maryland
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Mitigating Uncompensated Care through Strategic Investment

Presentation to the Health Insurance Coverage Protection Commission

September 11, 2026

Agenda

1. Overview, Key Goals and Legal Framework
   Health Services Cost Review Commission (HSCRC)
2. Reinsurance and the State-Based Health Insurance Subsidies Program
   Maryland Health Benefit Exchange (MHBE)
3. Funding for Federally-Qualified Health Centers (FQHCs) and Local Health Departments (LHDs)
   Maryland Health Care Commission (MHCC)

Overview, Key Goals and Legal Framework

William Henderson
Acting Executive Director, HSCRC

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Background

Each year the HSCRC completes an Update Factor process, which sets hospital global budgets for the upcoming fiscal year. Consideration of uncompensated care is a part of the annual Update Factor. Anticipating upcoming coverage losses for the Medicaid program and the individual market and the resulting impact on hospital uncompensated care, HSCRC proposed funding to mitigate the effects of these changes for Marylanders and Maryland hospitals.

Commissioners discussed the draft recommendation in June 2026, then voted in favor of the final recommendation in July 2026, following a public comment period.

Final recommendation, as approved:

1. $100 million to MHBE to provide funds for reinsurance and Maryland premium subsidies

2. $50 million for advance funding to address coverage losses:
    a. $25 million for FQHCs and LHDs to provide primary care to avoid hospital utilization, to be administered by MHCC
    b. $25 million to increase the reserves in the Uncompensated Care (UCC) Fund

Key Goals

- Address affordability and coverage challenges; facilitate access to primary and preventive care to avoid potential future hospital uncompensated care.
- Provide reserves for hospital uncompensated care to help address increases in uncompensated care prior to the standard funding process.

Individual Market Stabilization	***Preserve Coverage:*** Improve affordability of plans in the individual market, allowing consumers to maintain or enroll in coverage.
FQHC and LHD Grants	***Maintain Access:*** Increase the capacity of safety net providers to provide primary and preventive care for individuals without coverage.
UCC Fund Reserves	***Protect Maryland Hospitals:*** Ensure increased funding is available to help address increases in uncompensated care.

Public Comment Period

Call for Comment:

- Followed discussion of the draft recommendation–including funding for MHBE and the UCC Fund reserves–held during the June 2026 Commission meeting.
- Added a question of whether and how to direct UCC funding to FQHCs, in addition to MHBE and UCC Fund reserves.
- HSCRC received 19 responses, including consumers and consumer groups, hospitals, payers, providers, employers, public health entities and others.

Broad Comment Themes:

1. The HSCRC should consider how it allocates the proposed 0.50 percent UCC adjustment and should monitor trends in UCC.
2. HSCRC should provide prospective hospital UCC funding and should ensure the proposed 0.10 percent UCC Fund reserve increase is adequate.
3. Commenters supported the MHBE funding to preserve marketplace coverage and encouraged the HSCRC and MHBE to evaluate the program for effectiveness.
4. Commenters supported the inclusion of the HSCRC directing uncompensated care funding to FQHCs.

Legal Framework

- **HSCRC statutory authority**. Health-General § 19-219 gives HSCRC broad authority over hospital rates and permits the Commission to establish hospital rates and payment methodologies consistent with Maryland's federal payment model.
- **Hospital cost and utilization connection**. Funding FQHCs and local health departments is reasonably related to HSCRC's statutory responsibilities because strengthening primary and preventive care can reduce avoidable hospital utilization and mitigate uncompensated care. Therefore, the authority rests on the funding's substantial relationship to the hospital system.
- **AHEAD Model consistency**. The funding advances AHEAD objectives, including strengthening primary care, reducing avoidable hospital utilization, improving population health, and controlling health care expenditures. HSCRC generates the funding through hospital rates, while MDH and MHCC administer the funds under their respective statutory authorities.

Update on Maryland's Affordability Programs: Reinsurance and the State-Based Health Insurance Subsidies Program

Health Insurance Coverage Protection Commission

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Maryland Health Benefit Exchange

Johanna Fabian-Marks, MHBE Executive Director

MARYLAND HEALTHBENEFIT EXCHANGE

The Maryland Health Benefit Exchange (MHBE)

- MHBE is an independent unit of state government, established in 2011, that operates Maryland Health Connection to provide high-quality, affordable health coverage for all Marylanders.
  - Only source of financial assistance for Marylanders in the individual market.
    - Federal subsidies - Advance Premium Tax Credit (APTC)
    - Maryland State Premium Assistance program
  - Serves almost 1 in 4 Marylanders
    - 218,264 enrollees in individual market as of June 2026
    - 1.15 million in Medicaid
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Overview of Maryland's Affordability Programs

Reinsurance

Began in 2019

Reinsurance reimburses insurers for a portion of their claims costs. Lower costs allows for lower premiums.

Enrollment Increases and Cost Offsets

Maryland's reinsurance program receives Federal funding, further reducing overall costs for enrollees.

Premium Subsidies

Preserves Enrollment

Designed to mitigate coverage losses in the individual market.

Supports Affordability

State-level subsidies support health care affordability for young adults and enrollees with low-to-moderate income.

Funding

State Premium Assessment

Set at 1% for 2020–2028 on state-regulated health premiums.

Federal Pass-Through Funding

Federal premium tax credit savings are redirected back to Maryland to fund reinsurance.

HSCRC's UCC Funding in 2027

A .40% funding increase finalized for 2027 to mitigate individual market coverage losses and reduce hospital uncompensated care.

Maryland’s Reinsurance Program

Impact of Maryland's Reinsurance Program

- Implemented 2019
- Reinsurance reimburses insurers for a portion of their claims costs. Lower costs allow carriers to charge lower premiums.
- CMS approves reinsurance programs in 5-year increments; current approval ends December 31, 2028.

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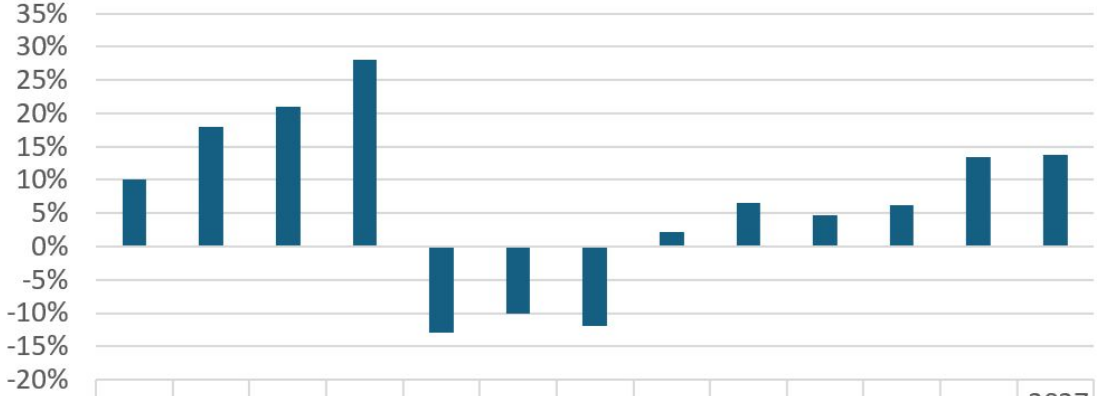

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Rate Change	10%	18%	21%	28%	-13%	-10%	-12%	2.1%	6.6%	4.7%	6.2%	13.4%	13.7%

MARYLAND HEALTHBENEFIT EXCHANGE

Maryland’s State-Based Health Insurance Subsidies Program

State Subsidy Goals

(As set forth in HB 1082 / Md. Ins. Art., §31-125(D))

- Mitigate reduction in lost enhanced Federal tax credits
- Maximize enrollment in the individual market
- Consider state funds necessary to ensure the State Reinsurance Program continues to provide market stability through 2028
- Account for uncertainties in enrollment in Medicaid, the individual market, and small group market due to changes in state and federal regulation and funding

Note: State subsidy authorized for 2026 and 2027 only.

