



**Proposal of the Regulatory Working Group: Cost-Shifting and Medicare
Advantage**
November 2025

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Governor's Directive

In November 2025, the State of Maryland and the Center for Medicare and Medicaid Innovation (CMMI) executed an Amended and Restated Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Maryland State Agreement (AHEAD Model). The AHEAD Model will test whether a flexible framework that includes statewide accountability targets for all-payer and Medicare Fee-For-Service (FFS) cost growth, primary care investment, and population health outcomes results in improved population health and healthier living, enhanced quality outcomes, and lowered growth of health care costs.

The AHEAD Model constitutes a shift from the prior Total Cost of Care Model. Among other components, and in addition to modifying Maryland-specific hospital quality programs to align with national requirements, AHEAD will transition rate-setting authority for Medicare FFS from the Maryland Health Services Cost Review Commission (HSCRC) to CMMI under the AHEAD hospital global budget approach. The HSCRC will continue to set hospital rates and implement global budgets for all other payers.

Achieving success under the AHEAD Model demands a coordinated and proactive approach across multiple state agencies. On September 23, 2025, Governor Wes Moore directed the Secretary of Health to form a Regulatory Working Group composed of representatives from the Maryland Department of Health (MDH), Maryland Insurance Administration (MIA), HSCRC, Maryland Health Care Commission (MHCC), and the Maryland Health Benefit Exchange (MHBE) to collaborate on policy proposals that will enable the State of Maryland to achieve the goals and objectives set forth in the AHEAD Model. The Working Group is also charged with assessing and addressing impacts on constituencies throughout the healthcare landscape, including hospitals, healthcare providers, insurers, individuals and employers, that arise from the implementation of House Resolution 1 and AHEAD.

The Working Group will address six priority topics over the course of its work, including:

- Cost-Shifting Policy
- Medicare Advantage Market Stabilization
- Choice and Competition
- Workforce and Graduate Medical Education
- Post-Acute Care
- Total Cost of Care Growth and Primary Care Investment Targets

The Working Group process will prioritize stakeholder insight, input and guidance to the greatest extent possible through listening sessions, opportunities for public comment, and the integration of stakeholder input during the development of policy proposals. Details of the workgroup process and timeline are provided in the multi-agency [workplan](#), as submitted to the Governor in October 2025. The Working Group will provide regular updates on the progress of discussion to members of the General Assembly designated by the Senate President and Speaker of the House as directed in Chapter 615 of the Acts of 2025. A final report with identified policy solutions and proactive steps will be submitted to the Governor by June 2026.

The Governor's Directive identified three core values for the process:

1. Health care quality, access, outcomes and affordability are paramount;
2. No critical health infrastructure should shoulder this burden alone, and the savings requirement will not be borne exclusively by hospitals; and
3. The State will operate as it always does—by being data-driven and heart-led.

Overview of Policy Recommendation

This document focuses on the first two policy areas identified in the Governor's Directive: 1) a framework for cost-shifting to help the State achieve the AHEAD savings targets; and 2) Medicare Advantage (MA) market stabilization.

The Regulatory Working Group respectfully recommends that the Governor request the relevant agencies and commissions to implement the following:

(1) Cost Shifting Proposal - A \$435 million annual cost increase to commercial rates for hospitals to replace dollars lost under other payers, (*i.e.*, Medicare FFS and Medicaid), with the amount to be phased in steadily from 2028 to 2032, amounting to \$87 million each year. By 2032, it is estimated that this will increase commercial premiums by 1.8% or an annual increase in premiums of 0.30%.

(2) Medicare Advantage Proposal - A solution that leverages the HSCRC's rate-setting authority to reduce hospital costs for qualified MA plans and maintain hospital funding by increasing commercial rates. Plan eligibility would be determined by factors such as a percentage of eligible beneficiaries in relevant H-contracts, counties with high proportions of underserved beneficiaries, and minimum ratings in Centers for Medicare and Medicaid Services' (CMS)

quality star program. Qualified plans would be designated in the first quarter of each year for the following year, starting in 2026. During the HSCRC's annual update factor process, Qualified Plans would be confirmed and awarded an additional 11.55% public payer differential for their beneficiaries, and this amount would be offset by increases in rates for other payers. Once fully implemented this is estimated to increase commercial rates by 0.65%.

