



Maryland
Hospital Association

March 19, 2026

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the state's efforts, led by the Health Services Cost Review Commission (HSCRC), to develop a methodology for setting the statewide all-payer Total Cost of Care (TCOC) targets under the AHEAD Model. Over the last decade, Maryland, through the All-Payer and TCOC Models, pioneered approaches that hold the state and hospitals accountable for controlling costs while preserving access to high-quality care. Establishing all-payer TCOC targets for AHEAD continues this legacy and reinforces the state's commitment to improve transparency and understanding of health care spending trends across the health care system.

As the state considers how to set these targets, it is important to recognize that Maryland's hospital global budget revenue system already incorporates strong cost containment measures that have meaningfully limited hospital cost growth and contributed to one of the lowest average commercial hospital reimbursement rates in the nation. Additionally, under AHEAD, Medicare TCOC spending targets will be achieved through reductions in hospital global budgets. While Maryland hospitals have led the way in controlling cost growth, commercial health plans are increasingly unaffordable due to high and increasing premiums and cost-sharing requirements. Hospitals remain committed to controlling costs under the AHEAD Model; payers and other stakeholders in the health care system should also be held accountable for their contributions to the costs consumers incur when accessing health care services.

The statewide targets, and the benchmark that informs those targets, must reflect Maryland's experience and focus on drivers of health care spending beyond hospital utilization. The targets should support transparency and monitoring of system-wide spending trends with a focus on the areas driving affordability challenges while ensuring continued access to life-saving acute care and system sustainability to improve the health and wellbeing of Marylanders. We urge the All-Payer Total Cost of Care Target Technical Advisory Committee to consider the following principles as it continues discussions about data parameters and benchmarking options.

Monitoring: Any policy effort to control total cost of care growth should have a monitoring focus until the data is complete and actionable.

Cost growth benchmarks from other states have typically been used to monitor health care spending trends, identify cost drivers, and inform policy discussions and decisions. States such as Massachusetts, Oregon, Delaware, and Washington primarily use their benchmarks as analytical tools that trigger additional review and reporting when spending exceeds targets, rather than automatic regulatory action. A monitoring-only focus is most appropriate, especially when taking into consideration data limitations. Claims-based spending data often requires a significant run-out period—between six and 12 months for commercial claims—before final spending can be accurately measured. While these limitations make it difficult to use benchmark results for real-time policy intervention, they support a monitoring and transparency focus.

Achievable: The benchmark should consider expected inflation and other projected cost increases in national trends to ensure the state’s success under the AHEAD Model.

All-payer TCOC growth targets set by the state must be achievable in order to serve their intended purpose of managing cost growth while avoiding unintended consequences. Targets that are unattainable are not only less actionable, but they may also threaten access to hospital care and trigger corrective action under the AHEAD state agreement.

The experiences of other states with similar cost growth targets highlight the importance of setting targets that reflect economic realities, contemporary health care spending trends, and data limitations. Connecticut, Delaware, Massachusetts, Oregon, and Rhode Island established annual cost growth targets, ranging from 2.9% to 6% for 2022 and 2023, all of which were based on one or a blend of three economic indicators: Gross State Product (GSP), wage growth, and median household income. While there are important differences in how each state structured their cost growth targets, including spending definitions, data sources, and the economic indicators on which their targets were based, available data shows that all five states failed to meet their established targets (Table 1). The consequences of missing these targets and enforcement of those consequences vary by state but have generally been limited to date.

Table 1. State Cost Growth Benchmarks and Performance, 2022-2023

State (Year)	Benchmark	Actual*	Result	Benchmark Growth Rates Basis
MA (2023)	3.6%	8.6%	×	Potential GSP
OR (2023)	3.4%	5.2%	×	GSP + median wage
CT (2022)	2.9%	3.4%	×	Potential GSP + median wage + inflation
RI (2023)	6.0%	7.8%	×	Potential GSP + median income + inflation**
DE (2023)	3.8%	9.1%	×	Potential GSP

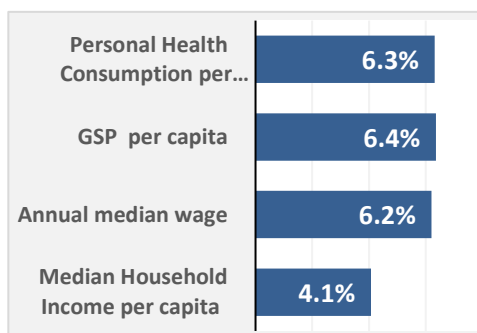
* Actuals based on limited data available; ** Added in 2023

The Advisory Committee has been asked to consider the same three economic indicators in use by these other states as potential options for a counterfactual that could be used to establish Maryland’s cost growth targets. While these represent economic growth measures against which health care spending growth can be evaluated, use of any one of the three may result in

unattainable targets that could have unintended negative consequences for the state. While per-capita health expenditures have grown slightly lower than GSP in recent years, health care cost growth has historically outpaced GSP largely due to medical innovation, changes in demographics, and rising workforce costs: a trend that is expected to continue over the next decade (Figures 1, 2). At the same time, per-capita health care expenditures have grown at a considerably slower rate than the nation in recent years (Figure 3).¹ Wage growth and median household income have their own limitations, including significant lags in the availability of data, as noted by HSCRC, that make the targets less actionable and monitoring performance more difficult.

