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Written Testimony in Support of House Bill 1367:
Establishing the Commission on Re–Imagining Health Care in Maryland

Good afternoon, Chair Beidle Vice Chair Hayes and honorable members of the Senate Finance Committee. Thank you for this opportunity to present HB 1367 Establishing the Commission on Re–Imagining Health Care in Maryland.

The health care infrastructure within the State of Maryland currently stands at a precipice, necessitating a fundamental evaluation of its delivery models, financial sustainability, and equity outcomes. House Bill 1367 (HB 1367) proposes the establishment of a Commission on Re–Imagining Health Care, a body tasked with envisioning a comprehensive health care system that is entirely patient-centered, integrated across somatic and behavioral disciplines, and agile enough to evolve alongside the needs of its residents.[1] This legislative initiative emerges in response to a systemic failure where, despite high expenditures, the state faces outcomes that often pale in comparison to other developed nations.[1] The current landscape is characterized by a "health care divide" where rural residents face life expectancies up to seven years shorter than those in affluent suburban areas, and where one in three Marylanders skips necessary medications due to prohibitive costs.[1]

Maryland in a Global Context:
Spending Levels, Structural Cost Drivers, and the Fiscal Imperative for Reform

Total health care expenditures in Maryland reached approximately $69.5 billion in 2020. This translates to an astounding $11,482 for every man, woman, and child across a population of roughly 6.25 million residents.[29] If Maryland were evaluated as a standalone nation, its per-person spending would rival that of the most expensive health systems globally.

International comparisons provide critical context. The United States spends approximately $12,555 per capita (USD PPP) on health care, or 16.6% of GDP, the highest share among comparable peer nations.[30] By contrast, other advanced economies sustain universal or near-universal systems at significantly lower cost.

Country	Health spending per capita (USD PPP)	Health spending as % of GDP
United States	$12,555	16.6% (OECD)[30]
Switzerland	$8,049	11.3% (OECD)[30]
Germany	$8,011	12.7% (OECD)[30]
Netherlands	$6,729	10.2% (OECD)[30]
France	$6,630	12.1% (OECD)[30]
Sweden	$6,438	10.7% (OECD)[30]
Australia	$6,372	9.6% (OECD)[30]
Canada	$6,319	11.2% (OECD)[30]
New Zealand	$6,061	11.2% (OECD)[30]
United Kingdom	$5,493	11.3% (OECD)[30]

Compared to similarly wealthy nations, the United States spends 4 to 6 percentage points more of our GDP on health care.[30] More recent OECD-based data estimate U.S. per-capita spending at $13,432 in 2023, compared to an average of $7,393 across comparable nations, a difference of approximately $6,039 per person annually.[31]

Applied to Maryland's population, that international spending gap represents the equivalent of $37.7 billion annually (6,039 × 6.25M). A more conservative benchmark reinforces the point. If Maryland's per-capita spending were aligned with the Netherlands, $6,729 per person[30], this would amount to a difference of $4,753 per resident and would scale to approximately $28.8 billion saved annually.[29,30] And while Maryland cannot simply import another country's financing model, the data demonstrate that it is possible to deliver healthcare access at dramatically lower spending levels as a share of national income. More importantly, it demonstrates that we are missing a piece of the puzzle.

Evidence indicates that excess U.S. spending is not primarily driven by higher utilization of services. A cross-national analysis published in *JAMA* found that the United States does not consistently use more health care services than peer nations; rather, its spending is largely attributable to higher prices and administrative costs.[32] This divergence was found to be due primarily to price levels and system complexity, not greater clinical volume.[32]

Administrative Fragmentation as a Primary Cost Driver

Administrative spending represents one of the most measurable structural differences between the U.S. and peer systems. A 10-country comparative study found that administrative expenditures account for a conservative estimate of 8% of total health spending with other sources citing as much as 30% of health spending in the United States, compared to 1–3% in other high-income countries.[33,36] More granular sector analysis published in peer-reviewed literature estimates that administration constitutes nearly one-third of total U.S. health expenditures, roughly twice the share observed in Canada.[34]

These costs include what researchers define as "billing and insurance-related" (BIR) expenses:

1. Claims submission and adjudication
2. Prior authorization processing
3. Denial management and appeals
4. Insurance marketing and underwriting
5. Multi-payer compliance documentation

Private insurance overhead alone averages approximately 17% of premiums, compared to far lower administrative margins in public systems and single-payer models.[35] This is precisely the reason why a reassessment of our current system is necessary. While many OECD countries operate with centralized or standardized claims processing structures that significantly reduce duplicative administrative staffing, Maryland's system relies on unnecessarily burdensome fragmentation at a systemic level. While it does not directly improve clinical quality, it consumes substantial financial and workforce resources.