Both solutions would also require an annual report on key related factors. The Regulatory Working Group recommends that these policies remain in place unless changed through a multi-agency public policy process similar to the one by which these recommendations were developed. The remainder of this document provides the background for these recommendations as well as the specific detail for each recommendation that will guide future actions.

Background

Cost-Shifting

Historical Policy

Since the 1970's the Maryland model has been built on an all-payer concept, where all payers pay the same rate for hospital care with the exception of certain small policy-driven adjustments.¹ Maryland has experienced multiple benefits from the all-payer approach, including a more even distribution of hospital costs across payers, expanded and more equitable access to high-quality care for residents across the state, a reduction in the impact of uncompensated care on hospitals and significantly higher per-service reimbursement rates for Medicare and Medicaid. As a result, commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country.² These reduced costs are passed along in reduced premiums to Maryland consumers.

¹ At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures. The public payer differential is 5.7% for all public payers. Payers may also be eligible for an additional 2% prompt pay discount. Additionally, the Medicare Performance Adjustment-Savings Component has been a Medicare-specific adjustment that allows the State to produce Medicare-FFS-specific savings without impacting rates set for other payers. There is no permanent adjustment in place under the Medicare Performance Adjustment.

² Based on HSCRC commercial total cost of care benchmarking but consistent with data available elsewhere. More information can be found in the benchmarking section of this page: <https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx>

To date, Maryland has achieved Medicare FFS savings targets by setting all-payer hospital rates in a way that maintained Maryland's higher per service Medicare FFS reimbursement levels while incentivizing reductions in hospital utilization relative to the nation. This has allowed the State to accomplish three key goals: (1) total costs per capita have remained in line with Medicare FFS savings targets, (2) hospitals have remained relatively financially stable while maintaining patient access and quality of care, and (3) commercial hospital rates have remained lower relative to other states. This approach is effective as long as the combination of (1) incremental savings related to lower cost trend due to reductions in hospital utilization already achieved and (2) new savings related to continued reduction in hospital utilization compared to national growth rates are sufficient to achieve Medicare FFS targets while maintaining patient access and quality of care. However, if this is no longer feasible, hospital per service reimbursement levels will decline and hospital financial stability will be at risk.

The term "cost shift" is used throughout this document, and reflects impact from a payer perspective. However, from a hospital perspective this same mechanism is a revenue shift; that is, greater revenue comes from one set of payers, and less from others.

Savings Targets Under AHEAD

The AHEAD Model sets a Medicare FFS savings goal that requires Maryland to reduce Medicare FFS spend by 2.66% compared to national trends by Calendar Year (CY) 2032. This has typically been expressed as \$460 million, which is the projected impact of a 2.66% trend reduction using current national trend estimates. Because Medicaid and MA rates are tied to Medicare FFS, the Medicare FFS target drives additional changes in those programs.³ HSCRC has estimated the impact under AHEAD at \$870 million versus national trends across all three programs.

The AHEAD Model requires the State to continue building on the successful reductions in hospital utilization achieved under the TCOC Model; each additional dollar of savings is likely to be harder to generate as easier solutions have already been implemented. However, this challenge is mitigated by the fact that the required rate of savings is declining. Through 2023 Maryland achieved reductions of 4.62% over 10 years during TCOC; over the first seven years the reduction was 3.89%. The savings target under the original AHEAD Model agreement signed in 2024 was 1.15% over nine years. In comparison, the

³ Medicaid payment rates cannot exceed Medicare FFS payment rates. This requirement has been most recently emphasized via a Presidential Memoranda released on June 6, 2025, which directed the Secretary of Health and Human Services to "[ensure] Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law." Medicare Advantage rates follow Medicare FFS payment rates because the benchmark for how premiums for MA plans are determined is based on Medicare FFS rates.

current agreement includes a seven-year target of 2.66%, roughly two-thirds of the rate achieved in the first seven years of TCOC.