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*Overview data as of the end of June 2026

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All ages, excl. 18-34	**125,154**	**154,558**	**+24%**	**27,681**
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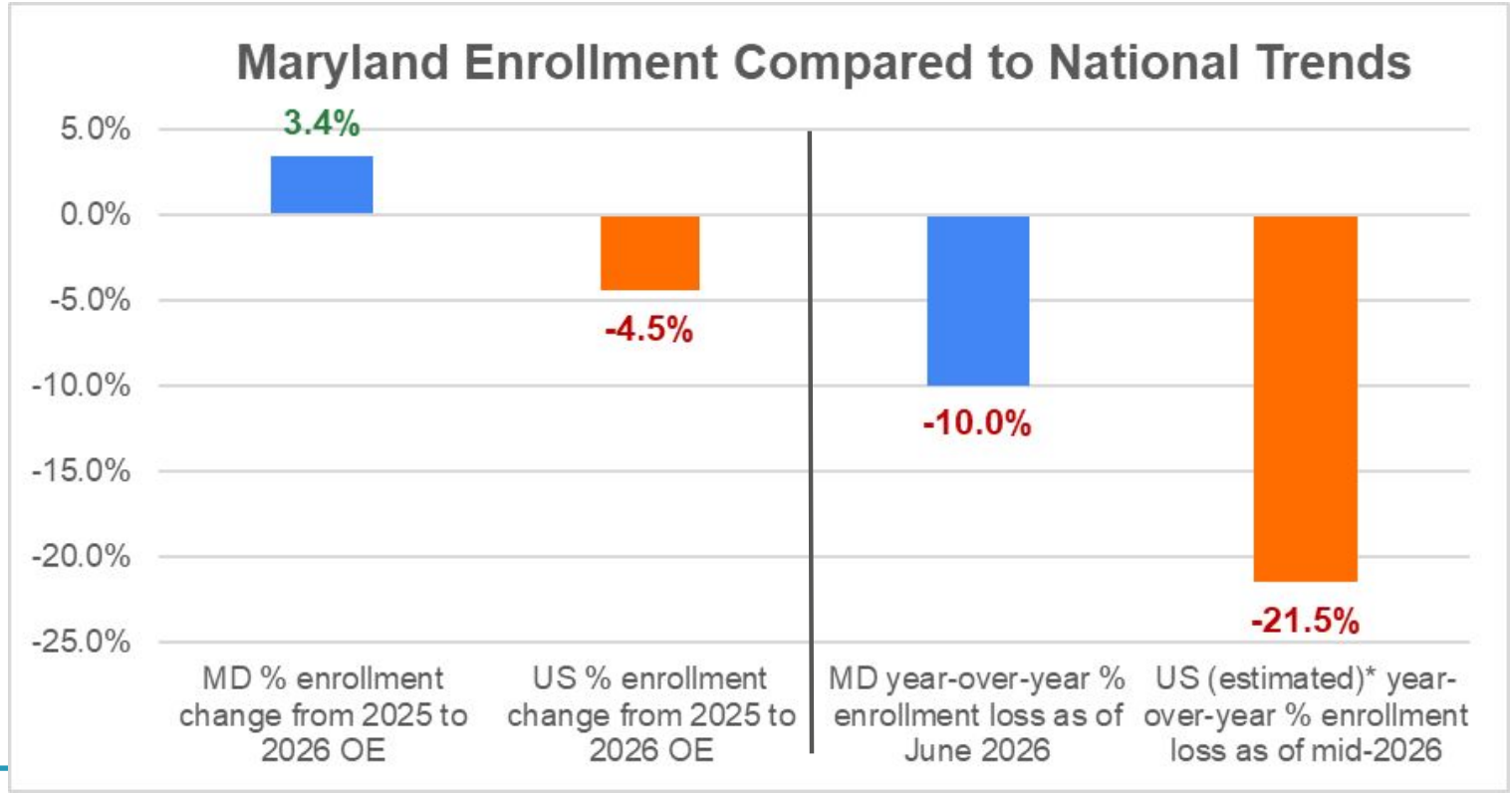

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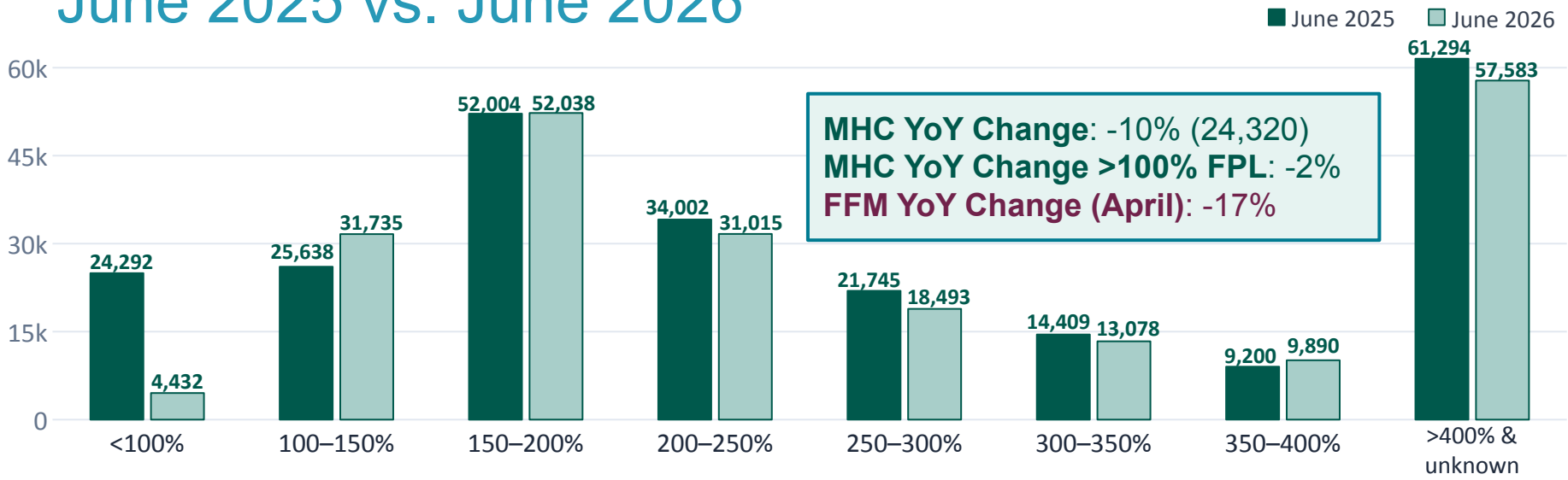
Individual Market Enrollment by FPL: June 2025 vs. June 2026



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June 2025	24,292	25,638	52,004	34,002	21,745	14,409	9,200	61,294	242,584
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Change	▼ 82%	▲ 24%	▲ 0%	▼ 9%	▼ 15%	▼ 9%	▲ 8%	▼ 6%	▼ 10%
	Lost ePTC	Full ePTC replacement		~75% ePTC	50% ePTC			Lost ePTC	

