Maryland
Hospital Association

July 20, 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, we appreciate the opportunity to comment on the draft report on the Regulatory Working Group Policy Draft Recommendation: All-Payer Total Cost of Care Growth and Primary Care Investment Targets.

MHA supports the overall direction of the draft recommendations and appreciates the incorporation of many principles discussed throughout the Regulatory Working Group process. Maryland hospitals respectfully recommend several modifications to better align the methodology with the AHEAD Model, improve the accuracy of spending measures, strengthen accountability across the health care ecosystem, and ensure the benchmark supports affordability without compromising access to care.

All-Payer Total Cost of Care Growth

MHA supports the Health Services Cost Review Commission's (HSCRC) efforts to improve transparency in health care spending and to establish all-payer total cost of care (TCOC) growth targets that reflect Maryland's unique all-payer system. The methodology should account for the non-hospital drivers of spending growth and provide meaningful insight into the affordability challenges facing Maryland residents. We appreciate staff's incorporation of the guiding principles discussed during prior meetings, including recommendations submitted by MHA. We offer the following recommendations to further align the methodology with those principles and support Maryland's success under the AHEAD Model:

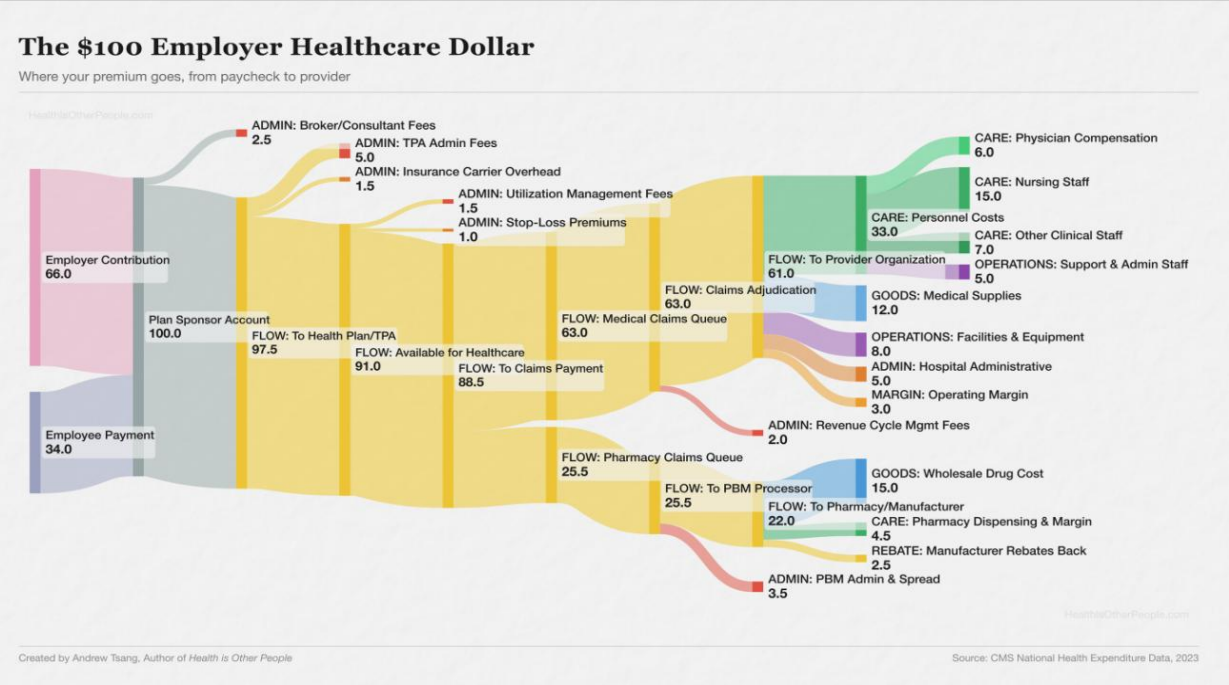
- Include the administrative cost of private insurance in the all-payer TCOC calculation
- Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years
- Exclude 2025 from the historical trend calculation to mitigate the impact of the changes in the federal workforce for that year and reduce the weighting of wage growth
- Maintain CY 2026 as the fixed base year for future target setting
- Evaluate the methodology after the state has produced a historical trend of all-payer TCOC

Recommendation: Include the administrative cost of private insurance in the all-payer TCOC calculation

Unlike any other state, Maryland's all-payer model already constrains hospital prices and volume through global budgets for acute care hospitals, making it essential that any all-payer TCOC benchmark captures the non-hospital drivers of health care spending. Gov. Wes Moore's directive to form a multi-agency regulatory work group also guided the working group's focus to ensure "no critical health infrastructure should shoulder this burden alone, and the savings requirement will not be borne exclusively by hospitals."[1] For commercial payers, hospital costs are lower in Maryland (20% lower) than they are for comparable areas across the country, yet premiums are only 4% lower than the U.S. average for an individual plan and on par with the national average for a family plan. Affordability measures should be designed to produce a comprehensive analysis of all cost-drivers, including non-hospital and carrier administrative costs, to inform policies to lower premium costs for Marylanders.