It is also important to note that the required savings are relative to national metrics, which are trending up. In their modeling for AHEAD, CMMI assumed average national trends of 4.99%. To achieve the 2.66% reduction over the seven-year window the State needs to manage trends down to a 4.70% annual increase, a relatively small change.

Factors in Establishing a Cost Shifting Policy

Given the savings targets, the State identified a need to define a cost-shifting policy, acknowledging that savings resulting from hospital utilization changes alone may not be sufficient, and to plan a controlled transition of costs to commercial payers. A policy that explicitly adopts cost shifting will be a significant departure from State historical practice, and may impact affordability through increased premiums and cost-shares in the commercial market.

AHEAD Model concepts: The AHEAD Model does not have the same restrictions on cost-shifting policy as the TCOC Model. However, the stated goal of the AHEAD Model is to improve the total health of a state's population while lowering costs.⁴ Achieving savings solely through a cost-shift approach would dilute the focus of the State and hospitals on reducing acute care costs through incentivizing population health improvements and investing in primary care.

Current Level of Utilization Performance: A complete analysis of care management opportunities is beyond the scope of this discussion; however, HSCRC analyses indicate that hospital utilization, as measured by IP Days per 1000, is between the 25th and the 50th national percentiles in most regions in Maryland. The readmission rate is above the 25th national percentiles in all regions in Maryland and above the average national percentile for many. The State believes that decreasing both metrics to the 25th percentile is possible while improving health, maintaining access, and improving quality.⁵

Long term investments in Care Transformation: The State and hospitals have been investing in care transformation and primary care over the life of the Model and expect that some of these investments will produce greater savings over the long-term. For example, in 2019 the State began investing in the Maryland Primary Care Program (MDPCP) under the TCOC Model, with the investment reaching approximately \$200 million annually in recent years. According to an analysis conducted for prior Joint Chairmen's Reports on MDPCP, the program performance reflected a net cost of \$75 million in 2022,

⁴ [CMS.gov AHEAD Model](https://www.cms.gov/AHEAD-Model), accessed November, 2025

⁵ Metrics are derived from HSCRC's benchmarking process as described in footnote 2.

which reduced to a net cost of \$31 million in 2023 and became a net savings of \$22 million in 2024⁶. In addition, the 2024 TCOC⁷ report by Mathematica reflected reductions in admissions and improvements on timely follow-up after acute exacerbation of a chronic condition. Benefits of this kind typically take years to accrue. The state anticipates continuing and expanding care transformation investments under AHEAD.

Medicare Advantage Market Stabilization

Also known as Medicare Part C, MA is a program that provides an alternative to traditional Medicare FFS, through plans offered by private health insurers. MA plans are required to include coverage for all of the benefits within Medicare Parts A and B, except hospice. Many MA plans also provide prescription benefits typically included under Medicare Part D, as well as benefits not included in FFS, such as vision, hearing or dental services. In addition, MA plans may include ‘supplemental benefits,’ such as transportation, gym memberships, or financial support for meal or nutrition services. Beneficiaries in Medicare FFS are generally responsible for premiums for both Part B and Part D, as well as 20 percent coinsurance after their deductible is met, with no cap on out-of-pocket costs. For example, in 2026 a hospital stay of under 60 days would be subject to a deductible of \$1,736 for a beneficiary of Medicare FFS, and additional payments may be required if the beneficiary has more than one hospital stay per year. In contrast, MA plans may offer zero-dollar premium options for Part B, and often have annual limits on out-of-pocket costs. However, MA plans are permitted to establish preferred provider networks which are narrower than Medicare FFS, and may apply utilization management tools, such as prior authorization and referral requirements, to a broader set of services than Medicare FFS.