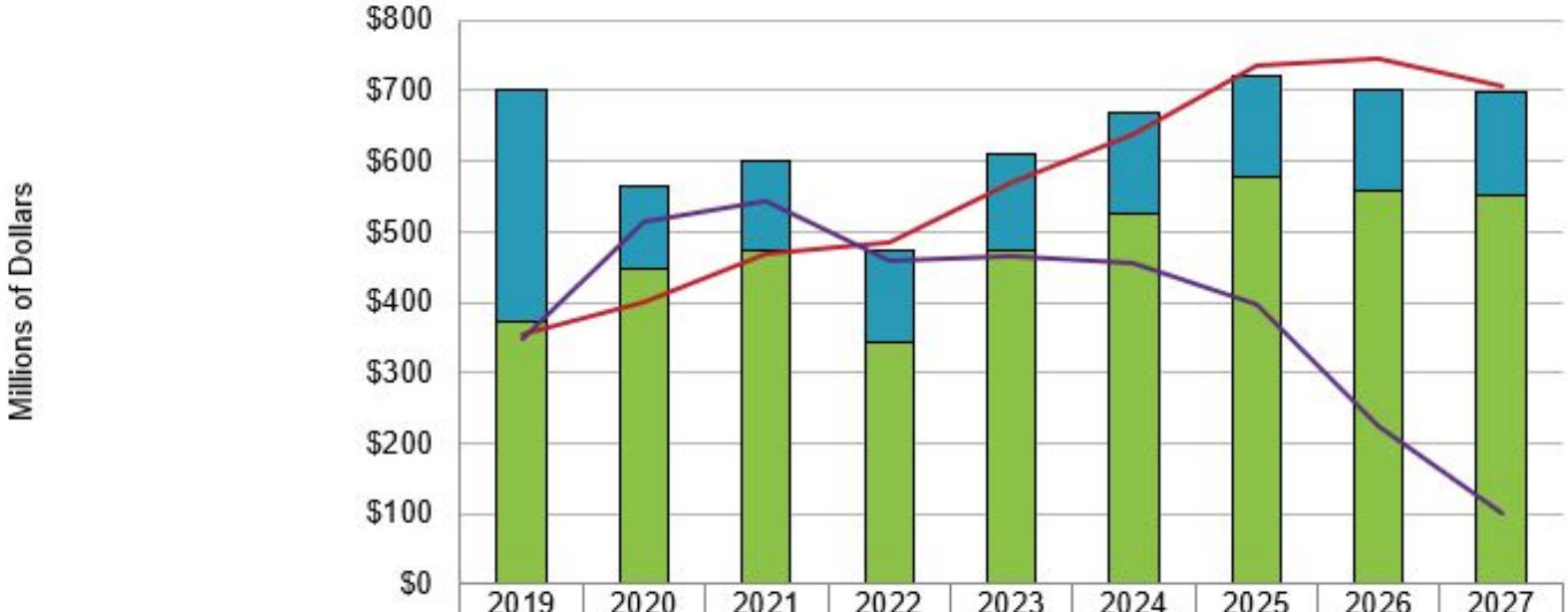
MARYLAND HEALTHBENEFIT EXCHANGE

MHC Enrollment Source: MHBE Executive Data Reports, June 30, 2025 and June 30, 2026. 100–138% and 138–150% FPL combined into 100–150%. '>400% FPL' and 'Unknown' combined. Estimated FFM enrollment YoY change from ACA Signups, May 12, 2026.

2027 Impact of UCC Funding

- Absent the UCC funding dedicated to MHBE, MHBE likely would not have been able to sustain the state subsidy in 2027
  - Holding 2026 subsidy parameters steady in 2027, with no additional funding, was projected to lead to a $0 fund balance as of the end of 2027
- Discontinuing the state subsidy was projected to lead more than 31,000 individuals to drop out of the individual market
- By retaining the state subsidy, these individuals are projected to remain covered

SRP Fund Projections 2019-2027 (w/ Final 2027 State Subsidy parameters + HSCRC Funding)



	2019	2020	2021	2022	2023	2024	2025	2026	2027
State Funding	$327	$119	$124	$131	$137	$141	$142	$144	$147
Federal Funding	$373	$447	$475	$344	$473	$527	$578	$557	$550
Reinsurance Cost	$353	$400	$468	$485	$568	$639	$735	$747	$705
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$454	$396	$224	$100

2027 Fund balance would have been $0 without UCC funding ↑

Upcoming Legislative Considerations

- In the 2027 legislative session, Maryland will need to consider legislation to extend the Reinsurance Program and the State-Based Health Insurance Subsidies Program.
  - The State-Based Health Insurance Subsidies Program is only authorized for plan years 2026 and 2027.
  - The 1% fee that supports the Reinsurance Program expires on December 31, 2028.

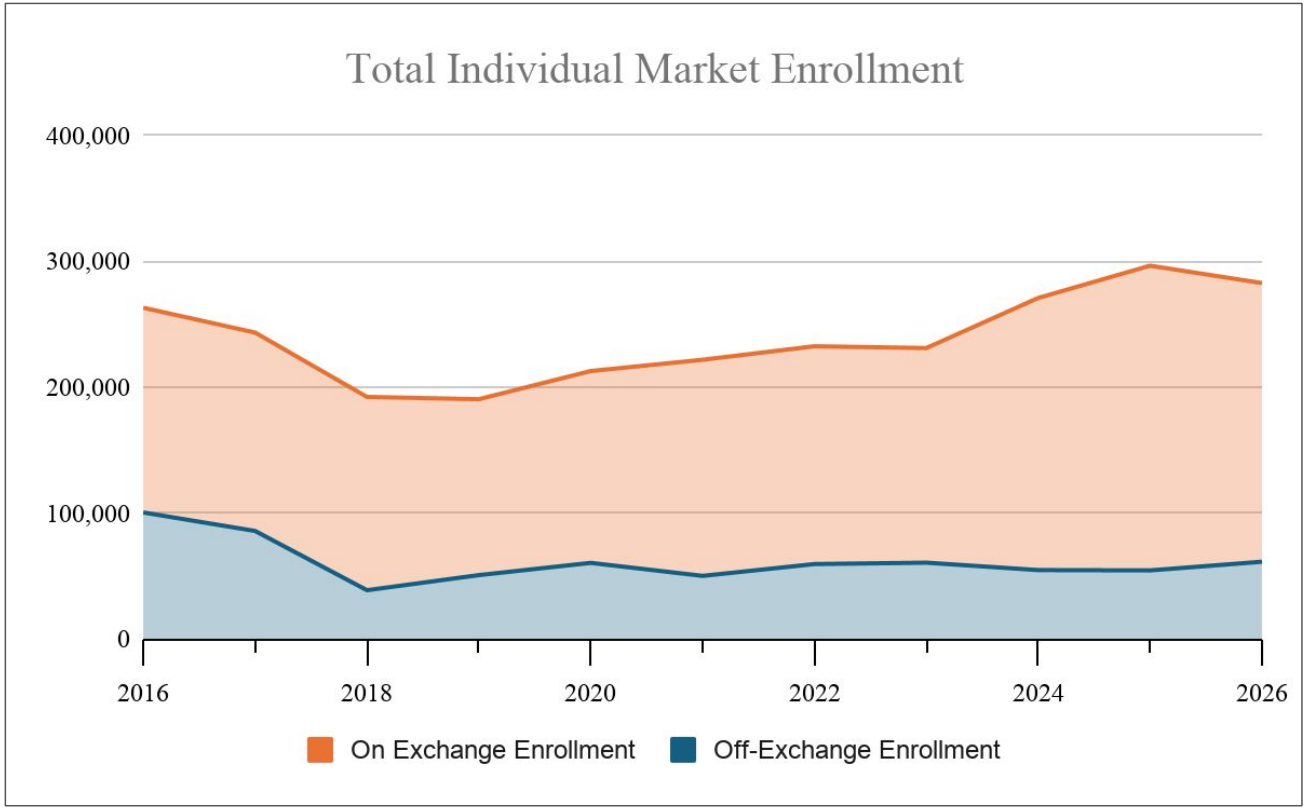
Appendix

How Does Reinsurance Work?

