Maryland
Hospital Association

June 23, 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, thank you for the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation related to uncompensated care (UCC) included in the final recommendation for the Rate Year 2027 update factor.

We appreciate HSCRC's recognition of the need to explore strategies to mitigate the expected rise in UCC. However, we are concerned that the proposed policies may not adequately address the higher burden of UCC hospitals are likely to face in the upcoming year as the coverage landscape changes. **While the proposal to direct funding to the Maryland Health Benefit Exchange (MHBE) Fund could help stabilize the Marketplace, the impact on premiums and enrollment is uncertain. We respectfully urge HSCRC to provide a 0.66% ($158 million) prospective adjustment to the UCC provision in rates for RY 2027 and offer the following comments as justification for this request.**

Loss of health coverage has real consequences for Maryland families and communities. As more people become uninsured, hospitals and health systems will continue to care for everyone who comes through their doors, regardless of their ability to pay. The resulting increase in UCC will further strain the resources hospitals need to preserve access to essential services.

Prospective UCC Adjustment
RY 2027 uncompensated care funding levels must reflect contemporary conditions and the changing coverage landscape. It is especially important that HSCRC act now because CY 2026 revenue will serve as the baseline for Medicare hospital global budgets starting in 2028. As noted in our comment letter on the update factor, any increase in UCC in the upcoming year due to federal policy changes and resulting coverage losses would not be reflected in rates until RY 2029 under the current UCC policy, placing further financial strain on hospitals and threatening their ability to preserve access to essential acute care services for Marylanders in the interim.

The draft recommendation includes a 0.10% (~ $25 million) increase to the reserves held in HSCRC's UCC Fund, which would be released as additional UCC emerges. The proposed UCC provision in rates for RY 2027 (4.05%), even after accounting for the release of these additional

funds, will likely not be sufficient to address the UCC burden hospitals will face in the upcoming year. Therefore, we urge HSCRC to prospectively adjust the UCC provision in rates by 0.66% for RY 2027 and reconcile this amount to actuals once the necessary data are available.

In our May 20 comment letter, MHA requested a 0.69% prospective adjustment to the UCC provision in rates based on a total state-estimated coverage loss of 65,000 due to policy changes that take effect in CY 2026. This request has been updated to 0.66% to reflect the UCC per uninsured estimate ($2,438) in HSCRC's analysis of UCC included in the recommendation. The actual increase in UCC could be higher due to additional coverage losses resulting from policy changes taking effect in CY 2027 that are not reflected in MHA's analysis.[1]

A comparison of MHA's UCC estimates with HSCRC's, as shown in Table 1, reveals that the primary difference is HSCRC's and the Maryland Department of Health's (MDH) assumptions about the extent to which Medicaid enrollment losses and associated increases in UCC will be mitigated by Emergency Medicaid Services, procedural re-enrollments, and work requirement exemptions. However, questions remain about the effectiveness of these mitigation strategies due to the limited scope of Emergency Medicaid Services, greater churn due to more frequent redeterminations, and recent federal guidance that restricts the medical frailty exemption from work requirements. Given these limitations, it is reasonable to assume higher levels of UCC associated with the reduction in Medicaid enrollment to ensure hospitals are adequately resourced to manage higher UCC in the upcoming year.

Table 1. Comparison of HSCRC and MHA Uncompensated Care Analyses

	HSCRC Analysis	MHA Analysis
Projected *Marketplace* Enrollment Loss	48,000	50,000
Estimated UCC Impact of Projected *Marketplace* Enrollment Losses	$117 million	$122 million
Projected *Medicaid* Enrollment Loss	27,000	15,000
Estimated UCC Impact of Projected *Medicaid* Enrollment Losses	$11 million	$37 million
Total Projected Enrollment Loss	75,000	65,000
Total Estimated UCC Impact	**$128 million**	**$158 million***

* $158 million represents approximately 0.66% of the $24.029 billion Final Approved RY 2026 GBR.

