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

FAV

Dear Madam Chair and Members of the Committee:

My name is John Spillane and I live in D-22 in Prince George's County. As you know, the 2025 Budget Reconciliation Act reduces federal Medicaid funding by $1 trillion over the next decade. The cuts will be particularly deep in Maryland 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. Medicaid is a lifeline for five out of eight nursing home residents.

I'm here to tell you that I have firsthand experience with this. Without Medicaid, it would not have been possible to find a nursing home to care for my mother in the final years of her life, due to her dementia. It's fair to say the 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.

Yes, we do 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 Commission to examine 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.

In fact, 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 3-4 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.

Just as important as 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 right now to explore this option. The nine or ten cents from each Medicaid dollar that doesn't go 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 practitioners and a decrease in denials are also worth pursuing.

Other states actively working on similar legislation include Minnesota, Illinois, New York, Hawaii, and Rhode Island.

For all these reasons I urge you to give Favorable consideration to HB1112. Let's reclaim the revenue we need to respond to the harm of federal budget cuts to Medicaid.

Thank you.

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