- Reinsurance reimburses insurers for a portion of their claims costs. Lower costs allow carriers to charge lower premiums.
- The MHBE Board sets the parameters for the reinsurance program.
- CMS approves reinsurance programs in 5-year increments; Maryland's current approval ends December 31, 2028.

Parameters	Final 2019-2022	Final 2023	Final 2024	Final 2025	Final 2026	Final 2027
Attachment Point	$20,000	$18,500	$20,000	$21,000	$24,000	$28,000
Coinsurance Rate	80%	80%	80%	80%	80%	80%
Cap	$250,000	$250,000	$250,000	$250,000	$250,000	$250,000
Dampening Factor	0.760-0.805	0.840	0.850	0.850	0.850	0.857

Total Individual Market Enrollment 2014-2026



Total market enrollment data from MIA, data as of 3/31 for 2016, 2017, and 2022, as of 4/30 for 2023, 2025, and 2026, as of 6/30 for 2018, 2020, and 2021, as of 7/31 for 2019 and 2024. On-exchange data from MHBE as of the end of open enrollment for 2016-2018, and as of May for 2019-2026. Off-exchange enrollment calculated as total enrollment minus on-exchange enrollment for all years.

Year-over-Year Enrollment Change by FPL and Metal Level: June 2025 vs. June 2026

FPL band	Bronze	Silver	Gold	Total
<100%	▼ **1,008** (76%)	▼ **15,109** (82%)	▼ **3,647** (82%)	▼ **19,860** (82%)
100–150%	▲ **550** (40%)	▲ **5,891** (31%)	▼ **359** (7%)	▲ **6,097** (24%)
150–200%	▲ **638** (11%)	▲ **2,022** (8%)	▼ **2,602** (13%)	-
200–250%	▲ **1,615** (19%)	▲ **363** (12%)	▼ **4,946** (22%)	▼ **2,987** (9%)
250–300%	▲ **271** (3%)	-	▼ **3,432** (28%)	▼ **3,252** (15%)
300–350%	-	-	▼ **1,444** (19%)	▼ **1,331** (9%)
350–400%	▲ **762** (20%)	-	-	▲ **690** (8%)
>400% & unknown	▲ **730** (3%)	-	▼ **4,408** (13%)	▼ **3,711** (6%)
Total	▲ **3,565** (6%)	▼ **6,717** (10%)	▼ **20,947** (19%)	▼ **24,320** (10%)

Total column includes all metal levels (catastrophic and platinum not shown in breakout by metal level). Blank cells indicate change of less than 200 individuals.

Year-over-Year Enrollment Change by Metal Level: June 2025 vs. June 2026

Metal Level	June 2025		June 2026		Change in % of Total
	Enrollment	% of Total	Enrollment	% of Total	
Catastrophic	1,754	1%	1,782	1%	0%
Bronze	56,517	23%	60,082	28%	4%
Silver *(Base + CSR 73)*	7,944	3%	8,423	4%	1%
Gold	111,750	46%	90,803	42%	-4%
Gold+ Equivalent *(Silver CSR 87)*	24,781	10%	26,803	12%	2%
Platinum	2,695	1%	2,446	1%	0%
Platinum+ Equivalent *(Silver CSR 94)*	37,143	15%	27,925	13%	-3%
Total	242,584	100%	218,264	100%	-

Uncompensated Care Grant Fund

Draft Plan

SEPTEMBER 11, 2026

Presentation Overview

- Background and Approach
- Uncompensated Care Grant Funding Proposal – Draft Plan Highlights
- Next Steps and Key Milestones

Background

- Recent federal policy and coverage changes will leave thousands of Marylanders uninsured; HSCRC approved an amendment at its July 22, 2026, Commission meeting that will allocate $25 million in one-time funding for FQHCs and LHDs in areas that are not currently served by FQHCs
  - Maryland's 16 FQHCs (162 sites statewide except in Carroll and Calvert Counties) and 24 LHDs are vital hubs that support community access to health care
  - The funds are intended to preserve access to primary and preventive health care for individuals affected by care coverage losses

Evidence-Based & Cost-Effective Approach

- Systematic reviews show that continuity of primary care is consistently associated with fewer Emergency Department (ED) visits and hospital admissions [1, 2]
- National and Maryland-specific studies demonstrate that connecting uninsured ED patients to a regular source of primary care at safety-net clinics decreases future ED utilization [3, 4]
- FQHCs outperform other primary care clinics in reducing ED visits for complex, low-income patients, likely due to their comprehensive service models [5, 6]

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1 Huntley A, Lasserson D, Wye L, et al. Which features of primary care affect unscheduled secondary care use? A systematic review. BMJ Open 2014;4:e004746. doi: 10.1136/bmjopen-2013-004746.

2 Kitzman H, Mamun A, Fleming N, Sykes K, Zsohar J. Community-Based Proactive Primary Care Reduces Emergency Health Care Use for Adults Without Insurance. Med Care. 2026 Jul 1;64(7):436-441. doi: 10.1097/MLR.0000000000002311.

3 Cuellar A, Helmchen LA, Gimm G, Want J, Burla S, Kells BJ, Kicinger I, Nichols LM. The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years. J Gen Intern Med. 2016 Nov;31(11):1382-1388. doi: 10.1007/s11606-016-3814-z.

4 Kim, T., Mortensen, K., Eldridge, B. Linking Uninsured Patients Treated In The Emergency Department To Primary Care Shows Some Promise In Maryland. Health Affairs 2015 34:5, 796-804. doi: 10.1377/hlthaff.2014.1102.

5 Pourat N, Chen X, Lu C, Zhou W, Yu-Lefler H, Benjamin T, Hoang H, Sripipatana A. Differences in Health Care Utilization of High-Need and High-Cost Patients of Federally Funded Health Centers Versus Other Primary Care Providers. Med Care. 2024 Jan 1;62(1):52-59. doi: 10.1097/MLR.0000000000001947.

6 Myong C, Hull P, Price M, Hsu J, Newhouse JP, Fung V. The impact of funding for federally qualified health centers on utilization and emergency department visits in Massachusetts. PLoS One. 2020 Dec 3;15(12):e0243279. doi: 10.1371/journal.pone.0243279.

Program Goals

- Mitigate the loss of Medicaid and other payer reimbursement by providing funding for specified services for uninsured Marylanders that are best addressed in a primary care setting
- Avoid unnecessary ED and hospitalization costs
- Support continuous access to community-based primary care for uninsured

Grant Structure – Overview

- Funds for FQHCs and select LHDs that provide patients with a routine source of comprehensive primary care, preventive care, chronic disease management, and/or who provide behavioral health services
- The approach is similar, though not identical, to the FQHC Prospective Payment System used by Medicare and Medicaid under which a health center receives a per-visit, standardized, encounter-based rate regardless of what services are performed during a patient's visit
- Utilizes a two-tiered grant approach:
  - Per-patient-per-month reimbursement for eligible patients receiving eligible services (90%)
  - Performance-based quality bonus to be paid to eligible grantees at the end of the grant period (8-10%)

Grant Structure – Overview *(Continued)*

- Applicants will be requested to:
  - Project anticipated increases in the uninsured seeking care at their facility in CY 2027
  - Include examples of current services that are vulnerable to closure or limitations due to the shift in payment mix and anticipated burden of uncompensated care
  - Identify activities or services they anticipate being able to sustain or add with grant funds

Reimbursement Methodology

- To receive reimbursement, providers must demonstrate that patients receiving qualifying services claimed on monthly invoices lack coverage and are at risk of seeking care in an ED for non-emergency services, as specified below:
  - Lack coverage: Patient must be uninsured and have no other source of funding to cover the services
  - Demonstrate clinical acuity/ED risk: Patient must have a diagnosis code of two or more chronic conditions, an acute condition, or an unmanaged chronic condition
- Grantees will be required to invoice MHCC monthly for each eligible patient who receives at least one eligible service; invoices will be paid, subject to availability of grant funds, once they are approved
  - Grantees will be reimbursed a set fee per unique patient per month, less any amount(s) paid by the patient, regardless of the number of visits or services each unique eligible patient received