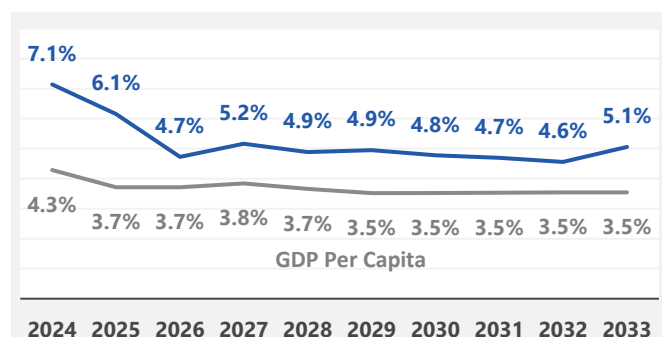
A more attainable target could be derived from the projected National Health Care Expenditure trend, which is expected to grow between 5% and 6% over the next decade. This approach balances the need for cost containment that supports affordability to health care access to hospital services, while also considering Maryland’s progress in managing cost growth.

Figure 1. Annual Average Growth Rates, 2021 to 2024



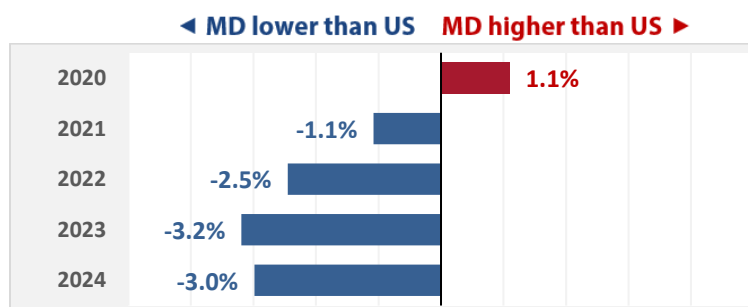
Source: U.S. Bureau of Economic Analysis

Figure 2. Annual Growth Rate Projections, 2024 to 2033



Source: CMS National Health Expenditures Data (NHE)

Figure 3. Health Expenditures Per Capita – Maryland vs. Nation, 2020 to 2024



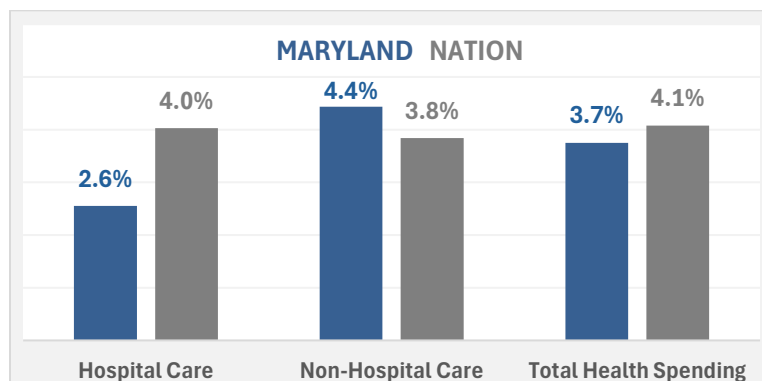
Source: U.S. Bureau of Economic Analysis

¹ Data sources: U.S. Bureau of Economic Analysis, Per Capita Personal Consumption Expenditures: Services: Health Care (PCE), Annual, Not Seasonally Adjusted; Gross domestic product per capita, Dollars, Annual, Not Seasonally Adjusted; U.S. Census Bureau, Median Household Income, Current Dollars, Annual, Not Seasonally Adjusted; U.S. Census Bureau Annual Median Wage; retrieved from FRED, Federal Reserve Bank of St. Louis.

Affordability: The benchmark framework should focus on health plan affordability and other drivers of cost growth beyond hospital spending.

Maryland hospitals have successfully limited hospital spending growth. The average annual hospital growth rate rose 2.6% in Maryland compared to 4% across the nation from 2013 to 2019 (Figure 4). Additionally, hospital spending will continue to be constrained under AHEAD’s global budgets. Under the renegotiated terms of the AHEAD Model, Maryland is expected to achieve \$460 million in Medicare savings through progressively greater annual savings targets between 2026 and 2033. These targets will be addressed through reductions to Medicare hospital global budget payments. These savings targets have been projected to result in a total hospital payment reduction of \$870 million over the next seven years when accounting for corresponding reductions in hospital payments from Medicaid and Medicare Advantage.

