

HB1112 Testimony Senate Finance Committee.pdf

Uploaded by: Alankrita Olson

Position: FAV

For Senate Finance Committee

Hearing: Wednesday March 25th

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

Position: Favorable

Dear Madam Chair and Members of the Committee,

My name is Alankrita Olson. I am a preventive medicine physician residing in Maryland and a member of Physicians for a National Health Program. I am submitting this testimony in support of HB1112.

In light of the federal Medicaid cuts, Maryland has few options outside of raising taxes, reducing services, or cutting coverage, if additional revenue or savings cannot be identified. This bill is an opportunity to explore a solution for savings: removing Medicaid managed care organizations (MCOs). MCOs are supposed to assume the financial risk for Medicaid costs, reduce spending, and improve care coordination. The reality is far different. The state still covers costs for the sickest beneficiaries that MCOs leave out, while MCOs control their share of the risk by wasting money on administrative hurdles for patients and physicians alike.

From prior authorizations to appealing denials, physicians spend more time fighting the system than we do with our patients. The narrow networks created by MCOs also make it difficult to connect patients to specialists. Recently, a colleague shared the distress she was experiencing from getting a pediatric patient on Medicaid to a pediatric urologist as there was only one in their network which meant a 6 month wait. The distress of dealing with MCOs compounds day in and day out, leading many physicians and other healthcare workers to leave the field.

When Connecticut removed MCOs from Medicaid in 2012 they saw increased physician participation in the Medicaid Program, with a recent 97% physician satisfaction rating. More participating physician plus the eradication of narrow networks meant improved access to care for beneficiaries which led to better health outcomes, with a decline in ER visits and hospitalizations, and an increase in early cancer detection and cancer survival rates. More importantly, Connecticut has saved \$4 billion in Medicaid spending since then. If Maryland were to do the same, we could see a potential savings of \$521 million a year.

Connecticut utilizes administrative service organizations (ASO) to administer their Medicaid program, and Maryland does the same to administer behavioral services covered within the Public Behavioral Health System, which includes Medicaid beneficiaries. For Maryland, the use of an ASO for behavioral services was motivated by the desire to reduce practitioner administrative burden and to streamline payment, credentialing, and utilization review. This bill allows us to examine how Maryland can best administer a Medicaid FFS program that will reduce practitioner administrative burden and increase

access for patients. An ASO also provides an opportunity to standardize policy on authorization and reimbursement, and demonstrate transparency in financial and clinical decision-making, which is not possible with multiple MCOs.

Connecticut also implemented care coordination programs to improve access and health outcomes. Through the Total Cost of Care model, and now with the Achieving Healthcare Efficiency Through Accountable Design model, Maryland has been a champion of enhanced primary care delivery and improve care coordination for our Medicare population. The Hilltop Institute at the University of Maryland, Baltimore County found that relative to a matched comparison group of Medicare FFS beneficiaries in Maryland, the introduction of MDPCP was associated with significant reductions in Medicare expenditure and inpatient utilization as well as moderate reductions in ED utilization. Removing Medicaid MCOs provides an opportunity to improve care coordination for our Medicaid population as well.

To generate healthcare savings, help physicians provide better care, and improve access for patients, I urge the Health Committee to issue a favorable report on HB1112.

HB1112 Senate Testimony - Google Docs.pdf

Uploaded by: Ann Gordon

Position: FAV

Testimony For Senate Finance Committee Hearing:
Wednesday March 25th

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

FAV

Madam Chair and Members of the Committee:

My name is Jacqueline MacMillan. I am a member of Progressive Maryland's Healthcare Taskforce, and I live in Baltimore.

HB1112 provides that the Health Insurance Coverage Protection Commission consider whether to adopt a direct payment, fee-for-service model for the Maryland Medical Assistance Program, or Medicaid. Under Maryland's current Medicaid system, 85% of patients receive healthcare coverage through Managed Care Organization (MCOs).

Medicaid MCOs, like other private insurers, restrict the providers that patients can see. And it is well documented that provider directories are often outdated and inaccurate. This causes a variety of problems, from difficulty finding specialists, and harmful delays in needed care, to surprise bills that result when a patient sees a provider who was incorrectly identified as "in network."

Restrictive networks are particularly problematic for Medicaid patients enrolled in MCOs because provider participation rates are already so low. Only 75% of providers take Medicaid patients, compared to 88% for Medicare, and 94% for private insurance.

In 2023, Qlarant, Maryland's external Medicaid quality review organization, evaluated the [network adequacy](#) of Maryland's nine Medicaid MCOs to ensure they could provide enrollees with timely access to necessary care and a sufficient

number of in-network providers. The telephone surveyors were unable to *even reach* 40% of the MCOs' network providers.

Qlarant's surveyors' task was to verify: the accuracy of online provider directories; provider acceptance of the listed MCO; acceptance of new Medicaid patients; and first availability for routine and urgent appointments. Based on the 2023 assessment, six of the nine MCOs were required to submit Corrective Action Plans to Qlarant to improve compliance.

