WRITTEN TESTIMONY

House Bill 1367 — Commission on Reimagining Healthcare in Maryland

Maryland General Assembly, Senate Finance Committee

Position: FAVORABLE WITH AMENDMENT

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I. Introduction

I am Santi KM Bhagat, a physician (MD, MPH) and founder of a voluntary non-profit organization that committed over twenty years of health policy advocacy in Maryland. Physician-Parent Caregivers (PPC) is a Maryland nonprofit think tank whose work has reached the CDC, Congress, and the pages of JAMA. The Invisible Wave is a growing social movement for young adults ages 18 to 40 who grew up managing childhood-onset chronic conditions and face a near-total absence of designed support across healthcare, higher education, and the workforce.

I submit this testimony in strong support of HB 1367, with one amendment request: that the Commission's composition explicitly include a representative of young adults living with chronic conditions — some call themselves Young Invisibles.

I come to this not only as a physician and policy advocate, but as a mother. My daughter developed epilepsy at age 8. She is now in her thirties and still cannot commit to full-time employment because of her condition. She did not fall through the cracks. She was never in the system at all — because no system was ever designed for her. Every Young Invisible I have met tells me how systems and society exclude them.

II. This Is a New Population — One Our Health System Was Never Designed to Serve

Our healthcare system was built for four life stages: children, adolescents, adults, and the elderly. Young adults as a distinct psychosocial and neurobiological developmental stage were never part of that architecture — and for most of history, they did not need to be. Young adults were, on the whole, healthy.

That is no longer true. Advances in pediatric medicine have ensured that millions of children with serious chronic physical and mental health conditions now survive into

adulthood. They arrive at age 18 with no system designed for them, no clinical roadmap, and no field of young adult medicine that claims them as patients.

One in three young adults in this country is managing a lifelong condition that began in childhood. That is not an edge case. It is a public health reality that Maryland's current health infrastructure has yet to confront.

The data bear this out — starting here in Maryland. The most recent National Survey of Children's Health (NSCH 2023–24) shows that **29.4% of Maryland adolescents ages 12 to 17 have special health care needs — above the national average of 27%.** Those conditions do not disappear at 18. A 2025 study by Dr. Lauren Wisk published in *Academic Pediatrics* found that **29% of young adults ages 18 to 25 are now living with a chronic condition, with an additional 80,000 young adults entering adulthood with a chronic condition every year.** Their families are already absorbing the cost: nationally, **1 in 5 caregivers of children with special health care needs has left a job or cut back hours because of their child's health — compared to fewer than 5% of caregivers of other children. For the most complex cases, that rises to 1 in 3.** (NSCH 2022–23, HRSA/MCHB National Data Brief.) This is not a future risk. **It is a present and growing burden — one that Maryland's health system is not yet designed to address.**

Young Invisibles do not need charity. **They need young adult health care designed for their stage of life — care that meets them where they are, stabilizes their conditions, teaches them self-management, and optimizes their health so they can do what every young adult is trying to do: learn, work and socialize.** Without that foundation, the rest of the system cannot reach them. Colleges cannot retain them. Employers cannot keep them. No workforce initiative, apprenticeship program, or higher education reform will close this gap if the underlying health infrastructure is missing.

III. Maryland Has Named This Problem. Now It Must Act.

Maryland did not miss the Young Invisibles. Maryland named them. Studied them. Documented them. The bipartisan, bicameral recognition this population has received in our state is without precedent anywhere in the nation:

- Senator Chris Van Hollen and Congressman Jamie Raskin introduced a joint congressional resolution calling on the nation to act on young adults with chronic health conditions.
- Lieutenant Governor Aruna Miller has championed inclusion of Young Invisibles across health, education, and workforce policy.
- Speaker Joseline Peña-Melnyk, Senators Mary Beth Carrozza and Brian Feldman, and Delegate Sarah Wolek have all advanced their cause in Annapolis.

That foundation is powerful. But continued inaction is not neutral. If Maryland now designs a healthcare reimagination commission without

explicitly including the population most failed by the current system, it will not be delivering on the promise of HB 1367. It will be decorating the same system.

Governor Moore and Lieutenant Governor Miller campaigned on a promise to Leave No One Behind. They are running on that promise again in 2026. **This Commission — if designed correctly — is precisely the vehicle to honor it.**

IV. Young Invisibles Are the Test Case for Every Purpose This Bill States

The policy note establishing this Commission sets out seven purposes for the reimagined health system it will design. Young Invisibles are not an add-on to those purposes. They are the population that will determine whether each one is achieved — or left unfinished.

1. "Entirely patient-centered." Young Invisibles are the patients most failed by the current system's design. A commission that does not include their voice is patient-centered in name only. Patient-centeredness at the system design level — the level at which this Commission operates — requires that those receiving care have a seat in the room where the architecture is drawn.