Determining MA Plan Payments

CMS pays MA plans a premium for each beneficiary. Premiums are based on two factors; the ‘benchmark’ for the county in which the plan will operate, and the plan’s ‘bid.’ Benchmarks are set annually by CMS, and are based on the FFS spending within each county in the United States, with adjustments for geographic area and risk. The benchmark represents the maximum amount that CMS will pay any MA plan for each enrolled beneficiary. Counties are divided into four groups, or ‘quartiles,’ based on their level of FFS spend. Higher cost counties get lower benchmarks; for example, in the highest cost tier of counties the benchmark is set at 95% of the risk adjusted FFS spending, while the lowest cost

⁶ HSCRC analysis of MDPCP program developed to support the Joint Chairmen’s Report

⁷ [Evaluation of the Maryland Total Cost of Care Model: Progress Report](#)

tier is set at 115% of the risk adjusted FFS spending - these areas are typically rural and the high payment is intended to attract plans into rural areas by subsidizing the plan's operations.

MA plans generate and offer bids for counties they select based on their estimate of the cost of providing coverage in that area. If the bid amount is lower than the benchmark, CMS retains a portion of the savings. The remainder is returned to the MA plan's enrollees through either reduced cost sharing or supplemental benefits offered by the plan. If the bid amount is above the benchmark, the balance is covered by beneficiaries in the form of a premium, which would be in addition to any Medicare Part B premium. MA plans with high quality ratings, also known as 'star ratings,' may receive positive adjustments to the benchmark and higher levels of rebate.

Maryland MA Market Overview

The breadth of coverage offered, and the limits on out-of-pocket costs, make MA an attractive option for many Medicare beneficiaries. Accordingly, enrollment in MA has increased steadily over the past 15 years. A recent analysis indicates that 51 percent of Medicare beneficiaries nationally, and 25% of Maryland beneficiaries, are enrolled in MA plans.⁸ Although MA enrollment in Maryland has historically been lower than national levels, the Maryland market has seen steady growth over the past several years with enrollment increasing by 115% since 2020 to 298,000 Marylanders in September 2025.

In line with national trends, multiple carriers have already limited their footprint in Maryland for 2026. The impact of these changes on consumers can be significant, including reduced access to benefits, increased costs, and disrupted access to their known care providers. Further, beneficiaries in these circumstances who consider transitioning to Medicare FFS may find that they are no longer eligible for guaranteed issue of a Medigap plan unless they quickly enroll through a special enrollment period.⁹ Medigap plans provide supplemental coverage that assist beneficiaries with out-of-pocket costs such as deductibles and copays, so a lack of access to this coverage can have a significant impact.

Historically, MA plans in Maryland have struggled to be financially profitable. MIA analysis shows that in 2024 plans would have needed to increase revenue by over \$200 million to cover their medical expenses, and increase by over \$551 million to also cover administrative expenses and generate margins.

⁸ [Medicare Advantage Market Growth Slows Amid Intensified Headwinds, Chartis, March 25, 2025, accessed June 5, 2025](#)

⁹ See Code of Maryland Regulations 31.10.06.09-1B(2).

Potential Impact of the AHEAD Model on MA

CMMI is concerned about the impact of the Maryland model on MA and included provisions in the AHEAD Model agreement for the State to propose solutions. The Governor's Directive requires the State to explore options to stabilize the MA market in Maryland and to ensure that Maryland residents continue to have access to MA as an option for their coverage. Under the AHEAD Model agreement, Maryland has the opportunity to propose solutions to CMMI to improve the MA market in the state.

Any policy solutions for MA stabilization will need to be considered within the framework of cost-shifting and may require approval by CMMI or the Center for Medicare and Medicaid Services (CMS), even for temporary stabilization efforts. The State is committed to developing a policy in time for MA plans to make decisions for the CY 2027 plan year, *i.e.*, in early 2026.

Stakeholder Engagement Process

The Working Group scheduled two listening sessions on the topics of cost-shifting policy and MA stabilization, held virtually on October 29th and November 5th. Email messages with instructions for submitting comments and participating in each session were sent to a wide range of stakeholders including State agencies, members of agency standing workgroups, payers, hospitals, providers and community advocates. Further, recipients were invited to share the emailed information broadly within their own networks, in an effort to maximize outreach.

