



Maryland
Hospital Association

July 27, 2025

Marie Grant
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Dear Commissioner Grant:

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the 2026 premium rate requests for individual and small group market plans filed with the Maryland Insurance Administration (MIA).

Carriers in the individual market are requesting an overall average rate increase of 17.1% for the 2026 plan year—the highest proposed rate increases since the start of Maryland’s reinsurance program. In the small group market, carriers want an overall average rate increase of 5.5%, ranging from 3.3% to 12.2%. Rate increases of this magnitude threaten the affordability of care and could restrict access to health care coverage for Marylanders and drive up uncompensated care across the state.

MHA urges MIA to carefully evaluate the proposed rate increases and carrier justifications, analyses, and assumptions to ensure they are not excessive or unfairly discriminatory. We offer the following comments for your consideration.

Impact of Loss of Federal Enhanced Premium Tax Credits

More than half of the average proposed rate increase in the individual market (9.2%) is attributed to the anticipated loss of federal Enhanced Premium Tax Credits (EPTCs), which are set to expire at the end of the year. Carriers maintain that the loss of these credits will result in a significant reduction in enrollment and relatively sicker risk pools, necessitating higher premiums. The rate increases Maryland carriers attribute to the expiration of EPTCs in their 2026 filings are notably higher than those from carriers in other states. Carriers in Connecticut, Rhode Island, and Washington estimate EPTC-related rate increases of 3.5% to 6.8%, an average of 7.3%, and as much as 6.4%, respectively. In light of this significant variation, we urge MIA to review and evaluate the analyses that carriers performed to arrive at these estimates.

MHA supports the Maryland Health Benefit Exchange’s (MHBE) efforts to identify state policy solutions to mitigate enrollment losses associated with the expiration of enhanced federal subsidies. MIA should carefully consider the anticipated impact of the policy options under consideration when evaluating the proposed rate increases, including any potential state-based

subsidy program that partially replaces enhanced federal subsidies and associated modifications to the State Reinsurance Program. State-based actions to replace the expected loss of federal funding will mitigate the need for carriers to increase rates.

High Premiums Threaten Affordability, Increase Uninsured and Uncompensated Care

The price of insurance premiums greatly influences the ability of consumers to purchase health insurance. While premium rates may need to be adjusted to account for certain costs and changes in the availability of EPTCs, we are concerned that the historic level of the proposed increases could price many Marylanders out of coverage, particularly lower-income individuals who may be more sensitive to price increases. Though some individuals may be able to access more affordable coverage through their employers, many will become uninsured—as many as half of those who lose coverage, according to one estimate.¹ These coverage losses, coupled with the anticipated reduction in Medicaid enrollment due to recent federal policy changes, will erode coverage gains Maryland has worked so hard to achieve over the past decade and significantly increase uncompensated care statewide, further straining hospitals and other providers in the state. Without coverage, patients may also delay or forgo necessary care, which adversely affects health outcomes and leads to higher long-term health care costs.

Need for Greater Transparency of Carrier Financial Performance

When evaluating premium rate requests, MIA must apply a consumer-centered approach that considers both carrier solvency and consumer affordability. This evaluation should include careful and transparent consideration of carrier financial performance to verify that a proposed rate request is actuarially sound, justifiable, and reasonable. However, the documents carriers are required to submit as part of their rate filings lack sufficient visibility into their recent financial performance including key financial metrics such as profit margins, reserve adequacy, and administrative expenses and allocations. Carriers should be required to include data on these metrics in a manner that is accessible to the public. Furthermore, carriers should explain how their financial performance factors into their rate requests. Such requirements would promote greater transparency in the rate review process, equip consumers with the context needed to evaluate and understand premium rate filings, and be in closer alignment with the detailed financial data Maryland hospitals are required to submit to the Health Services Cost Review Commission (HSCRC) on an ongoing basis.

Low Medical Loss Ratio in Group Market Compared to Nation

Premium rates are but one measure of plan affordability. The medical loss ratio (MLR) works to protect consumers by ensuring that premiums are used to cover medical claim costs. According to data collected by the National Association of Insurance Commissioners (NAIC), the average medical loss ratio (MLR) in Maryland's group market in 2024 was 78.9%, the lowest ratio of any state for plan year 2024. Given this is the second year in a row that the MLR in Maryland's group market has hovered around the statutorily-mandated minimum MLR for small group plans

¹ Urban Institute, December 2024: Hospitals, Physicians, and Other Stakeholders Face Billions of Dollars in Uncompensated Care Costs and Lost Revenue if Enhanced ACA Tax Credits Expire. Available [here](#).

and significantly lower than national peers, we respectfully ask that MIA investigate this observed trend, and if it could be related to inappropriately high premiums, excessive cost-sharing requirements, high administrative costs, high rates of denials, or profits.

Denials Continue to Drive Costs and Care Delays

MHA appreciates the steps MIA is taking to address the significant challenge of payer denials. Denied cases have grown substantially in the past decade and this growth has accelerated in recent years, particularly in the emergency department and outpatient setting. Denied cases as a percentage of total outpatient services and emergency department services increased from 8.5% to 12.5% and 6.1% to 15.2%, respectively, between FY 2019 and the end of FY 2024. Denials can cause delays in patients receiving necessary care, and higher out-of-pocket costs resulting from claim denials can cause patients to defer receiving care altogether—both of which lead to sicker patients and higher overall health care costs for the state. They also contribute to financial pressure on hospitals and divert valuable resources away from direct patient care. Denials, as well as their relationship to MLRs and carrier financial performance, should be taken into consideration when evaluating the requested premium rate increases.

Thank you for the opportunity to comment on this important matter. We look forward to continuing our work with MIA to make health care accessible and affordable for all Marylanders.

Sincerely,



Melony G. Griffith
President & CEO