislators enacted the Working Families and Small Business Health Coverage Act, intended to stabilize or even reverse the loss of employer-sponsored coverage in Maryland, especially among workers in very small firms. The new law authorized up to $30 million in annual subsidies to small businesses with 10 or fewer workers to help offset the cost of providing coverage to their employees. The subsidies would provide up to $2,000 per employee, to be shared between the small business and the enrollee, to small firms that begin offering health insurance. To qualify for the subsidies, firms would have to offer a wellness benefit.

Modest increases in enrollment in high-deductible plans may also affect the level and distribution of health care expenditures among Marylanders with private insurance. These products reduce the proportion of expenditures that private insurance pays and increase the proportion paid out-of-pocket for insured health care services. Effective in 2007, increased limits on tax-exempt contributions and other provisions affecting health savings accounts (HSAs) may encourage higher-income Marylanders to enroll in HSA-qualified high-deductible plans; indeed, nationally the estimated percentage of workers enrolled in these plans edged up in 2007. However, these tax savings are less likely to appeal to individuals at middle- and lower-income levels.

Nationally and in Maryland, the growing cost of health care and, therefore, health insurance is likely to remain the signature issue through 2008. Further erosion of employer-based coverage, combined with federal efforts to stem greater enrollment in Medicaid and SCHIP, seems likely to create continued growth of the uninsured population.[56] Economic recession, if it occurs, can only add to the numbers of uninsured and a growing sense of urgency about expanding coverage, improving health system efficiency, and constraining cost.

[56] R. Pear (January 4, 2008), U.S. Curtailing Bids to Expand Medicaid Rolls. *New York Times* (http://www.nytimes.com/2008/01/04/washington/04health.html?_r=1&oref=slogin, accessed 1/4/08).

METHODS

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.

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.

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 MEPS data for a group of states selected as Maryland-like, 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 2002 and 2005 are estimated, and data for 2006 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 Medicaid (http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/) enrollments are obtained from the CMS Web site. 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, 2006

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	**$7,282,556**	**$5,695,209**	**$3,644,462**	**$2,050,748**	**$1,279,089**	**$13,078,998**	**$5,365,229**	**$32,701,082**
Hospital Services								
Inpatient	3,109,092	1,490,695	739,552	751,143	272,464	2,607,028	62,004	7,541,282
Outpatient	893,490	551,439	166,748	384,690	58,233	987,438	219,064	2,709,663
Physician Services	1,330,278	385,971	105,992	279,979	150,216	3,008,014	757,270	5,631,749
Other Professional Services	317,163	531,432	385,754	145,678	523,992	1,587,317	1,632,545	4,592,448
Prescription Drugs	638,454	516,143	380,816	135,328	73,862	2,369,058	1,360,349	4,957,867
Nursing Home Care	412,859	1,072,456	1,002,076	70,380	64,496	165,602	663,439	2,378,852
Home Health Care	163,353	764,911	764,911	n/a	13,314	107,099	230,547	1,279,224
Other Services	146,324	42,478	42,478	n/a	17,431	51,617	440,012	697,863
Administration and Net Cost of Insurance	271,543	339,684	56,134	283,550	105,082	2,195,825	n/a	2,912,133

TABLE 12B: Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2005

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	**$6,180,523**	**$5,430,663**	**$3,553,975**	**$1,876,688**	**$1,271,593**	**$12,163,186**	**$5,323,533**	**$30,369,499**
Hospital Services								
Inpatient	2,891,855	1,329,186	667,231	661,955	265,363	2,457,387	57,364	7,001,155
Outpatient	835,087	452,850	150,696	302,154	63,461	922,066	199,229	2,472,693
Physician Services	1,273,492	339,707	95,645	244,062	146,071	2,867,245	716,003	5,342,518
Other Professional Services	294,711	486,981	363,342	123,639	524,728	1,445,741	1,512,949	4,265,111
Prescription Drugs	8,261	726,934	523,060	203,873	69,464	2,249,664	1,595,356	4,649,680
Nursing Home Care	368,955	1,040,493	963,589	76,903	63,630	154,759	617,765	2,245,601
Home Health Care	160,370	694,628	694,628	n/a	12,903	97,878	206,227	1,172,006
Other Services	136,697	40,567	40,567	n/a	19,980	49,481	418,641	665,366
Administration and Net Cost of Insurance	211,095	319,316	55,216	264,101	105,993	1,918,965	n/a	2,555,370