Stakeholders were asked to submit written comments on one or both topics, and to also prepare a short verbal summary of their comments for presentation at one of the listening sessions. Stakeholders who did not choose to submit written input were invited to attend the sessions, and to speak as time allowed. The initial email invitation also included the timeline and process for developing policy proposals, setting a mid-November goal for publicly posting the draft proposal, and early December for submission of the final proposal to the Governor. A decision from the Governor is anticipated in late December.

Stakeholder Comments

Over 130 participants attended each listening session. Written and verbal comments reflected a consensus that policy proposals must thoughtfully balance health care accessibility and affordability, keeping in mind the needs of a wide range of stakeholders, including consumers, employers, hospitals, providers and payers. In addition, respondents agreed that policy proposals must be sufficiently flexible to allow adaptation and refinement over time, given the developing and difficult to predict impacts of recent and

ongoing changes in state and federal health care policy. (See Appendix A for a list of respondents and attached comment letters).

Input on the development of a cost-shifting policy emphasized the need to consider likely changes in Medicaid eligibility and levels of uncompensated care, other impacts of House Resolution 1 and hospital rate changes related to the planned transition to a CMMI-led methodology for the Medicare FFS portion of hospital global budgets in CY 2028. Respondents provided varying estimates for the magnitude of these changes, the recommended amount of shift and the associated timeline. Representatives of the commercial market suggested that a cost-shift policy would be burdensome for consumers and potentially undermine the value of the Model; as such, they indicated that such a policy should only be considered as a last resort. In contrast, hospital representatives proposed a full cost shift of the potential reduction in Medicare FFS, Medicaid and MA payments, estimated at \$855 million, and anticipated that such a policy would have minimal impacts on affordability. Several respondents suggested that the payer differential, which currently exists within the HSCRC's regulatory authority, would be an appropriate mechanism to effect these changes. Multiple respondents highlighted the need for close tracking and ongoing study of the impacts of any cost-shifting policy across the health care sector.

Stakeholder input regarding the stabilization of the MA market in Maryland encompassed both short- and long-term concerns. Suggested long-term solutions included recommendations that the State negotiate changes to CMS' benchmarking process (described above) in Maryland in an attempt to address perceived misalignment between how CMS pays MA plans and the Maryland Model, provide additional State support for MA plans through grant programs, and consider aligning hospital payments by MA plans with Medicare rates. In addition, multiple respondents observed that MA carriers in Maryland are following a national trend of adjusting plan benefits and/or premiums, limiting broker commissions and withdrawing from selected markets, in response to struggles with financial instability.

Several stakeholders noted that plan withdrawals are estimated to impact approximately 100,000 Maryland MA enrollees in 2026. Representatives of some of the remaining MA plans in Maryland expressed concern about their ability to absorb and adequately serve these beneficiaries. Although the listening sessions were intended to consider input for long-term MA market stabilization, respondents also requested that the Working Group agencies evaluate options to address these more immediate-term needs, including suggestions such as a temporary "grant" or "bridge" program, while a longer-term solution is developed.

Finally, several commenters offered suggestions for improved stakeholder communication and engagement, including targeted outreach to strengthen partnerships with community organizations,

particularly in underserved areas, establishing consistent and timely opportunities for sharing information with and seeking input from regulatory agencies, and ensuring that any changes are communicated clearly and with sufficient time for thoughtful implementation. Stakeholders representing commercial payers and employers particularly emphasized the importance of predictability and timely information to allow their members to make informed decisions balancing quality of care with affordability and long-term stability for their consumers.