Figure 4. Average Annual Growth Rates – Maryland vs. Nation, 2013 to 2019



Source: CMS National Health Expenditures Data (NHE)

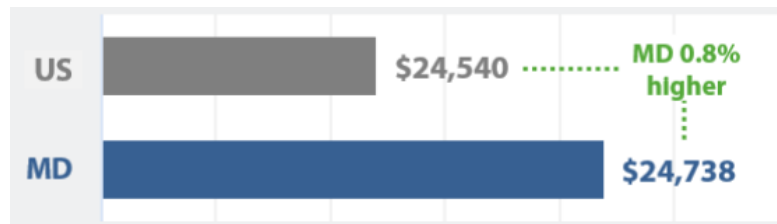
While Maryland hospitals continue to lead the way in controlling cost growth, recent premium filings highlight growing affordability pressures within Maryland’s insurance markets. For plan year 2026, carriers in the individual market increased premiums by 13.4%, on average.² Additionally, Maryland’s average annual commercial insurance premium for a family was 0.8% higher than the United States average in 2024 (Figure 5), yet commercial payers in Maryland incur approximately 20% lower hospital costs compared to demographically similar areas across the country as noted by the Regulatory Working Group.³

Significant premium increases often reduce coverage affordability and can increase the number of uninsured Marylanders. Coverage losses can lead to increases in uncompensated care across the health system and cause patients to delay or forgo necessary care. This would also exacerbate burdens on the health care system and ultimately increase health care costs.

² Maryland Insurance Administration Approves 2026 Affordable Care Act Premium Rates, available [here](#).

³ AHEAD Regulatory Working Group Proposal on Cost-Shifting and Medicare Advantage, available [here](#).

Figure 5. Average Annual Family Premium, Employer-Based Health Insurance, 2024



Source: Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component (MEPS).

Premium rates are but one measure of plan affordability. In addition to high premiums, Marylanders pay more out-of-pocket for care. The Maryland Health Benefit Exchange reports that due to high premium costs, more consumers are shifting from gold plans with \$1,000 deductibles to bronze plans with \$10,000 deductibles.⁴ Deductibles for single and family coverage in employer-sponsored insurance in 2024 are almost six and five times higher than deductibles in 2002, respectively.⁵ In addition, the medical loss ratio (MLR) works to protect consumers by ensuring that premiums are used to cover medical claim costs. The average MLR in Maryland's group market in 2024 was 78.9%, the lowest ratio of any state for plan year 2024, according to the National Association of Insurance Commissioners.⁶

Considering these trends, the benchmark methodology should evaluate affordability and cost growth across the full health care system rather than focusing solely on hospital spending. This includes examining how insurance premiums, plan designs, insurance administrative costs, and other payer practices increase the total costs Maryland residents pay for coverage and care.

Alignment: The benchmark methodology should measure spending consistently across payers and sectors to accurately identify cost drivers to align with the current measures of total cost of care for the AHEAD Model.

The TCOC benchmark should capture spending across Medicare, Medicaid, and the commercial insurance market, align with the AHEAD Model's measurement of total costs, and allow policymakers to understand spending growth across sectors, including hospital services, physician services, and insurance administrative costs. The methodology should exclude retail pharmacy and additional Medicaid benefits. Retail pharmacy datasets often report gross drug spending without accounting for manufacturer rebates and may overstate spending growth. Estimates of pharmaceutical costs may not adequately account for emerging pharmaceutical technologies and associated costs. If retail pharmacy spending is included, it should be reported separately or both gross and net spending should be reported when possible.

⁴ MHBE January 20, 2026 Briefing to the House Appropriations Committee. Available [here](#).

⁵ SHADAC Analysis of Average Annual Employer Sponsored Insurance Deductible. Available [here](#).

⁶ NAIC. U.S. Health Insurance Industry Analysis Report – 2024 Annual Results. Available [here](#).

Self-funded ERISA plans also represent a significant portion of the commercial insurance market, though these plans are not always fully captured in existing claims databases. Other states with existing cost growth targets estimate these expenditures when calculating total spending. If HSCRC utilizes estimation in their methodology, any assumptions should be tested using external benchmarks. Additionally, assumptions and limitations should be clearly documented to ensure transparency.

Predictability: The benchmark methodology should be transparent, predictable, and stable to support long-term planning across the health care system.

The benchmark framework must be predictable to allow policymakers and stakeholders to evaluate performance and implement adjustments in a timely manner should spending trends deviate from expectations. To improve the benchmark's stability, several states have incorporated additional methodological adjustments, including blended economic indicators, inflation adjustments, and multi-year trend calculations. These approaches can help reduce volatility and ensure that benchmark targets remain predictable and achievable over time. The growth target methodology should be based on projected growth rates with a potential add-on adjustment for unexpected changes.

MHA supports HSCRC's efforts to improve transparency and understanding of health care spending trends through the development of all-payer TCOC growth targets. The methodology used to establish these targets should reflect Maryland's unique all-payer system, recognize the broader drivers of health care spending growth, and provide meaningful insights into affordability challenges facing Maryland residents.

We look forward to continuing to work with HSCRC, the Maryland Insurance Administration, and the Maryland Health Care Commission as the methodology is developed.

Sincerely,



Melony G. Griffith
President & CEO

Cc: Marie Grant, Commissioner, Maryland Insurance Administration
Dr. Douglas Jacobs, Executive Director, Maryland Health Care Commission