Performance-Based Quality Bonus

- Designed to reward outcomes aligned with the goals of Maryland's AHEAD Model
- Seeks to ensure that providers are not adversely affected or penalized for treating high volumes of complex, costly, or higher-risk patients, and that bonus funding incentivizes care that averts unnecessary ED use
- Aims to minimize the reporting burden on safety-net providers by supplementing monthly grantee reporting with data linkages where possible
- Bonus payments will be awarded at the end of the grant funding cycle

Performance-Based Quality Bonus *(Continued)*

- Quality bonuses are projected to be measured and weighted in the following areas:
  - **Rate of potentially avoidable ED visits for persons without insurance:** Measures how often an assigned patient population utilizes an ED for non-urgent or primary-care-treatable conditions
  - **Third next available appointment for persons without insurance:** A standard measure of access to care that indicates how long a patient waits to be seen and how easily they can schedule a visit when needed, regardless of the reason

Program Evaluation Options

- Measure whether shifting $25 million from hospital rate adjustments to community settings preserves access and helps avoid unnecessary ED utilization
- Analyze variation in rates of avoidable ED visits at hospitals or across regions with varying levels of grant-supported individuals
- Compare trends in ED utilization in Maryland to other states
- Identify additional program metrics or evaluation criteria

Next Steps

- Evaluate 21 comment letters submitted by:
  - *Abbella Group Healthtech*
  - *Carroll County Health Department*
  - *CCI Health Services*
  - *Chase Brexton*
  - *Choptank Community Health*
  - *Department of Health and Human Services Montgomery County*
  - *Health Care for the Homeless*
  - *La Clínica del Pueblo*
  - *LifeBridge Health*
  - *LOVE- Nurse & Allied Staffing*
  - *Maryland Community Health System*
  - *Mary's Center*
  - *Maryland Hospital Association*
  - *Mid-Atlantic Association of Community Health Centers*
  - *Primary Care Coalition*
  - *Public Commenters (2 letters)*
  - *Sailwinds Medical*
  - *St. Mary's County Health Department*
  - *The Hilltop Institute*
  - *The League of Life and Health Insurers of Maryland*
- Modify the draft plan accordingly
- Prepare Request for Applications (RFA) for release

Key Milestone Targets

Date	Activity
October	MHCC releases RFA
October	Q&A – RFA informational webinar will provide an opportunity for potential applicants to clarify program requirements, application procedures, and expectations for grant activities
November	RFA submission deadline
December	Award announcement
January 2027	Grant funding commences
December 31, 2027	Grant ends – close out and final reporting

Questions?

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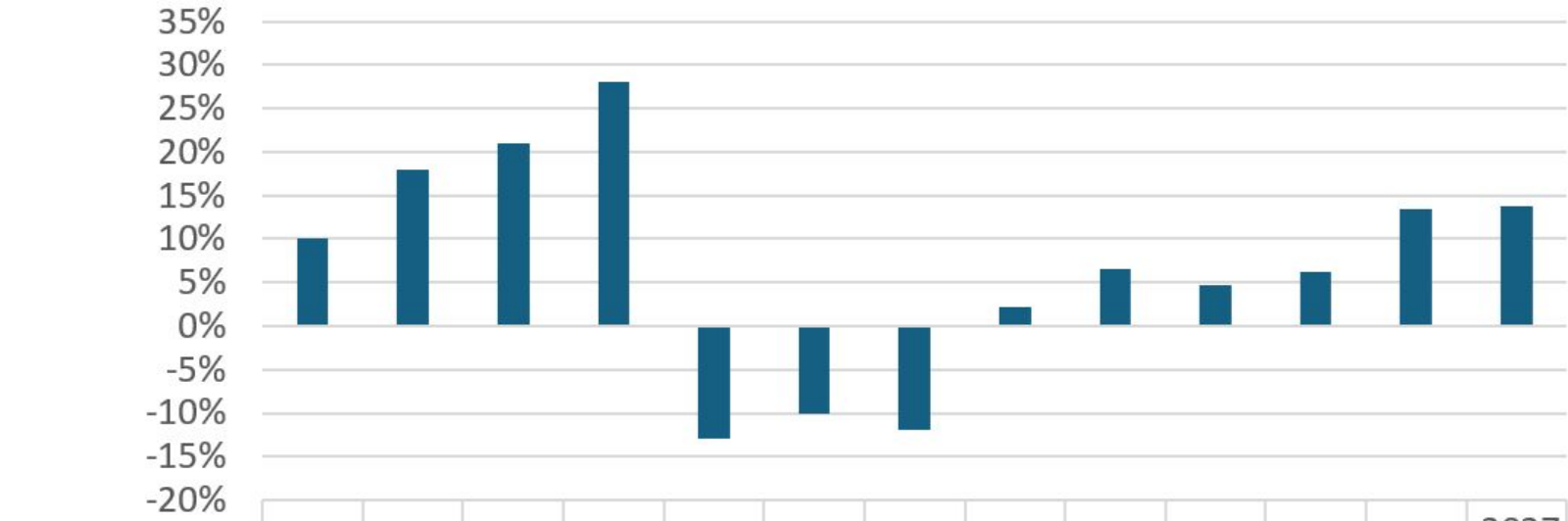

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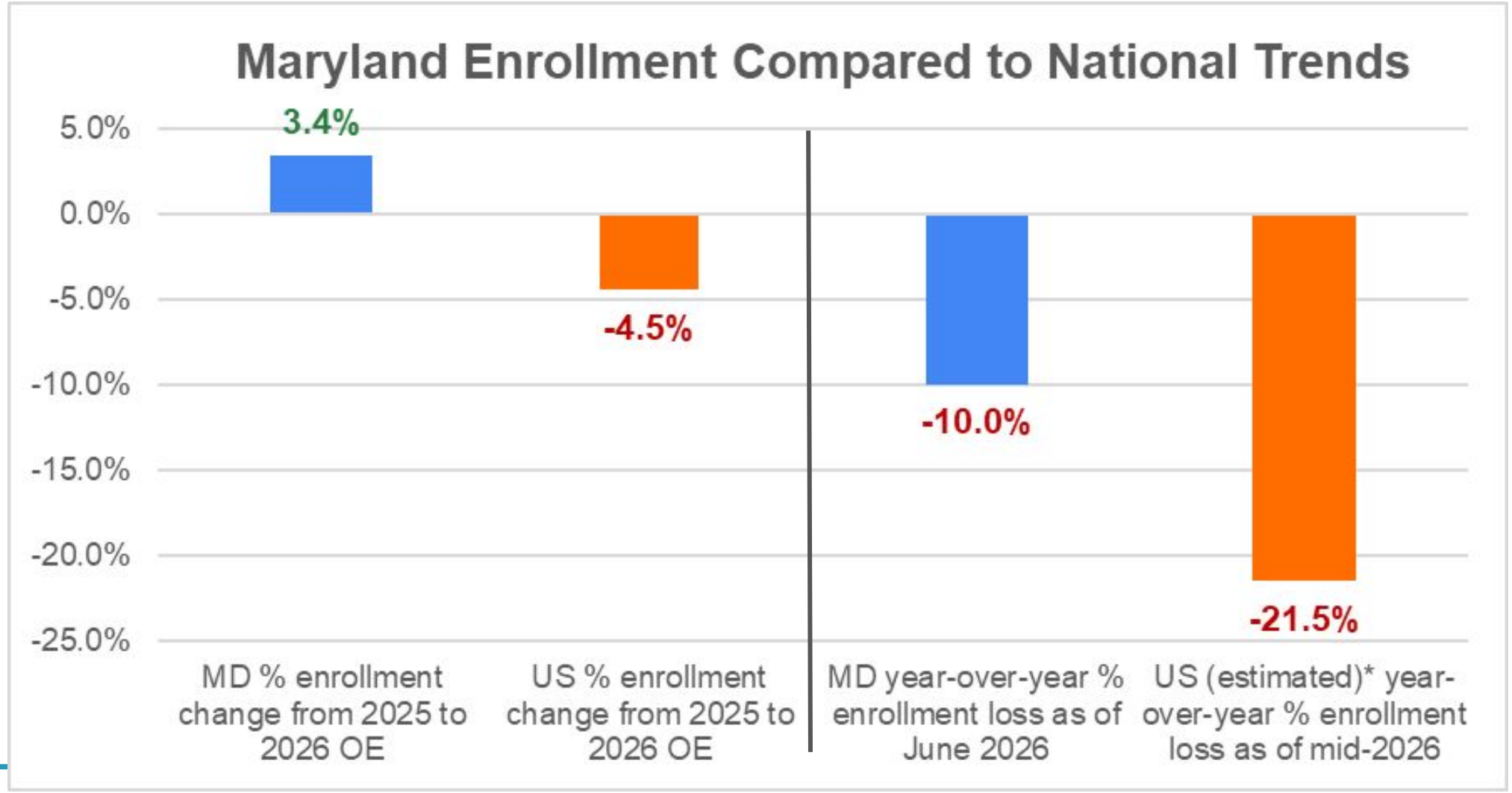