Policy Proposals

The two issues addressed in this proposal—cost-shifting and MA stabilization—require state-level investment. The Working Group is challenged to identify a source or sources of funding for these policies that are both meaningful enough to achieve their aims while not increasing budgetary pressure on consumers, risking the AHEAD Model’s financial tests, or putting pressure on the State’s General Fund. In developing these policies, MDH, MIA, MHCC, MHBE and HSCRC considered three primary funding options: cost shifts from commercial (*i.e.*, non-MA, non-Medicare FFS, non-Medicaid) plans, hospital revenue and State General Funds.

Cost Shifting

The AHEAD Model agreement details the methodology for calculating the Medicare FFS total cost of care (TCOC) savings targets against which Maryland’s performance under the Model will be assessed. Savings targets are moderate in the early years before accelerating in the later years, reaching a maximum of 2.66% in 2032, which is equivalent to approximately \$460 million. Failing to meet the Annual Medicare FFS TCOC target may result in changes in payment to the State, issuance of a warning notice and enforcement action notice, and potentially even a requirement for the State to submit a Corrective Action Plan describing action the State will take to correct its non-compliance.

As described above, the savings in Medicare FFS also require equivalent trend reductions in Medicaid and MA, resulting in a total target of approximately \$870 million. The Governor’s Directive indicated that the Regulatory Working Group should maintain affordability and access while not allowing any segment of the healthcare system to bear all the burden. To balance these concerns and address the various pressures on commercial insurance rates and hospital funding, the Regulatory Working Group adopted the following principles:

- The approach should support the overall goals of the model;

- The approach should value predictability for payers, hospitals, Maryland consumers and businesses;
- Any effect on annual premiums for consumers and businesses should serve the goal of maintaining affordability and not lead to further loss in coverage; and
- Annual amounts must be finalized in time for payer and hospital rate-setting.

Policy Recommendation - Cost Shifting

The Regulatory Working Group is proposing a cost shift approach that commits to a fixed level of cost shift now, and establishes criteria for future revisions. The Regulatory Working Group respectfully submits the following proposals for the Governor's consideration:

1. Request that the HSCRC:
 - a. During the Fiscal Year (FY) 2028 HSCRC update factor process¹⁰, whereby hospital revenues are adjusted for items like inflation and population related volume growth, increase commercial hospital rates by \$87 million annually beginning January 1, 2028. This will increase hospital commercial revenue to offset anticipated slower growth in governmental payer revenue.
 - b. During the annual update factor process, increase another \$87 million for each year from 2029 to 2032 such that by 2032 the total is equal to \$435 million or half the anticipated required Medicare FFS savings when those savings are extended across all public payers (Medicare FFS, Medicaid and MA).
 - c. Maintain the cost shift amount at \$435 million beyond 2032 unless modified through a multi-agency public policy process similar to the one by which this recommendation was established.
 - d. Implement the change through a combination of the available policy tools (payer differential, mark-up, etc.) as determined to be appropriate by the HSCRC.
2. Direct the Regulatory Working Group to report back to the Governor annually on the following related to cost shift:

¹⁰ The annual update factor policy is a revenue update that incorporates adjustments for items like inflation and population related volume growth hospital revenue under Global Budget Revenues (GBR). This policy is a stakeholder involved process that begins early in the calendar year and culminates with a Commission vote in June to ensure implementation for the next fiscal year, which begins in July. Beginning January 1, 2028 the Medicare FFS payments will transition to Hospital Global Budget Methodologies, but the remaining population will remain under a GBR methodology. There will still be an annual update factor policy/process to help determine the appropriate revenue update for the next fiscal year.

- a. The affordability of commercial insurance compared to other states in order to assess the impact of existing cost shifts and other policies on Maryland's historic premium cost advantage.
- b. Metrics regarding hospital affordability, healthcare access and hospital viability that could be used to assess the need to change the cost shift in future periods, considering other changes in the market impacting these topics such as Medicare reimbursement levels, uncompensated care and clinical delivery trends.
- c. The opportunity for additional investments in population health that could reasonably be expected to result in declines in spending over the life of the model.