Transitioning from Managed Care to a direct, fee-for-service mode of payment would benefit Medicaid patients by eliminating restrictive provider networks. All qualified Medicaid providers would be available to all Medicaid enrollees, affording patients a much larger pool from which to find appropriate specialists.

The state of Connecticut moved from managed care to a fee-for-service model in 2012, and saw a significant increase in the number of providers taking Medicaid patients. The reduction in paperwork from the nine MCOs in Maryland to a single payer would attract providers by making the administration of Medicaid simpler and less expensive, as it did in Connecticut.

There are many good reasons for Maryland to transition to a direct fee-for-service payment system for Medicaid, which should be thoroughly explored by state officials. These include significant cost savings to the state and greater transparency, as demonstrated by Connecticut's experience, better access to care for Medicaid patients—fewer care and claim denials, more providers taking Medicaid, the elimination of restrictive networks—and better health outcomes.

I urge you to give favorable consideration to HB1112.

Thank you,
Jacqueline MacMillan

HB 1112 Sponsor Testimony in Support - FIN.pdf

Uploaded by: Bonnie Cullison

Position: FAV

BONNIE CULLISON
Legislative District 19
Montgomery County

Vice Chair, Health Committee

Subcommittees

Chair, Insurance

Pharmaceuticals

Rules and Executive
Nominations Committee

House Chair

Joint Committee on Legislative Ethics



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THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

Testimony in Support of HB 1112

**Health Insurance Coverage Protection Commission –
Study on Individual and Group Health Insurance Market Stability**

Good afternoon, Chair Beidle Vice Chair Hayes and honorable members of the Senate Finance Committee. Thank you for this opportunity to present HB 1112 – **Health Insurance Coverage Protection Commission – Study on Individual and Group Health Insurance Market Stability**. This bill takes advantage of a commission we already have in place to address ways to support our current health care coverage models.

The Maryland Health Insurance Coverage Protection Commission was established in law with the passage of HB718 in 2025. The bill identified a comprehensive set of charges to monitor, assess and make recommendations relating to the federal changes to the Affordable Care Act (ACA), Mental Health Parity and Addition Equity Act (MHPAEA), Medicaid programs, the Maryland Children’s Health Program, Medicare, or the Maryland All-Payer Model.

While the Commission has not yet begun its work, due to delays in identifying members, there is intention for the first meeting to be in May 2026.

In the meantime, we have already seen some changes at the federal level that threaten access to care for Maryland residents. These include the changes in our all payor model for hospitals in the withdrawal of the Medicare pass through funds, beginning in 2028. In addition, the passage of H.R. 1 in 2025 shifts administrative costs to the states and eliminates options for collecting funds to cover state Medicaid share in the short-term. The leadership of the Maryland Health Benefit Exchange and the Department of Health report that they are monitoring rule changes at the federal level every day and they anticipate more significant impact over time.

In October 2025, the then Chair of the Health and Government Operations committee convened a group of delegates, and current and past leaders in the health care arena, for the purpose of brainstorming policy and legislative options for a public option or other health system transformations to address rising uninsurance rates and coverage instability in Maryland.

The outcome of that discussion was that a public option may not be the most beneficial approach, due to the fact that Maryland's all-payer hospital rate setting compresses the pricing gap between Medicaid and commercial rates. In states like WA, CO, NM, large hospital rate differentials (25–30%) made public options effective. In Maryland, the gap is ~7%, limiting potential premium reductions to perhaps 10–15%. Our reinsurance program already achieved significant rate relief; this fund is “under siege” but remains vital at this point.

In response to the public option question, the group felt that an actuarial analysis comparing Medicaid and commercial rates to estimate realistic premium savings would be helpful. We could explore regulatory exemptions to allow Medicaid MCOs to sell in the individual market without meeting full insurer capital requirements. So, we left the meeting with the need for more information.

The composition of the Commission includes significant knowledge and expertise about health care and health care economics in our state.

HB1112_Study on Individual and Group Health Insura

Uploaded by: Cecilia Plante

Position: FAV



**TESTIMONY FOR HB1112 – Health Insurance Coverage Protection Commission –
Study on Individual and Group Health Insurance Market Stability – FAVORABLE**

Bill Sponsor: Delegate Cullison

Committee: Health and Government Operations

Organization Submitting: Maryland Legislative Coalition

Person Submitting: Jessica Gorski, Executive Committee

Position: FAVORABLE

Chair, Vice Chair, and Members of the Committee,

My name is Jessica Gorski, and I am submitting this testimony in strong support of HB1112 on behalf of the Maryland Legislative Coalition. Our coalition represents more than 30,000 Marylanders across every legislative district, united by a commitment to ensuring that state policy protects people’s health, stability, and well-being. We believe that the government has a responsibility to act proactively, especially when Maryland families’ access to healthcare is at stake. HB1112 does exactly that.

This bill strengthens Maryland’s ability to maintain stable, affordable health insurance markets by expanding the responsibilities of the Health Insurance Coverage Protection Commission. HB1112 requires the Commission to study and make recommendations regarding the stability of both the individual and group health insurance markets—an essential step as Maryland continues to navigate rising healthcare costs, federal uncertainty, and persistent coverage gaps.