Notes: MHA's analysis is based on MDH and MHBE projections of coverage losses due to policies that have already taken effect, or will take effect, in CY 2026; these include changes to immigrant eligibility for Marketplace premium tax credits, the loss of federal enhanced premium tax credits (ePTCs), and changes to immigrant eligibility for Medicaid coverage.[2] More information on these policy changes and coverage losses is available in the Appendix.

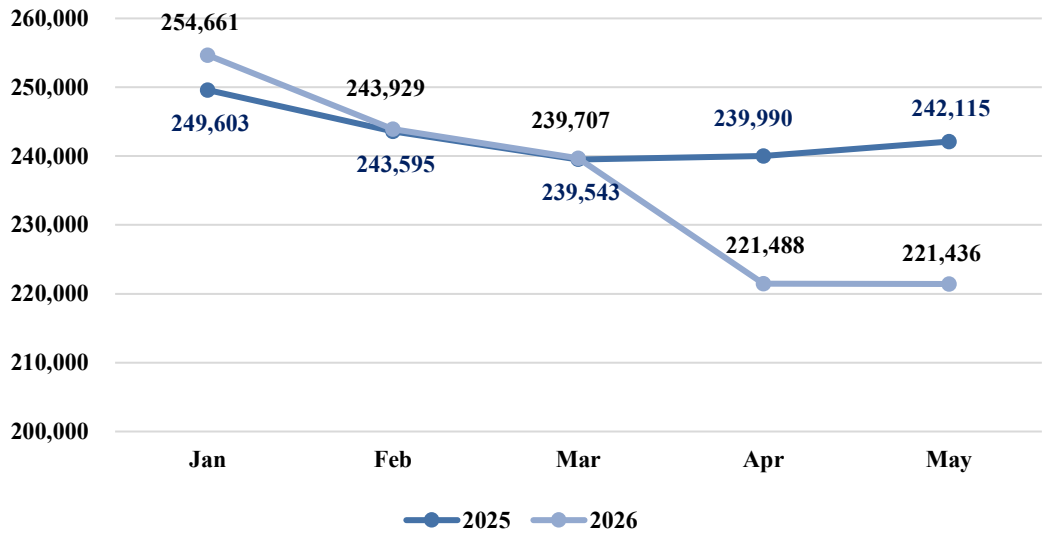
MHA estimated the increase in UCC by multiplying the total coverage loss associated with these policy changes (65,000) by the UCC per uninsured ($2,438) derived from HSCRC's UCC estimate in the draft recommendation.

[1] A summary of all policy changes that take effect in CY 2026 and CY 2027 is available in the Appendix.
[2] Maryland Department of Health and Maryland Health Benefit Exchange January 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available here. MHBE presentation starts on slide 42; MDH on slide 69.

The impacts of Marketplace policies that went into effect at the beginning of the year are already emerging. As noted in the draft recommendation, the number of individuals enrolled in coverage through Maryland Health Connection (MHC) has declined significantly year-over-year. As shown in Figure 1, enrollment as of May 2026 was 20,679 (8.5%) lower than it was in May 2025.[3] This loss in coverage could lead to an approximately $50 million (0.21%) increase in UCC: more than twice as much as the proposed 0.10% increase in UCC reserves, before accounting for anticipated increases in bad debt due to higher patient cost exposure as enrollees shift to less comprehensive coverage. Hospitals are seeing the effects of these coverage trends as they are observing an increase in self-pay patients and bad debt, with one member hospital reporting that they saw twice as many self-pay patients from January to May of 2026 as the same time period last year.

We encourage staff to routinely monitor trends in enrollment, hospital payer mix, increased use of emergency departments, and other predictors of UCC throughout the year to determine if subsequent policy action is needed to align funding with contemporary UCC levels.