Excluding the administrative cost of private insurance would understate total spending and limit the state's ability to assess affordability comprehensively. Administrative costs account for an estimated 15% to 20% of premium spending and are included in comparable measures used by other states. As shown in Exhibit 1, these costs reflect substantial administrative complexity and may present opportunities to improve efficiency, patient experience, and clinical care while preserving system sustainability.

Exhibit 1: A diagram of health care spending



Source: Health is Other People blog - by Andrew Tsang

[1] 2025-10-10_AHEAD RWG_Initial Plan v5

In order to improve affordability and access to care, we must tackle the administrative complexity that misdirects care resources and adds billions in unnecessary costs each year. Simplifying and accelerating prior authorization for medicines and procedures, standardizing billing processes, and reducing duplicative, outdated regulations and administrative burdens would free up resources for patient care rather than paperwork.[2] The medical loss ratio (MLR) is an important policy lever for states and the federal government to control administrative cost of private health insurance. However, MLR does not extend to self-funded health insurance plans, which are plans for which the employer is responsible for the payment of covered claims; "mini-med" plans, which have total annual benefits of $250,000 or less; or expatriate plans (**45 CFR § 158.120**). Recognizing the limitation of these regulations, all other states with all-payer TCOC growth limits include administrative costs in their measurement. Consistent with that approach, the AHEAD agreement provides enough flexibility for states to include administrative costs in the TCOC measurement.

Recommendation: Set the initial target without pharmacy costs and work toward the inclusion of rebate information after three years

Prescription drug spending is an important and growing contributor to health care costs and an increasing affordability challenge for patients, employers, and public programs. National data show that prescription drug spending increased **7.9% to $467 billion in 2024**, following **10.8% growth in 2023**, while net U.S. medicine spending rose **11.4% in 2024 to $487 billion**, driven largely by greater use of high-cost therapies such as obesity drugs rather than broad-based price inflation.[3]The work group recommended measuring retail pharmacy cost using the Average Wholesale Price (AWP). However, AWP does not represent the average price pharmacies pay wholesalers. Instead, it functions much like a manufacturer's suggested retail price (MSRP) or "sticker price" and is usually higher than the actual acquisition cost.[4] Given the high rate of growth in prescription drug spending, the state's limited ability to influence those costs, and current data limitations in measuring the actual cost of prescription drugs, retail pharmacy costs should not be incorporated into the benchmark until rebate information is available. Rebates represent a significant portion of prescription drug spending and can materially affect net costs. Including pharmacy spending without accounting for rebates could result in an incomplete and potentially misleading measure of spending growth.

MHA therefore recommends establishing the initial benchmark without pharmacy spending and developing a pathway to incorporate pharmacy costs once rebate information becomes available and the state has gained several years of experience with the benchmark methodology.

[2] Op-ed: Tackling health affordability is a shared responsibility
[3] National Health Expenditures Fact Sheet
[4] Average Wholesale Price (AWP)

Recommendation: Exclude 2025 from the historical trend calculation due to the impact of federal employment and reduce wage growth

MHA supports starting with 2023 to measure the historical period for target setting to exclude the impact of exogenous factors due to the COVID-19 pandemic. Similarly, MHA recommends additional adjustments for wage growth in 2025, when the federal workforce was reduced as using three-year average does not adequately control for this exogenous event (Exhibit 2). Maryland has the third largest federal workforce in the nation and has long relied on federal jobs for economic stability. Federal workers earn significantly above the median wage, and their spending contributes substantially to local economies. Maryland has lost more federal jobs than any other state due to federal government cutbacks, more than 25,000 positions.[5]

Exhibit 2: Historical Economic Indicators

	2020	2021	2022	2023	2024	2025
State GDP	-1.3%	8.2%	7.6%	6.9%	6.0%	4.0%
Wage Growth	1.5%	6.6%	5.5%	5.3%	6.4%	2.6%

2025-2023 Average-State Proposal	**5.2%**
2025-2021 Five-year Average	**5.9%**
2024-2023 Two-year Average	**6.2%**

In addition, MHA suggests the regulatory working group consider potential unintended consequences of including wage growth in the all-payer total cost benchmark. Health care and social services employs more Marylanders than any other sector and has added over 51,000 jobs since 2022—nearly as many as all other industries combined.[6] We recommend reducing the weight of wage growth to 20% due to the complexity of the relationship between wages and the health care sector and developing affordability targets based on wage growth, premium costs, and out-of-pocket spending.