TABLE 12C: Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2002

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	**$4,831,705**	**$4,075,833**	**$2,722,884**	**$1,352,949**	**$1,260,876**	**$10,001,867**	**$4,493,610**	**$24,663,891**
Hospital Services								
Inpatient	2,288,196	1,025,908	561,596	464,312	285,552	1,927,960	50,419	5,578,036
Outpatient	620,773	311,414	103,265	208,149	54,915	681,935	132,935	1,801,973
Physician Services	1,025,719	260,760	68,209	192,551	143,269	2,509,379	569,631	4,508,759
Other Professional Services	213,936	422,830	333,187	89,643	502,083	1,385,509	1,388,749	3,913,106
Prescription Drugs	5,477	489,302	342,201	147,101	104,212	1,877,339	1,290,623	3,766,952
Nursing Home Care	283,961	912,015	820,619	91,396	38,657	150,721	584,927	1,970,280
Home Health Care	130,791	424,951	424,951	n/a	6,310	89,383	156,150	807,584
Other Services	109,586	12,766	12,766	n/a	20,769	45,074	320,177	508,372
Administration and Net Cost of Insurance	153,266	215,888	56,091	159,797	105,109	1,334,567	n/a	1,808,830

TABLE 13A: Rate of Growth in Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2005–2006

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR			PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**17.8%**	**4.9%**	**0.6%**	**7.5%**	**0.8%**	**7.7%**
Hospital Services						
Inpatient	7.5	12.2	2.7	6.1	8.1	7.7
Outpatient	7.0	21.8	-8.2	7.1	10.0	9.6
Physician Services	4.5	13.6	2.8	4.9	5.8	5.4
Other Professional Services	7.6	9.1	-0.1	9.8	7.9	7.7
Prescription Drugs	n/a	-29.0	6.3	5.3	-14.7	6.6
Nursing Home Care	11.9	3.1	1.4	7.0	7.4	5.9
Home Health Care	1.9	10.1	3.2	9.4	11.8	9.1
Other Services	7.0	4.7	-12.8	4.3	5.1	4.9
Administration and Net Cost of Insurance	28.6	6.4	-0.9	14.4	n/a	14.0

TABLE 13B: Rate of Growth in Health Care Expenditures in Maryland by Expenditure Component and Source of Payment, 2002–2006

EXPENDITURE COMPONENTS	GOVERNMENT SECTOR			PRIVATE SECTOR		TOTAL EXPENDITURES
	Medicare	Medicaid	Other Government	Private Coverage	Out-of-Pocket	
TOTAL HEALTH EXPENDITURES	**10.8%**	**8.7%**	**0.4%**	**6.9%**	**4.5%**	**7.3%**
Hospital Services						
Inpatient	8.0	9.8	-1.2	7.8	5.3	7.8
Outpatient	9.5	15.4	1.5	9.7	13.3	10.7
Physician Services	6.7	10.3	1.2	4.6	7.4	5.7
Other Professional Services	10.3	5.9	1.1	3.5	4.1	4.1
Prescription Drugs	n/a	1.3	-8.2	6.0	1.3	7.1
Nursing Home Care	9.8	4.1	13.7	2.4	3.2	4.8
Home Health Care	5.7	15.8	20.5	4.6	10.2	12.2
Other Services	7.5	35.1	-4.3	3.4	8.3	8.2
Administration and Net Cost of Insurance	15.4	12.0	0.0	13.3	n/a	12.6

TABLE 14: Enrollment and Populations, and Rate of Growth, Maryland and U.S., 2002, 2005, 2006

MARYLAND	2002	2005	2006	2002–2006	2005–2006
Population	5,441,349	5,589,599	5,615,727	0.8%	0.5%
Medicare Enrollees	663,739	694,546	707,742	1.6	1.9
Medicaid Enrollees	662,755	717,040	700,431	1.4	-2.3
Private Insurance Enrollees	4,202,944	4,048,084	4,142,192	-0.4	2.3
UNITED STATES	**2002**	**2005**	**2006**	**2002–2006**	**2005–2006**
Population	288,125,973	296,507,061	299,398,484	1.0%	1.0%
Medicare Enrollees	39,594,404	41,535,879	42,654,912	1.9	2.7
Medicaid Enrollees	40,229,696	44,776,664	44,716,391	2.7	-0.1
Private Insurance Enrollees	198,965,535	198,828,346	201,566,337	0.3	1.4

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