Figure 1. MHC Private Health Plan Enrollment (as of May 31, 2026)



Maryland Health Benefit Exchange Fund Proposal

MHA supports efforts to stabilize the ACA Marketplace through the state's reinsurance and subsidy programs and hopes these strategies will mitigate coverage losses and associated increases in UCC. To assess the potential impact of these policy interventions, key questions must be answered, including the portion of the proposed 0.40% allocation that is intended to support the reinsurance and subsidy programs, respectively, and the anticipated implementation timeline for any changes to these programs. It will also be important for stakeholders to understand the specific changes under consideration, whether it be modifications to the attachment point or coinsurance rate for the reinsurance program or the level of state subsidies

[3] Maryland Health Benefit Exchange. Maryland Health Connection Enrollment Data Dashboard. Available here.

available to enrollees in the individual market, as well as the expected impact of these changes on premiums and enrollment.

UCC Funding for Federally Qualified Health Centers

MHA recognizes the important role of Federally Qualified Health Centers (FQHCs) in providing primary and preventive care to uninsured individuals. At the same time, any efforts to strengthen the safety net through FQHCs should complement—not replace—the allocation of needed UCC funding to hospitals. Hospitals must have adequate UCC funding to meet the acute care needs of patients as coverage losses increase uncompensated care. HSCRC has a responsibility to set hospital rates in alignment with the reasonable costs hospitals are confronting; to carry out this mandate, HSCRC must prioritize adequate UCC funding for hospitals.

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Thank you for the opportunity to comment on this critical policy issue. MHA is ready to assist HSCRC, MDH, and other state partners in identifying an uncompensated care policy solution that helps preserve access to essential acute care for all Marylanders. Please do not hesitate to contact me if you have any questions.

Sincerely,

Patrick D. Carlson
Vice President, Care Transformation & Finance

cc: Dr. Joshua Sharfstein, Chair
Jonathan Blum
Dr. James Elliot
Ricardo Johnson
Dr. David Maine
Nicki McCann
Dr. Farzaneh Sabi

Appendix. Key Policy Changes and Estimated Coverage Losses

Policy Provision, Description	Effective Date	State Estimated Coverage Loss
Marketplace Policy Changes		
Immigrant Eligibility for Tax Credits (1st change) Ends eligibility for Marketplace premium tax credits for lawfully present immigrants under 100% FPL who are ineligible for Medicaid due to their immigration status.	January 1, 2026	20,000
Enhanced Premium Tax Credits (ePTCs) Ends federal Affordable Care Act enhanced premium tax credits made available via the American Rescue Plan Act.	January 1, 2026	30,000
Immigrant Eligibility for Tax Credits (2nd change) Ends eligibility for Marketplace premium tax credits for all lawfully present immigrants under 100% FPL except for lawfully present residents (LPRs), Cuban-Haitian entrants, and COFA (Compacts of Free Association) migrants.	January 1, 2027	20,000
Total Estimated Marketplace Coverage Loss		70,000
Medicaid Policy Changes		
Immigrant Eligibility Changes Limits Medicaid and CHIP eligibility to lawful permanent residents, certain Cuban and Haitian entrants, and individuals from the Compacts of Free Association nations. Excludes refugees, asylees, and other humanitarian groups.	October 1, 2026	15,000
Work Requirements Requires certain expansion adults to complete 80 hrs. per month of work, education, or community service as a condition of eligibility. Applies to individuals ages 19-64, with limited exemptions and must be verified through ex-parte processes.	January 1, 2027*	115,000
Six-Month Redeterminations Requires Medicaid eligibility redeterminations every six months for adult expansion enrollees or those receiving Minimum Essential Coverage (MEC) through a waiver.	January 1, 2027	--
Retroactive Coverage Reduces retroactive coverage from three months to one month for expansion adults and two months for all other groups.	January 1, 2027	--
Total Estimated Medicaid Coverage Loss		130,000
Total Estimated Coverage Loss – Marketplace and Medicaid		200,000

* States can request good faith effort extensions through December 31, 2028

Source: Maryland Department of Health and Maryland Health Benefit Exchange Jan. 20, 2026 Briefing to the House Appropriations Committee on H.R.1. Available here. MHBE presentation starts on slide 42, MDH on slide 69.