Discussion

MIA and the HSCRC modeled the impact on commercial premiums of cost shifting \$435 million of public payer payments to commercial payers. Based on this modeling, commercial premiums would be expected to increase by 1.8% over 7 years, or an annual increase in premiums of 0.30%. This would be in addition to increases due to other health cost drivers, *e.g.*, anticipated reductions in federal credits for the ACA market and the cost of emerging drugs.

The recommendation to implement the cost shift on a steady basis is intended to provide predictability for insurers, consumers, and businesses, and also to provide some forward funding to hospitals against the savings under AHEAD that are concentrated in the later years.

Under existing HSCRC tools the impact of this cost shift on commercial patient costs and insurance premiums will be greatest in those markets where fewer consumers have coverage through commercial insurance, because in those areas a smaller group of commercial patients is covering added costs for a larger group of public patients. The HSCRC estimates the 1.8% total increase could range from 1% to 4% by market. Prior to implementation of any cost-shift policy, the HSCRC and MIA will work to better understand the potential for these impacts.

Medicare Advantage

The ultimate aim of stabilizing the MA market in Maryland is to prevent further disruption and foster continuity of care for Marylanders who select MA for their health coverage, particularly for low-income Marylanders. The goal of the Regulatory Working Group is to determine a mechanism and funding source(s) to mitigate the unique challenges faced by MA plans in Maryland.

Although MA offerings are shrinking nationwide, MA plans have historically struggled to make a profit in Maryland. Commenters stated that several plans that operated in 2025 are departing Maryland or decreasing their service areas in 2026; they estimated that this could leave as many as 100,000 older adults needing to seek coverage with a different plan or switch to Medicare FFS. As described above, in 2024 Maryland MA plans were \$551 million away from covering administrative expenses and generating margins. However, there are many reasons why Maryland plans struggle and many plans outside Maryland also struggle. Therefore, the Regulatory Working Group does not believe the State should subsidize all MA plans losses.

Instead, the HSCRC quantified the amount of lost premium in Maryland by calculating the difference between the actual weighted state average MA benchmark (95.9%) and the benchmark that would be generated if each Maryland county had the benchmark of demographically similar counties in the rest of the country under the national Medicare FFS reimbursement system (100.4%).¹¹ This calculation indicates that weighted average Maryland premiums are 4.6% below the levels of their geographic peers. This correlates to an estimated funding shortfall of approximately \$300 million.

Policy Recommendation - Medicare Advantage

The Regulatory Working Group proposes a solution that leverages the HSCRC's rate-setting authority to generate reduced hospital costs equal to this amount for qualified plans and maintain hospital funding by increasing commercial rates. The Regulatory Working Group respectfully submits the following proposals for the Governor's consideration:

1. Request that the HSCRC and MIA designate Qualified Plans each year as follows:
 - a. Qualified Plans will meet all of the following:
 - i. At least 50% of MA beneficiaries in the relevant H-contract reside in Maryland;
 - ii. At least (1) 5,000 beneficiaries or (2) 20% of MA beneficiaries residing in Maryland in that H-Contract reside in these 8 jurisdictions: Allegany, Baltimore City, Caroline, Dorchester, Garrett, Somerset, Washington, Wicomico;¹²
 - iii. After the release of 2028 plan year data - at least 3.5 stars in the Medicare Stars quality program.¹³

¹¹ Similar counties were derived from the counties used in the HSCRC's Medicare benchmarking process, the same process used to evaluate Maryland utilization performance as discussed in footnote 2.

¹² These areas were selected based on an evaluation across a set of metrics related to income.

¹³ Specific Star standard may be subject to change based on program adjustments during federal rulemaking.

