Testimony on House Bill – Favorable

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

Senate Finance Committee

March 25, 2026

Dear Madam Chair and Members of the Committee:

My name is Rebecca Armendariz, MSW, LCSW-C; I'm a resident of Baltimore County and a clinical social worker. I am writing in support of HB 1112 from my position as a clinician and as a member of Progressive Maryland.

The Current Problem

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. As a healthcare provider with experience in oncology and hospice settings and providing psychotherapy services, these eliminating these gatekeeping agencies and the administrative burdens they cause would be a lifeline for care provision and access to care.

The Current Situation

We appreciate all that our state health officials have been doing to understand the implications of HR 1 and the ways in which Medicaid enrollees will need help to comprehend and meet the new work requirements. Maryland also needs to prioritize identification of new sources of significant revenue to offset the federal cuts and avoid cuts in services.

The Solution

HB 1112 offers a way to offset federal cuts and avoid cuts in services. It empowers 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. As a self-employed clinician, I am unable to accept

Medicaid as payment due to the administrative burden of their arcane claim submission process and navigating multiple payors.

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 This Strategy?

MCOs on average take about 13 cents of every Medicaid dollar for overhead and profits. The state would only need 3 to 4 cents on a dollar to administer and run our publicly funded Medicaid program. By removing the "middlemen" the state retains more of each Medicaid dollar which can then be directed towards patients, doctors and caregivers.

In addition to the extraordinary 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. After Connecticut's transition in 2012, the number of primary care physicians who participate in Medicaid rose by 14.6 percent. 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 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 this is not correct. 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.

Conclusion

We owe it to our kids, our seniors, our families, disabled people, healthcare workers, and our communities to move expeditiously to explore this option. The nine or ten cents from each Medicaid dollar that isn't going to MCOs can be used for the services and support people rely on to meet their healthcare needs.

At least four other states are actively working on similar legislation: Minnesota, Hawaii, Illinois, and West Virginia.

I urge you to give favorable consideration to this measure which will give the state a powerful way to respond to the harm of federal budget cuts.

Thank you,

Rebecca Armendariz, MSW, LCSW-C
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