Recommendation: Maintain CY 2026 as the fixed base year for future target setting

MHA recommends maintaining CY 2026 as the fixed base year for future target setting. Shifting the base year from CY 2026 to CY 2029 after three years would reduce predictability and introduce unnecessary volatility into future trend calculations.

A fixed base year is more consistent with Maryland's historical benchmarking approach, including the AHEAD total cost of care and all-payer hospital revenue benchmarks, which rely on fixed baseline periods.

[5,6] Maryland Industry Analysis: Healthcare and the Economy, April 2026

Recommendation: Evaluate the methodology after the state has produced a historical trend of All-Payer TCOC

Without historical analysis of all-payer TCOC trends, it is not possible to assess whether the proposed methodology aligns with the proposed principles of achievable targets. MHA recommends that future methodology decisions be informed by actual performance experience under the benchmark. Statewide targets should reflect Maryland's experience, improve transparency into systemwide spending trends, and focus on the drivers of affordability beyond hospital utilization. At the same time, we recommend that the benchmark preserve continued access to acute care and support the long-term sustainability of Maryland's health care system.

MHA supports the Regulatory Working Group's intent to develop a robust reporting and monitoring framework that detects unintended consequences of all-payer TCOC growth limits on access and quality. Regional and subpopulation level analysis will be critical for a comprehensive monitoring approach for this effort.

Primary Care Investment Targets

MHA appreciates the Maryland Health Care Commission's (MHCC) work to establish primary care investment targets that are intended to support critical community-based health care services. Strategic investment in primary care is essential to build a resilient, equitable health system that improves population health while controlling overall health care costs. The proposed targets reflect a thoughtful approach to addressing longstanding underinvestment in primary care, which accounted for only 4% of national health care spending across all payers in 2023.[7] Despite this relatively low level of investment, substantial evidence demonstrates that robust primary care improves health outcomes, reduces hospitalizations, and advances health equity.[8] Establishing measurable targets, aligned across public and private payers, sets a clear expectation for accountability and can catalyze multi-payer collaboration.

MHA supports investments in primary care to enhance access (particularly in shortage or underserved areas), expand provider capacity, and align with other efforts intended to reduce preventable hospitalizations and avoidable use of hospital emergency departments. MHA offers the following recommendations to strengthen MHCC's proposed approach to primary care investment.

Recommendation: Exclude primary care investment from all-payer TCOC growth target

As Maryland considers establishing an all-payer TCOC growth limit to cap per-capita health care spending across all payers and slow the overall rate of cost growth, it should also consider the implications of primary care investments. Maryland will be working to reduce overall TCOC while simultaneously increasing investment in primary care. The interaction of these policies could create financial pressure for hospitals and other parts of the health care system. To avoid this risk and mitigate tension between these two targets, MHA respectfully suggests that MHCC

[7] 2026 Primary Care Scorecard Data Dashboard | Milbank Memorial Fund
[8] National Academies of Science Engineering and Medicine (NASEM) 2021 Report

and HSCRC consider excluding primary care investment from the all-payer TCOC growth measurement.

Recommendation: Establish payer transparency and enforcement protocols
MHA agrees with the MHCC principle that "payer achievement of investment targets is essential to effect change."[9] As primary care investment targets are finalized, MHA recommends establishing protocols to promote payer data transparency and ongoing monitoring. This could include regular payer reporting and public-facing primary care scorecards to track progress toward the investment targets, assess impacts on premiums, and guide future investments.

In addition, because failure to meet the primary care investment targets is identified as a triggering event and could result in corrective action under the Amended and Restated AHEAD Model Maryland State Agreement, MHA recommends developing a payer enforcement plan. MHA encourages MHCC to collaborate with the Maryland Insurance Administration and Maryland Department of Health to consider appropriate performance incentives, corrective actions, or payment reforms that support adherence to the targets and help ensure Maryland's success under the AHEAD Model.

Thank you for the opportunity to comment on this important matter. The AHEAD Model statewide accountability targets, and the benchmark that informs those targets, should reflect Maryland's experience and focus on drivers of health care spending beyond hospital utilization. We encourage the state to establish targets that promote transparency and monitoring of systemwide spending trends, focus attention on the primary drivers of affordability challenges, and preserve access to life-saving acute care while supporting the long-term sustainability of Maryland's health care system.

Sincerely,

Melony G. Griffith
President & CEO

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

[9] Multi-Agency Regulatory Working Group–Progress Report (June 2026) v2