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Testimony in Support of HB 1112

Health Insurance Coverage Protection Commission – Study on Individual and Group Health Insurance Market Stability

Good afternoon, Chair Bagnall and honorable members of the committee. Thank you for this opportunity to present HB 1112 **– Health Insurance Coverage Protection Commission – Study on Individual and Group Health Insurance Market Stability.** This bill takes advantage of a commission we already have in place to address ways to support our current health care coverage models.

The Maryland Health Insurance Coverage Protection Commission was established in law with the passage of HB718 in 2025. The bill identified a comprehensive set of charges to monitor, assess and make recommendations relating to the federal changes to the Affordable Care Act (ACA), Mental Health Parity and Addition Equity Act (MHPAEA), Medicaid programs, the Maryland Children's Health Program, Medicare, or the Maryland All–Payer Model.

While the Commission has not yet begun its work, due to delays in identifying members, there is intention for the first meeting to be in May 2026.

In the meantime, we have already seen some changes at the federal level that threaten access to care for Maryland residents. These include the changes in our all payor model for hospitals in the withdrawal of the Medicare pass through funds, beginning in 2028. In addition, the passage of H.R. 1 in 2025 shifts administrative costs to the states and eliminates options for collecting funds to cover state Medicaid share in the short-term. The leadership of the Maryland Health Benefit Exchange and the Department of Health report that they are monitoring rule changes at the federal level every day and they anticipate more significant impact over time.

In October 2025, the then Chair of the Health and Government Operations committee convened a group of delegates, and current and past leaders in the health care arena, for

the purpose of brainstorming policy and legislative options for a public option or other health system transformations to address rising uninsurance rates and coverage instability in Maryland.

The outcome of that discussion was that a public option may not be the most beneficial approach, due to the fact that Maryland's all-payer hospital rate setting compresses the pricing gap between Medicaid and commercial rates. In states like WA, CO, NM, large hospital rate differentials (25–30%) made public options effective. In Maryland, the gap is ~7%, limiting potential premium reductions to perhaps 10–15%. Our reinsurance program already achieved significant rate relief; this fund is "under siege" but remains vital at this point.

In response to the public option question, the group felt that an actuarial analysis comparing Medicaid and commercial rates to estimate realistic premium savings would be helpful. We could explore regulatory exemptions to allow Medicaid MCOs to sell in the individual market without meeting full insurer capital requirements. So, we left the meeting with the need for more information.

The composition of the Commission includes significant knowledge and expertise about health care and health care economics in our state.