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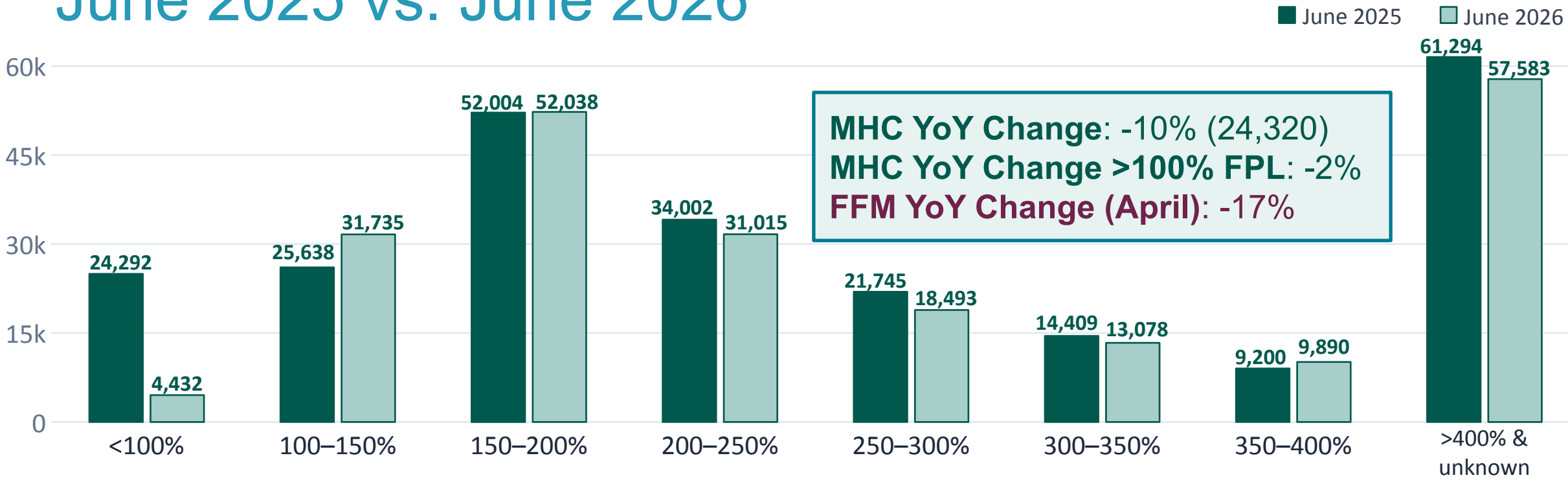

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	Lost ePTC	Full ePTC replacement		~75% ePTC	50% ePTC			Lost ePTC	

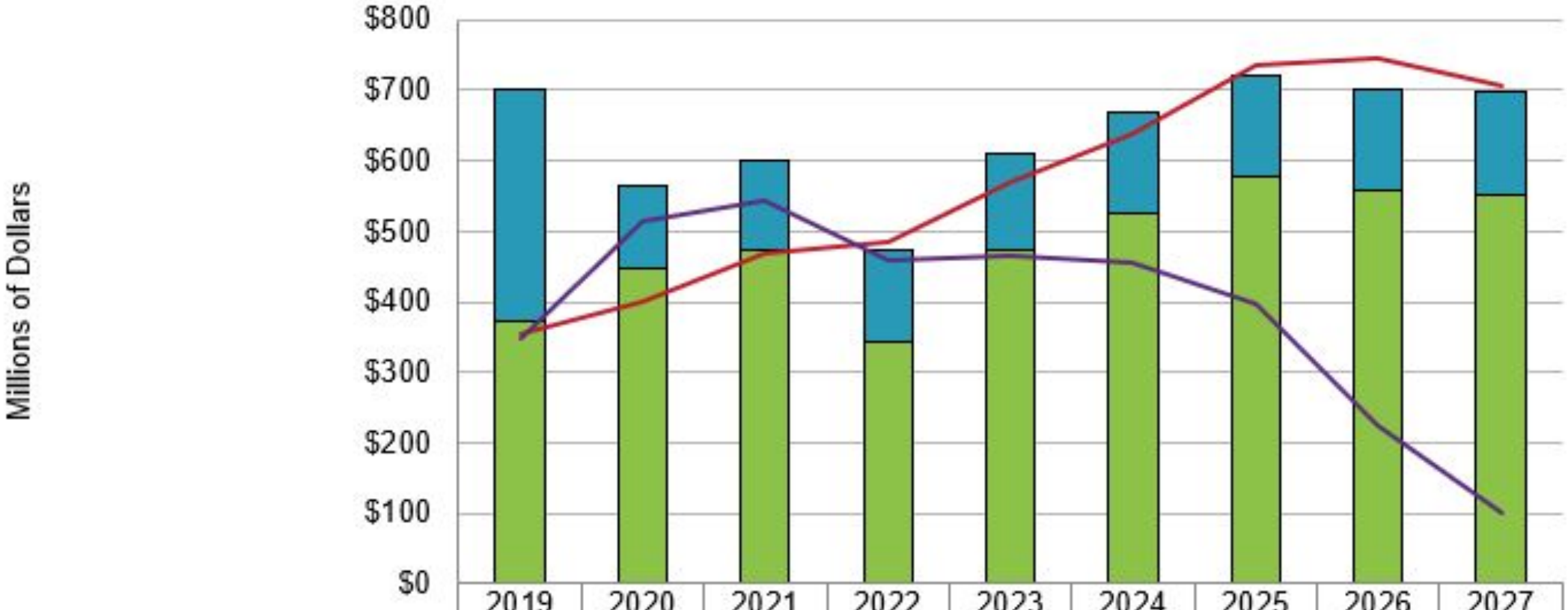
MARYLAND HEALTHBENEFIT EXCHANGE

MHC Enrollment Source: MHBE Executive Data Reports, June 30, 2025 and June 30, 2026. 100–138% and 138–150% FPL combined into 100–150%. '>400% FPL' and 'Unknown' combined. Estimated FFM enrollment YoY change from ACA Signups, May 12, 2026.