For Maryland, this distinction is critical. While the state has historically demonstrated leadership through its all-payer hospital rate-setting system, it remains embedded in a national financing structure that is characterized by unnecessary multi-payer complexity and administrative duplication. Systemic inefficiencies outside inpatient care, particularly in pharmaceutical pricing, and insurance administration continue to exert an upward cost pressure. This commission would serve to examine these burdensome arrangements. It creates an opportunity for Maryland to, once again, lead in making history.

The Fiscal Implications for Maryland

As Maryland transitions from the TCOC and AHEAD models, fiscal margins narrow further. The state must achieve savings targets while maintaining hospital solvency and addressing workforce deficits. In this context, incremental adjustments to reimbursement formulas will not resolve systemic cost drivers rooted in administrative complexity and price dispersion.

The Commission is, in part, intended to quantify where Maryland's system aligns with global best practices and where it diverges. The Commission proposed under House Bill 1367 provides a vehicle for disciplined, evidence-based examination of these structural factors. By explicitly analyzing:

1. International spending benchmarks (10–12% GDP vs. 16.6% in the U.S.)[30]
2. Per-capita expenditure gaps exceeding $6,000 annually[31]
3. Administrative cost shares ranging from 1–3% abroad vs. 8-30% or more domestically[33]
4. Sector-level estimates attributing up to one-third of U.S. spending to administrative functions[34]

At present, Maryland invests nearly $70 billion annually in health care.[29] That investment equals roughly the size of the state's entire annual operating budget. The question before policymakers is not whether Maryland can afford systemic examination, but whether it can sustain current spending trajectories without structural reform.

House Bill 1367 provides the structured forum necessary to align Maryland's financing architecture with evidence-based models of cost containment, integration, and equity. These inefficiencies are not marginal, they are systemic. A Commission empowered to examine global payment alignment, regulatory simplification, and administrative harmonization is therefore not aspirational policy but necessary fiscal stewardship.

The Structural Imperative for Systemic Re-Imagination

The primary impetus for HB 1367 is the recognition that the existing health care architecture in Maryland is fragmented and increasingly unable to withstand modern pressures. The bill outlines a vision for a system that is not only financially sustainable but also designed to ensure that health care quality and access are stronger than the current framework.[1] This requirement for "re-imagining" is driven by a series of cascading crises, including a historic physician shortage, the skyrocketing cost of prescription drugs, and a complex transition from the Total Cost of Care (TCOC) model to the federal States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model.

The Commission is mandated to study the role of the worker's compensation program within an integrated system and how high deductibles and limited networks deter care.[1] The necessity of such a study is underscored by data showing that high-deductible health plans (HDHPs) are associated with a 9% relative reduction in office visits for chronic conditions, as patients delay care to avoid upfront costs.[5] Furthermore, the state faces a critical workforce deficit; Maryland currently meets only 28.74% of its primary care needs, a figure that places it among the lowest-performing states in terms of practitioner density.[6]

Maryland Physician Workforce and Health Professional Shortage Area (HPSA) Data

Metric	**2024–2025 Statistic**
Percentage of Primary Care Needs Met	28.74% [6]
Practitioners Needed to Remove HPSA Designations	284 [6]
Projected Physician Shortage by 2030	1,052 [7]
Physicians within Retirement Range	35.8% [7]
Counties with HPSA Designations	22 of 24 [7]

The analysis of these figures indicates that workforce growth is failing to keep pace with the demand generated by an aging population and the increased prevalence of chronic disease. By 2030, the United States is projected to face a shortage of over 120,000 physicians, and Maryland's share of this deficit 1,052 doctors will be exacerbated by the fact that over one-third of the state's active physicians are nearing retirement.[7] This aging workforce is most prevalent in the capital region and among surgical specialties, suggesting that without the strategic intervention proposed in HB 1367, access to high-level specialized care will continue to erode.[7]

The Economic Barrier: Prescription Drug Costs and Medical Debt

A central pillar of the "broken" system described by advocates is the symbol of the prescription drug market. Medications account for nearly 30% of total health care expenditures in Maryland's privately insured markets.[1] The cost of life-saving drugs like insulin rose by $1,200\%$ between 1996 and 2017, forcing 30% of diabetics to ration their doses.[1] This trend is not isolated to older medications; the median annual cost for new prescription drugs reached $\$300,000$ in 2023.[1]

The Commission established by HB 1367 would work in tandem with the existing Prescription Drug Affordability Board (PDAB), which is already exploring upper payment limits for high-cost drugs like Jardiance and Farxiga.[1] These medications represent the single largest cost for the state employee health plan, with net spending doubling from $\$14.5$ million to $\$29.3$ million between 2020 and 2024.[1] The systemic failure is further highlighted by the fact that taxpayers contributed $\$870$ million toward the research and development of these specific drugs, yet they remain priced ten times higher in the United States than in other developed nations.[1]