2. "An integrated system of care addressing all aspects of health — somatic, behavioral, dental, vision, and hearing — at every stage of life." Young Invisibles are the only population that tests integration across every one of these dimensions simultaneously. Their conditions are multi-system by definition — involving somatic, behavioral, and often sensory health — and they fall through the gap precisely because no integrated pathway exists at their stage of life. "Every stage of life" must mean young adulthood, or it means nothing.

3. "Founded in the concept of quality health care that provides support for the development of health care practitioners." There is no recognized field of young adult medicine in the United States. Pediatricians are trained to treat children. Internists are trained for adults. No specialty claims the 18-to-40 population managing lifelong pediatric-onset conditions. A commission serious about practitioner development must contend with this gap — and it cannot do so without the perspective of the patients who live inside it and their parents.

4. "Accessible to and eliminates barriers for all residents of the State." Young Invisibles face compounding barriers that no other demographic faces in the same combination: loss of pediatric coverage, no young adult specialty, inability to sustain employment that carries insurance, and a health system that treats their chronic conditions as resolved once they age out of pediatrics. Eliminating barriers "for all residents" is an empirical claim. The data say it is not yet true for this population.

5. "Agile enough to evolve as needs of patients evolve." Young Invisibles embody the need for agility. Their conditions are not static — they shift across decades throughout the life span, intersecting with education, employment, family formation, and aging. They are at risk of developing secondary mental and physical health conditions and early aging.

A system designed at a fixed moment for a static patient population will fail them. Agility must be built in from the design stage, informed by the patients who require it most.

6. "Financially sustainable." A health system that fails to optimize the health of 29% of its young adult population — the cohort entering peak workforce and tax-contributing years — is not financially sustainable. Without young adult healthcare, Young Invisibles will be sicker, have higher emergency room use and admissions, use more medications and treatments – all of which will compound over time. They will be unable to work and turn to state welfare.

Millennials and Gen Z already comprise over half the workforce. The caregiver employment data are a preview of what downstream costs look like when this population goes unsupported: families leave jobs, public programs absorb costs, and Maryland's economy loses productive workers at scale. Investing in young adult health care now is the fiscally responsible position.

7. "Designed to ensure that health care quality and access is stronger than the existing health care system." The existing system was never designed for Young Invisibles at all. "Stronger than the existing system" is a low bar if it means only improving what already exists for populations already served. A truly stronger system closes the gaps the current one never addressed. For 1 in 3 young Marylanders, that gap has never been closed.

V. Including Young Invisibles Is Not a Courtesy — It Is a Quality Standard

HB 1367 directs the Commission to create a health system that is "entirely patient-centered" and "accessible to and eliminates barriers for all residents of the State." These are not aspirational phrases. They are technical standards with a rigorous pedigree.

The Institute of Medicine's Crossing the Quality Chasm established patient-centeredness as one of six core aims of a quality health system, and explicitly applied that standard across all four levels of health system design: the patient encounter, clinical microsystems, organizations, and the policy and regulatory environment. This Commission operates at that fourth level.

Dr. Donald Berwick, founder of the Institute for Healthcare Improvement and the foremost interpreter of that framework, made the implication plain: genuine patient-centeredness requires "radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it."

Young Invisibles are typically brought into system design conversations after the conceptual architecture is already fixed — able to adjust the furniture, but not the floor plan. HB 1367 represents a rare ground-zero moment. To build Maryland's reimagined health system without the voice of the population most failed by its current design would not be reform. It would be the same system, redecorated.

VI. Maryland Can Lead the Nation — If It Moves Now

Maryland is positioned to be the first state in the nation to explicitly include young adults with chronic conditions in the reimagination of its health system. That is not a narrow constituency win. Every state will eventually recognize this invisible population. The oldest millennials are now in their forties. When our advocacy work began in 2009, they were 28. A generation has now aged through the gap with no services, supports or system of care.

Being first to lead on young adult health — to design infrastructure that works for the generation managing the most complex, least-served chronic condition burden in American history — would set a national model. Maryland's academic medical centers, its established legislative relationships, and this Commission itself are exactly the instruments to do it.

Many Maryland leaders are ready to be the first changemakers. The question is whether they will execute.

VII. Amendment Request

I respectfully urge the Committee to adopt an amendment to HB 1367 ensuring that the Commission's composition includes a representative of young adults living with chronic conditions.

This representative should be an expert on how the healthcare system can meet the needs of young adults with childhood-onset chronic conditions, and who can speak to the experience of transitioning from pediatric care into a system not designed for them. This is precisely the voice that has been absent from every prior iteration of health system design.

The Commission's mandate is to build a system that is patient-centered at every level of design. Including this voice is not a courtesy. It is a quality standard. It is what Crossing the Quality Chasm demands. It is what Dr. Berwick's interpretation of that framework requires. And it is what the one-in-three young adults who belong to this population — and their families — have been waiting for.

Thank you for the opportunity to submit this testimony. I am available to provide additional information, technical assistance, or testimony at the Committee's request.

Respectfully submitted,

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