For Senate Finance Committee
Hearing: Wednesday March 25th

HB1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability

FAV with Sponsor Amendments

Dear Madam Chair and Members of the Committee:

I am a primary care physician in Baltimore City. Many of my patients depend on Medicaid and its services. Medicaid cuts are dangerous for public health and individual health.

The 2025 Budget Reconciliation Act reduces federal Medicaid funding by $1 trillion over the next decade. The cuts will be particularly deep in 2027 and 2028. Medicaid is a lifeline for one out of four Marylanders, including children and low income families, people with disabilities, the elderly and working adults who don't have affordable insurance options, and five out of eight nursing home residents. Medically and financially vulnerable folks are living in fear that they or someone in their family will lose Medicaid and the essential medical care they need.

My patients are vulnerable, with chronic conditions, and will be hurt by Medicaid cuts.

We appreciate all the work that our state health officials have been doing to understand the implications of HR 1 and the ways in which Medicaid enrollees will need information and support to meet the new work requirements.

But Maryland also needs to identify new sources of significant revenue to offset the federal cuts and avoid cuts in services.

The sponsor amendment for HB1112 will empower the Maryland Medicaid Advisory Committee to create a workgroup dedicated to studying the benefits of transitioning away from our use of middlemen Managed Care Organizations (MCOs) in favor of a direct payment system or fee-for-service model. Connecticut adopted such a system in 2012 and has saved $4 billion over the intervening years. Their state has also seen increased participation from clinicians.

A recent white paper published by Physicians for a National Health program estimates that Maryland could save up to $521 million annually by taking a similar step.

Why? MCOs on average take about 13 cents of every Medicaid dollar for overhead and profits. The state would only need 3 cents on a dollar to administer and run our publicly funded Medicaid program. By removing the "middle man" the state retains more of each Medicaid dollar which can then be directed towards patients, doctors and caregivers.

In addition to the significant cost savings, transitioning away from an MCO model would also simplify the lives of Medicaid enrollees and the clinicians who care for them. Instead of worrying about whether a specialist is part of their particular MCO's network, Medicaid enrollees would have a unified statewide network of Medicaid providers to choose from. Instead of worrying about whether a medication or procedure is covered by their patient's specific MCO, clinicians would have a unified statewide Medicaid system to deal with.

Connecticut has found that a simplified, unified Medicaid system has helped draw physicians into the program. When there is less paperwork and bureaucratic complexity to deal with, clinicians are more likely to choose to serve Medicaid patients.

Some of Maryland's MCOs are owned and operated by for-profit insurance companies with terrible track records of care denials. Others are owned by nonprofit health systems. The health systems who operate MCOs might object that scrapping the MCO model would destroy valuable opportunities for improving care coordination. But that is not the case. Connecticut has continued to effectively promote care coordination by providing dedicated funds for

primary care practices that operate as “patient-centered medical homes” (PCMHs). Some of Connecticut’s largest health systems participate in the PCMH model, and they have been able to use that model to streamline care and to minimize unnecessary emergency-room visits.

We owe it to our kids, our seniors, healthcare workers, and our most vulnerable residents to move expeditiously to explore this option. The ten cents from each Medicaid dollar that isn’t going to MCOs can be used to pay for healthcare treatment, to fund state eligibility operations, and expand the pool of local health department navigators we will need to help people keep up with the new “work requirements.” Additional benefits like simplifying the system for enrollees and providers and a decrease in denials are also worth pursuing.

Other states are actively working on similar legislation - Hawaii, Minnesota, Illinois, Wisconsin, New York, Rhode Island and West Virginia.

I urge you to give favorable consideration to this amendment and reclaim the revenue we need to respond to the harm of federal budget cuts.

Thank you.

Zackary Berger MD PhD
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