Testimony in SUPPORT (FAV) of HB1112
HB1112 Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability
Senate Finance Committee | Hearing March 25th, 2026
Position: **FAVORABLE**

Dear Madam Chair and Members of the Committee:

My name is Mike Walsh and I have been a resident of Anne Arundel County for 35 years in Shady Side, and I am writing in support of HB1112 because at a time when our most vulnerable communities are under attack by our Federal government giving tax cuts to the rich at the expense of funding for life-saving health care, the state of Maryland is in a position to do better to serve its people through HB1112.

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.

Medicaid saves millions of lives every year, and in 2018 it saved mine. That's when I got the news that nobody wants to hear - cancer - and of course there's no good time for bad news, so being unemployed at the time of my diagnosis only made things more stressful and difficult to navigate. I was fortunate enough to have the guidance of direct care workers that could advise me to enroll in Medicaid, but was still met with challenges selecting which MCO to be covered by and almost selected the wrong one for the providers I was about to embark on my treatment with over the next two years. Luckily it worked out and even more fortunately I am still cancer free 6 years after my treatment was completed. That really shouldn't have been the case though, for myself or anyone that is going through a difficult health care experience, and at the root of the difficulty is a problem that the state could solve to make health care easily accessible to more people while also finding new sources of revenue to offset the impending federal budget cuts and avoid cuts in services.

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.

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 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.

We owe it to our kids, our seniors, healthcare workers, and our vulnerable communities 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 so-called work requirements. The other benefits like simplify the system for enrollees and providers and a decrease in denials are also worth pursuing

At least seven 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 HB1112 and reclaim the revenue we need to respond to the harm of federal budget cuts to Medicaid.

Thank you.

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