2027 Impact of UCC Funding

- Absent the UCC funding dedicated to MHBE, MHBE likely would not have been able to sustain the state subsidy in 2027
  - Holding 2026 subsidy parameters steady in 2027, with no additional funding, was projected to lead to a $0 fund balance as of the end of 2027
- Discontinuing the state subsidy was projected to lead more than 31,000 individuals to drop out of the individual market
- By retaining the state subsidy, these individuals are projected to remain covered

SRP Fund Projections 2019-2027 (w/ Final 2027 State Subsidy parameters + HSCRC Funding)



	2019	2020	2021	2022	2023	2024	2025	2026	2027
State Funding	$327	$119	$124	$131	$137	$141	$142	$144	$147
Federal Funding	$373	$447	$475	$344	$473	$527	$578	$557	$550
Reinsurance Cost	$353	$400	$468	$485	$568	$639	$735	$747	$705
Fund Balance End-of-Year	$347	$513	$544	$459	$465	$454	$396	$224	$100

2027 Fund balance would have been $0 without UCC funding ↑

Upcoming Legislative Considerations

- In the 2027 legislative session, Maryland will need to consider legislation to extend the Reinsurance Program and the State-Based Health Insurance Subsidies Program.
  - The State-Based Health Insurance Subsidies Program is only authorized for plan years 2026 and 2027.
  - The 1% fee that supports the Reinsurance Program expires on December 31, 2028.

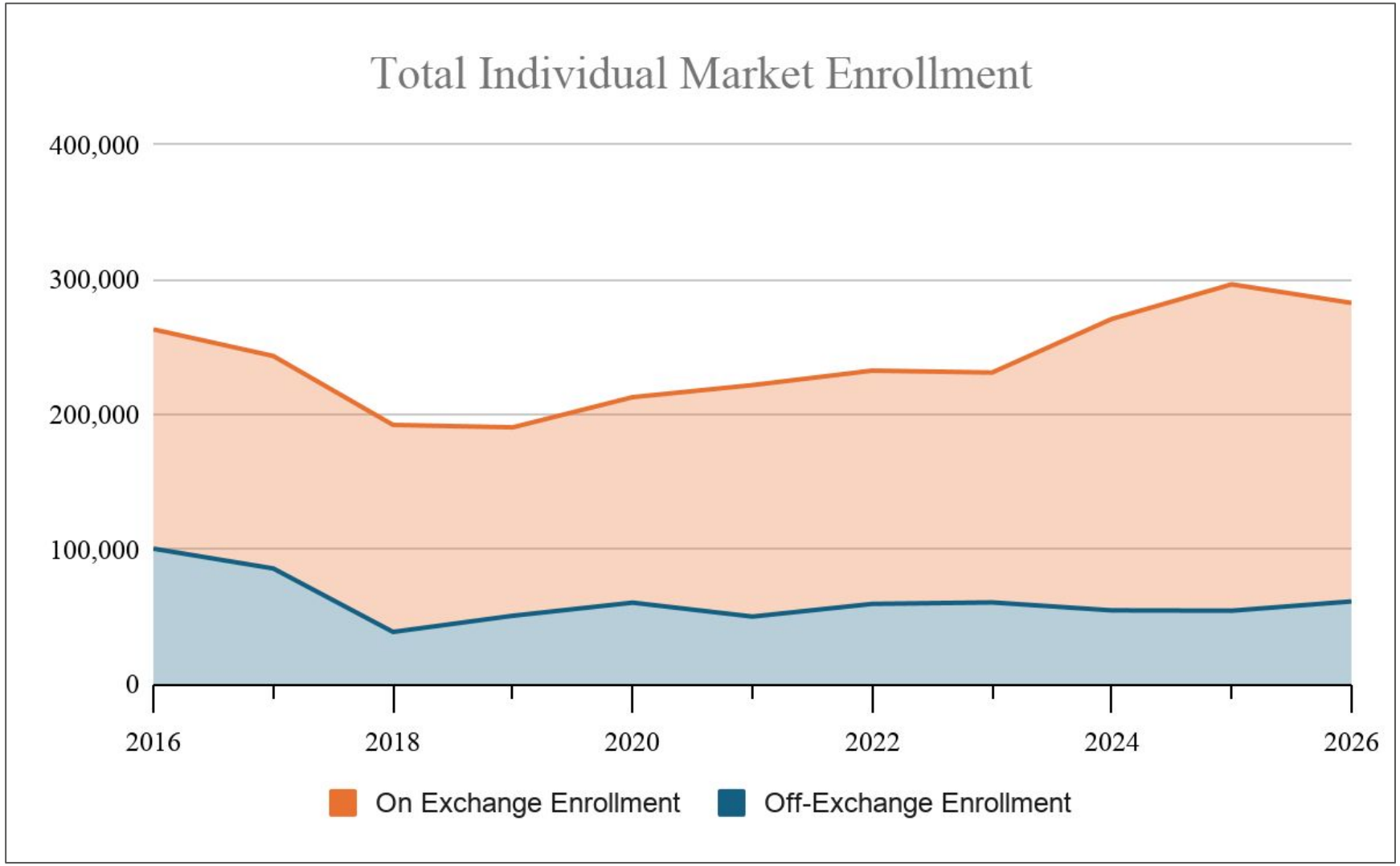
Appendix

How Does Reinsurance Work?

- Reinsurance reimburses insurers for a portion of their claims costs. Lower costs allow carriers to charge lower premiums.
- The MHBE Board sets the parameters for the reinsurance program.
- CMS approves reinsurance programs in 5-year increments; Maryland's current approval ends December 31, 2028.

Parameters	Final 2019-2022	Final 2023	Final 2024	Final 2025	Final 2026	Final 2027
Attachment Point	$20,000	$18,500	$20,000	$21,000	$24,000	$28,000
Coinsurance Rate	80%	80%	80%	80%	80%	80%
Cap	$250,000	$250,000	$250,000	$250,000	$250,000	$250,000
Dampening Factor	0.760-0.805	0.840	0.850	0.850	0.850	0.857

Total Individual Market Enrollment 2014-2026



Total market enrollment data from MIA, data as of 3/31 for 2016, 2017, and 2022, as of 4/30 for 2023, 2025, and 2026, as of 6/30 for 2018, 2020, and 2021, as of 7/31 for 2019 and 2024. On-exchange data from MHBE as of the end of open enrollment for 2016-2018, and as of May for 2019-2026. Off-exchange enrollment calculated as total enrollment minus on-exchange enrollment for all years.

MARYLAND HEALTHBENEFIT EXCHANGE

Year-over-Year Enrollment Change by FPL and Metal Level: June 2025 vs. June 2026

FPL band	Bronze	Silver	Gold	Total
<100%	▼ **1,008** (76%)	▼ **15,109** (82%)	▼ **3,647** (82%)	▼ **19,860** (82%)
100–150%	▲ **550** (40%)	▲ **5,891** (31%)	▼ **359** (7%)	▲ **6,097** (24%)
150–200%	▲ **638** (11%)	▲ **2,022** (8%)	▼ **2,602** (13%)	-
200–250%	▲ **1,615** (19%)	▲ **363** (12%)	▼ **4,946** (22%)	▼ **2,987** (9%)
250–300%	▲ **271** (3%)	-	▼ **3,432** (28%)	▼ **3,252** (15%)
300–350%	-	-	▼ **1,444** (19%)	▼ **1,331** (9%)
350–400%	▲ **762** (20%)	-	-	▲ **690** (8%)
>400% & unknown	▲ **730** (3%)	-	▼ **4,408** (13%)	▼ **3,711** (6%)
Total	▲ **3,565** (6%)	▼ **6,717** (10%)	▼ **20,947** (19%)	▼ **24,320** (10%)

Total column includes all metal levels (catastrophic and platinum not shown in breakout by metal level). Blank cells indicate change of less than 200 individuals.