The Impact of Medical Debt and High Deductibles on Maryland Families

Economic barriers extend beyond the pharmacy counter. In 2023, 14% of Maryland households approximately 327,600 families held unaffordable medical debt.[9] This debt is a primary driver of care avoidance and financial ruin, particularly for Black-led households, where 23% of surveyed residents reported carrying such debt.[10] The Commission is specifically tasked with investigating how high deductibles and limited networks decrease equal access to health care.[1]

In 2026, standard bronze plans in the individual market are projected to have an average deductible of $\$7,476$, while catastrophic plans will feature deductibles as high as $\$10,600$ for individuals.[11] For a family of four, these out-of-pocket maximums can reach $\$21,200$.[11] These figures suggest that many Marylanders are "underinsured," possessing a health plan that protects against catastrophic loss but provides little to no relief for routine or preventive care.

Household Medical Debt Source in Maryland	Percentage of Impacted Households
Hospital Visit Only	23% [9]
Outpatient Services Only	44% [9]
Combined Hospital and Outpatient	30% [9]
Debt from a Hospital Visit (General Poll)	53% [10]

The legislation passed in 2025, such as HB 268, attempted to mitigate this by expanding financial assistance to families earning up to 500% of the FPL and prohibiting lawsuits for debts under $500.[12] However, these are defensive measures; the Commission on Re–Imagining Health Care is required to take an offensive approach, developing a system where such debt is not the default outcome of seeking medically necessary care.[1]

The Transition to the AHEAD Model and Hospital Sustainability

Maryland stands apart as the only state with a unique all-payer hospital rate-setting system, currently managed through the TCOC model.[3] This system has successfully slowed hospital spending growth and reduced readmissions, keeping commercial hospital costs approximately 20% lower than national benchmarks.[3] However, the TCOC model is set to expire, and Maryland is transitioning to the federal AHEAD model.[3]

This transition introduces significant risk. Under AHEAD, rate-setting authority for Medicare Fee-For-Service will transition from the Maryland Health Services Cost Review Commission (HSCRC) to the federal CMMI.[13] This shift creates a potential "funding cliff" after 2027, as the federal government contemplates reducing its annual contribution of approximately $3 billion to the Maryland model.[3] The Commission must determine how the state's hospitals, which are already struggling with razor-thin margins and rising labor costs, will survive this transition.[14]

Hospital Financial Health and Operational Challenges

The Maryland Hospital Association (MHA) has indicated that the average operating margin for state hospitals was just 0.3% in late 2024, a figure that is insufficient for sustaining non-profit missions or making necessary capital investments.[14] Labor costs grew by 19% between 2019 and 2023, while net patient revenue grew by only 14.2% .[14] This imbalance is compounded by a 55% increase in losses related to physician coverage, as hospitals struggle to recruit specialists in areas like anesthesia and radiology.[14]

Hospital Operational Metric	**Maryland Statistic (2024)**
Average Operating Margin	0.3% [14]
Payer Denials (Total Dollar Value)	$\$1.39$ Billion [14]
Average Age-of-Plant (Maryland)	13.2 Years [14]
Average Age-of-Plant (National)	12.3 Years [14]
Growth in Labor Costs (2019–2023)	19% [14]

The Commission's mandate to study the "role of hospitals" and "how to balance patient-centered care and cost" is therefore a matter of survival for the state's critical health infrastructure.[1] If the state cannot maintain the financial stability of its hospitals while meeting the federal AHEAD savings targets which require a 2.66% reduction in Medicare spending by 2032 the result could be widespread service reductions or hospital closures, particularly in rural jurisdictions.[3]

Integrating Behavioral Health and Addressing the Health Care Divide

A "re-imagined" system must address the chronic underfunding and fragmentation of behavioral health services. Eight national studies conducted between 2019 and 2023 have identified Maryland's behavioral health data as among the worst in the nation for systemic inequity in access.[15] Over 325,000 residents rely on the public behavioral health system, but the workforce crisis has left the system unable to meet the growing demand for mental health and substance use care.[15]

The Commission's focus on an "integrated system of care, addressing all aspects of health, both somatic and behavioral" is vital.[1] Current models often silo these treatments, leading to poorer outcomes for patients with complex needs. The proposed integration would also examine the role of workers' compensation, a system that has traditionally operated independently of general health insurance. Research suggests that a connected payment and claims ecosystem in workers' compensation could facilitate faster return-to-work times and improve transparency for injured workers, who currently wait an average of 34 days for indemnity payments following catastrophic events.[16]

Racial and Geographic Health Disparities

The Commission is explicitly charged with eliminating barriers for all residents, a task that requires addressing the profound racial and geographic disparities in the state.[1] In Maryland, early death rates for Black residents are 5.7 times higher than for multiracial residents.[17] On the Eastern Shore, residents have life expectancies as many as seven years shorter than those in Montgomery County.[18]