- b. To allow for the inclusion of resulting discounts in MA bids, Qualified Plans will be designated for the following year in the first quarter of each year, starting in 2026, using the most recent available beneficiary counts.
2. Request that the HSCRC:
 - a. During the HSCRC's annual update factor process, starting with FY 2026, confirm the list of Qualified Plans and award those plans an additional 11.55% public payer differential effective January 1st. (11.55% is derived by calculating the impact of closing the 4.6% premium gap noted above across the 40% of MA plan costs that are at hospitals.)
 - b. Offset the cost of this discount to hospitals by increasing rates for other payers sufficient to offset the impact. This offset must be sufficient to cover the discount in commercial and Medicaid revenue in CY 2027 and just commercial revenue thereafter.
 - c. Make any necessary request to CMMI to approve this differential change and to offset any cost to Medicare FFS through a Medicare Performance Adjustment or the differential such that Medicare FFS will not bear any of the cost of the MA differential. In the event CMS does not approve the needed changes, the Regulatory Working Group will revise this proposal.
 - d. Unless modified through a multi-agency public policy process similar to the one by which this request was established, continue this process into the future.
3. Direct the Regulatory Working Group to monitor the impact of increased discounts to MA Plans and report back to the Governor annually on the following:
 - a. The impact on the affordability of commercial insurance compared to other states in order to assess the impact of existing MA discounts and other policies on Maryland's historic premium cost advantage in order to frame the decision regarding continued MA discounts.
 - b. Total cost of MA discounts including an assessment of trends and the degree to which discounts are supporting MA for underserved individuals.
 - c. The impact of changes in the MA discounts on metrics regarding MA plan availability, enrollment and quality.
 - d. The impact on the affordability of commercial insurance compared to other states in order to assess the impact of existing MA discounts and other policies on Maryland's historic premium cost advantage to frame the decision regarding continued MA discounts.

- e. Plans to add to the requirements for Qualified Plans to improve the efficiency of the MA market or promote population health or quality outcomes.

Discussion

The plan eligibility criteria were selected to ensure the benefits accrue to low-income Marylanders by providing a differential only to Qualified Plans that provide services primarily to Maryland residents and who serve a significant number of residents in lower-income areas.

As of September 2025, plans representing approximately half of the MA beneficiaries in Maryland would qualify, resulting in a program cost of \$150 million. This amount is likely to increase if this program is effective in stabilizing the MA market.

MIA and the HSCRC estimated the impact on commercial premiums of providing \$150 million of discounts to MA and adding the cost to commercial payers. Based on this modeling, the impact on commercial premiums would be an increase by approximately 0.4% in CY 2027 and a further 0.25% in CY2028 resulting in a total increase of 0.65%. This would bring total increases across both proposals to 2.45% by 2032 with the largest single year increases occurring in 2028, at 0.55% combined for the two programs. This would be in addition to increases due to other health cost drivers.

Effective January 1, 2028, CMMI will take responsibility for setting Medicare FFS global budgets. Due to operational changes related to this shift, the cost of the discounts to MA will be borne by Medicaid and commercial payers for 2027 and only commercial payers starting in 2028. Medicaid would experience an increase in 2027 totaling approximately \$50 million.

Because the exact volume of MA claims entitled to the discount is not known at the time the HSCRC sets the differential, there is some risk that the realized size of the discount will be more or less than the targeted amount; this risk will be borne by hospitals. The HSCRC may propose revisions to the approach used to implement the program if this amount is persistently material.

Similar to the cost shift, under existing HSCRC tools the impact of this cost shift on commercial patient costs and insurance premiums will vary by market, in this case depending on the penetration of MA plans. The HSCRC may propose revisions to the approach used to implement the program if this variation is persistently material.

Additionally, the federal government will likely be releasing its annual MA and Part D rulemaking and advance notice before the end of the year. The effects of any resulting rule changes by CMS may require changes to this approach.

Appendix A. List of Stakeholder Respondents

Respondent Name
Adventist HealthCare
AHIP
Alterwood Advantage
CareFirst
Health Means Everything Coalition
Health Resource Advisors
Johns Hopkins Health Plans
Johns Hopkins Health System
Kaiser Permanente Mid-Atlantic
Dr. Terris King
League of Life & Health Insurers of Maryland
Maryland Health Care for All! Coalition
Maryland Hospital Association
Mattes Insurance & Financial Services, LLC
MedChi
National Association of Benefits and Insurance Professionals of Maryland
Step Up Maryland
University of Maryland Medical System