Year-over-Year Enrollment Change by Metal Level: June 2025 vs. June 2026

Metal Level	June 2025		June 2026		Change in % of Total
	Enrollment	% of Total	Enrollment	% of Total	
Catastrophic	1,754	1%	1,782	1%	0%
Bronze	56,517	23%	60,082	28%	4%
Silver *(Base + CSR 73)*	7,944	3%	8,423	4%	1%
Gold	111,750	46%	90,803	42%	-4%
Gold+ Equivalent *(Silver CSR 87)*	24,781	10%	26,803	12%	2%
Platinum	2,695	1%	2,446	1%	0%
Platinum+ Equivalent *(Silver CSR 94)*	37,143	15%	27,925	13%	-3%
Total	242,584	100%	218,264	100%	-

Revenue Proposals:

DEFENDING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE FOR ALL MARYLANDERS

Vincent DeMarco, President
Maryland Citizens' Health Initiative

September 11, 2026

The Problem

Maryland has long been a leader in improving health care coverage, dropping our percentage of uninsured from 13% to 6%, which also reduced uncompensated hospital care by over $460 million. Now our progress is under threat.

THE HISTORY

Maryland successfully expanded coverage to 400,00+ people under the Patient Protection and Affordable Care Act.

CURRENT THREATS

Federal policy changes including HR 1, Medicaid and Qualified Health Plan Administration Rules, and termination of enhanced Premimum Tax Credits (ePTCs).

CONSEQUENCES

Tens of thousands of Marylanders are losing coverage, and hundreds of thousands more are at risk, leading to an increase in emergency room reliance and uncompensated care, and driving up premiums for everyone.

Statement of Need

Substantial new state revenue should be raised by enacting measures in 2027 to:

- restore coverage for those who have lost it because of bad federal action or inaction;
- help Marylanders at risk of losing coverage retain their coverage;
- and, continue the progress we have made to achieve our goal of quality, affordable health care for all Marylanders.

Total Revenue Needed: **$849 million – $1 billion/year**

Medicaid	Qualified Health Plans (QHPs) through Maryland Health Connection	Health Equity Resource Communities
· Invest in robust Medicaid eligibility operations including IT and local navigators to prevent as many of the **~115,000 Marylanders** at risk of losing Medicaid under new work reporting requirements and 6-month redeterminations starting January 2027 **(~$25 million/year)** · Restore coverage **to ~15,000 immigrants** who will no longer be eligible for Medicaid starting October 2026 **(~$129 million/year)** · Expand ex parte renewals for Medicaid recipients under 100% FPL which would require CMS approval and provide continuous coverage for **~105,000 children/pregnant adults** per year **(~$100-$200 million)**	· Maintain the reinsurance program to prevent **~17,000 people** from losing coverage and help keep coverage affordable for tens of thousands more **(~$150 million/year)** · Maintain the state subsidy program including for young adults and low-income Marylanders to prevent **~30,000 people** from losing coverage **(~$190 million/year)** · Expand the state subsidy program to fully cover the loss of ePTC's that were available under the Inflation Reduction Act to restore coverage for **~30,000 people (~$60 million/year)** · Maintain provisional eligibility for QHP's for one month while data matching issues are resolved **(~$20 million/year)** · Expand eligibility for the state subsidy program to immigrants who fully lost federal tax credits for QHP's **(~$160 million/year for ~20,000 people under 100% of the federal poverty level (FPL), plus ~$90 million for ~20,000 people above 100% FPL)**	· **Continue Health Equity Resource Communities (HERC's)** created by the Health Equity Resource Act. Health inequities by race, ethnicity, ability, and place of residence persist and are being exacerbated by federal attacks on health care. HERC's are improving residents' health, reducing hospital admissions, and creating cost savings which will result in lower overall health care costs, including lower insurance premiums for everyone **($15 million/year)**
Total need: ~$254-~$354 million/year	**Total need: ~$580-670 million/year**	**Total need: $15 million/year**

Overview of Revenue & Savings Solutions

Strategy: Five key legislative measures to raise necessary revenue and protect access to care.

1

Continue the Insurance Assessment

2

Strengthen the Prescription Drug Affordability Board (PDAB)

3

Pass the RENEW Act

4

End tax-deductions for direct-to-consumer pharmaceutical advertising

5

Raise the Alcohol Tax

Continue the Insurance Assessment

Proposal 1

Action: Reinstate the state insurer assessment beyond 2028 at 1% or higher.

Historical Context: Maryland previously instituted a 2.75% assessment in 2019 to replace a repealed federal fee; the state currently operates at a 1% rate.

REVENUE POTENTIAL

Approximately $150 million/year at a 1% rate, plus hundreds of millions of dollars/year in federal pass-through dollars.

Every 0.25% above 1% would generate an additional ~$37.5 million in state funding per year.

IMPACT

Stabilize the individual insurance market and premiums by funding reinsurance and subsidy programs.

Strengthen the Prescription Drug Affordability Board

Proposal 2

Action: Authorize the PDAB to adopt federally determined Medicare Maximum Fair Prices (MFPs) as state upper payment limits without a separate, lengthy cost review process.

Strategic Focus: Allows the PDAB to focus resources on non-Medicare-negotiated drugs, including those primarily prescribed to children and adults not enrolled in Medicare.

SCALE

Medicare has successfully negotiated MFPs for **25 drugs** so far, and 15 more are selected for negotiation annually.

SAVINGS POTENTIAL

Hundreds of millions of dollars/year for state government, local governments, and private entities.

The first two selected drugs, Jardiance and Ozempic, are expected to save State and local government entities $320,000/year and $5.8million/year respectively.

Lead Sponsors: Sen. Dawn Gile & Del. Jennifer White Holland

Pass the RENEW Act

Proposal 3

Action: Require large out-of-state big polluters to pay an assessment for climate change damages, including health care costs.

Precedent: This policy has already been enacted in New York and Vermont, with the original federal version introduced in Congress by Senator Chris Van Hollen.

REVENUE POTENTIAL

Hundreds of millions of dollars/year for health care (plus more for other climate resiliency needs). Comptroller will publish a report by the end of 2026 with more specific numbers.

CONSUMER PROTECTION

The assessment would not be passed on to consumers because these major polluters would lose competitive standing if they attempted to raise prices.

Lead Sponsors: Sen. Katie Fry Hester & Del. David Fraser-Hidalgo

End Tax Deductions for Direct-to-Consumer Pharmaceutical Advertising

Proposal 4

Action: Decouple Maryland tax law from federal law by disallowing tax deductions for direct-to-consumer (DTC) pharmaceutical advertising spending.

THE ISSUE

Taxpayers are currently subsidizing prescription drug commercials while patients struggle with to afford their medication.

SAVINGS POTENTIAL

Approximately $10–$24 million/year to help fund Medicaid eligibility operations and premium assistance.

Lead Sponsors: Sen. Karen Lewis Young & Del. Natalie Ziegler

Raise the Alcohol Tax

Proposal 5

Action: Increase alcohol excise taxes by a dime a drink.

Historical Context: Maryland has not raised the excise rate since the 1970s. Maryland's beverage sales tax has not been updated since 2011, and current rates lag behind Washington D.C.

Proven Model: Builds upon the successful 2011 sales tax increase, which generated $70 million/year for critical public health needs.

PUBLIC HEALTH IMPACT

Historical evidence shows this leads to significant reductions in underage drinking, binge drinking, DUIs, and alcohol-related injuries/deaths.

REVENUE POTENTIAL

Estimated at least $220 million/year.

Summary: Legislative action is required to maintain Maryland's health care progress.

MARYLAND Health Care FOR All

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For more information go to healthcareforall.com/revenueproposal