Geographic Health Disparity (Maryland)	Impacted Population
Meets 100% Medically Underserved Area (MUA) Status	Caroline, Kent, Somerset, Worcester [18]
Early Death Rate Disparity (Black vs. Multiracial)	5.7x Higher [17]
Rural Counties in Maryland	18 of 24 [19]
Physician Density Deficit vs. National Average	16% Lower [2]

The Commission must synthesize recommendations from the 2025–2030 Rural Health Strategic Plan and the Office of Minority Health and Health Disparities.[19] These entities highlight that "curing disease is not enough to achieve health equity," and that addressing social drivers of health such as transportation isolation and food insecurity is essential for improving population-level outcomes.[21] Rural Marylanders often lose an entire workday to travel for a single appointment, a burden that makes preventive care functionally impossible for many families.[2]

Comparative Analysis: Successful State-Based Models

To re-imagine its own system, Maryland must look toward states like Vermont and Oregon, which have implemented ambitious all-payer and coordinated care models.

Vermont's All-Payer ACO Model

Vermont transitioned to a payment system based on value and high-quality outcomes rather than volume.[22] The model provided $9.5 million in start-up investment to assist providers with care coordination.[23] By its second performance year, Vermont saw improvements in 22 reported measures and met or exceeded five of its six population health outcome targets, including increased primary care access and reduced suicide rates.[22]

Oregon's Coordinated Care Organizations (CCOs)

Oregon's CCO model rewards quality of care through a pay-for-performance program.[24] In 2024, Oregon's CCOs collectively earned over $325 million in quality incentives.[24] The program specifically focuses on "Health Equity Plans," requiring organizations to prioritize organizational changes that embed equity in service delivery.[25] Oregon has also increased Medicaid behavioral health reimbursement rates by an average of 30% to ensure a robust provider network.[26]

Feature	Vermont All-Payer ACO	Oregon CCO Model	Maryland HB 1367 Vision
Core Focus	Value vs. Volume [22]	Quality Incentive Program [24]	Entirely Patient-Centered [1]
Integration	Somatic + Behavioral + Public Health [23]	Medical + Dental + Behavioral [26]	Somatic + Behavioral + Life Course [1]
Funding Strategy	Global Budgets & ACO scale [23]	Capitation Rates & Bonuses [26]	Financial Sustainability [1]
Equity Metric	Population-level outcomes [23]	Mandatory Health Equity Plans [25]	Eliminate barriers for all [1]

These models demonstrate that when a state aligns incentives across all payers and focuses on the social determinants of health, population health can measurably improve. HB 1367 positions Maryland to take the best elements of these successful models and adapt them to its unique regulatory environment.

The Role of Practitioner Reimbursement and Shortages

HB 1367 mandates an inquiry into why low physician reimbursement rates cause practitioner shortages, particularly for specialists.[1] Maryland Medicaid's reimbursement rates were approximately 91.5% of Medicare rates as of FY 2024.[27] While Maryland ranks highest among neighboring states for Evaluation and Management (E&M) procedures, it lags in other areas.[27] For example, Medicare reimbursement rates for anesthesia services are only about one-third of commercial payment rates.[28] This disparity creates a system where providers are disincentivized from seeing the most vulnerable patients, leading to access gaps that disproportionately affect those on public plans.

The Commission will also examine models of practitioner education. The University of Maryland School of Medicine is currently expanding its class size to 200 students by 2031 to address the projected 84,000-physician national shortage.[29] However, educating more doctors is only half the solution; the state must also create an environment where these providers can afford to practice, particularly in high-need rural areas. The Rural-MD Scholars program, which provides scholarships to students committing to practice on the Eastern Shore, serves as a pilot for the type of workforce development the Commission must standardize statewide.[18]

Conclusion: A Mandate for Action

The establishment of the Commission on Re–Imagining Health Care is not a luxury; it is a clinical and economic necessity. Maryland's health care system is "teetering on the edge of collapse," burdened by costs that strip dignity from the elderly and barriers that isolate the poor.[1] The transition to the AHEAD model provides a unique window of opportunity to codify a system that prioritizes people over profit margins.

The Commission's work, concluding in 2029, will provide the legislative and regulatory roadmap for the next generation of health care in the state.[1] By addressing the physician shortage, reigning in drug costs, integrating behavioral health, and dismantling the health care divide, Maryland can move from a system of survival to one of health equity and excellence. The passage of HB 1367 will signal that Maryland puts its people first, ensuring that every resident has access to the care they need, regardless of their zip code, income, or stage of life. The time to act is now, as the cost of inaction is measured in the lives of the 1.1 million Medicare recipients predicted to die this decade because they cannot afford their medications.[1] Maryland must choose to lead.

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