These improvements are not theoretical. They are urgently needed.

Maryland families and small businesses continue to face volatility in premiums, deductibles, and plan availability. Without proactive monitoring and evidence-based recommendations:

- Premiums may rise unpredictably, putting coverage out of reach
- Small employers may struggle to offer competitive health benefits
- Market disruptions could reduce plan choice and network adequacy
- Vulnerable populations may face disproportionate impacts
- Maryland could lose ground on the progress it has made in expanding coverage

HB1112 ensures that Maryland remains vigilant, data-driven, and prepared. By directing the Commission to analyze market trends, identify emerging risks, and recommend policy solutions, this bill helps safeguard the affordability and stability of coverage for millions of Marylanders.

This legislation aligns squarely with the mission of the Maryland Legislative Coalition. It strengthens healthcare access, advances public safety, supports economic stability for families and employers, and ensures that Maryland continues to lead with thoughtful, proactive health policy.

No Marylander should lose access to healthcare because policymakers lacked the information needed to act. HB1112 ensures that doesn't happen.

Thank you for your time and consideration. **We respectfully urge a FAVORABLE report on HB1112.**

HB1112 - Senate_FAV_MACHC_HI Cov. Protection Comm.

Uploaded by: Christine Krone

Position: FAV



Senate Finance Committee

March 25, 2026

House Bill 1112 – *Health Insurance Coverage Protection Commission – Study on Individual and Group Health Insurance Market Stability*

POSITION: SUPPORT

The Mid-Atlantic Association of Community Health Centers (MACHC) is the federally designated Primary Care Association for Delaware and Maryland Community Health Centers. As the backbone of the primary care safety net, Federally Qualified Health Centers (FQHCs) are united by a shared mission to ensure access to high-quality health care to all individuals, regardless of ability to pay. FQHCs are non-profit organizations providing comprehensive primary care to the medically underserved and uninsured. MACHC supports its members in the delivery of accessible, affordable, cost effective, and quality primary health care to those most in need. To this end, **MACHC strongly supports House Bill 1112**. This bill addresses a critical need to strengthen the financial and operational sustainability of Maryland’s 16 FQHCs, essential access points for comprehensive primary care throughout the State.

Maryland’s FQHCs deliver comprehensive, primary care to underserved populations regardless of ability to pay. As safety-net providers, FQHCs are facing mounting pressures associated with workforce shortages, escalating operational costs, and increasing patient acuity. A study examining sustainable funding mechanisms, particularly through targeted safety-net grant investments, is both timely and necessary.

This study is a valuable opportunity for Maryland to identify innovative, scalable funding models that enhance long-term financial stability for FQHCs and preserve high-quality, community-based primary care. Strengthening FQHC sustainability supports continuity of care, reduces avoidable emergency department utilization and hospitalizations, and improves population health outcomes.

MACHC strongly endorses House Bill 1112 and encourages efforts to increase understanding of community health center financial needs and the Maryland health insurance market. The association stands ready to support this effort through information sharing and stakeholder engagement and welcomes opportunities to contribute input that may help inform the study’s development and findings. Ensuring the long-term sustainability of Maryland’s FQHCs is essential to maintaining a resilient, high-performing, and accessible healthcare system. We urge a favorable vote.

For more information call:

Christine K. Krone
Danna L. Kauffman
410-244-7000

HB 1112 Written Testimony.pdf

Uploaded by: Crystal Parker

Position: FAV

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

Dear Madam Chair and Members of the Committee:

My name is Crystal Parker, and I live in Baltimore City. I am writing in **FAVOR** of HB1112

The 2025 Budget Reconciliation Act reduces federal Medicaid funding by \$1 trillion over the next decade. The cuts will be particularly deep in our state in 2027 and 2028. Medicaid is a lifeline for **1 out of 4** Marylanders, including children and low-income families, people with disabilities, the elderly and working adults who don't have affordable insurance options, as well as every **5 out of 8** nursing home residents.

I was one of those children diagnosed with a debilitating chronic illness. My elder grandmother was able to navigate our working-class low-income family only with the help of Medicaid. In its absence, there is a grave likelihood that I might not be here to share the story. It is still tough today as I advocate for others to witness decisions made to choose between medicine, food, and mortgage/rent. Unfortunately, this is a shared reality for far too many.

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. Healthcare in and of itself should be a human right.

We 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.

I urge you to vote in **FAVOR** of HB1112

Thank you for your time

Crystal Parker

DRM Written Testimony FWA HB 1112.pdf

Uploaded by: Daria Pugh

Position: FAV



Empowering People to Lead Systemic Change
The Protection and Advocacy System for the State of Maryland

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
DisabilityRightsMD.org

Senate Finance Committee
HB 1112: Health Insurance Coverage Protection Commission - Study
on Individual and Group Health Insurance Market Stability
March 25, 2026
Support with House Amendments

Disability Rights Maryland (DRM), the state's designated Protection and Advocacy agency, defends and advances the rights of people with disabilities. DRM works to expand opportunities for Marylanders with disabilities to achieve community integration and access to high-quality, affordable healthcare. DRM supports HB 1112 as passed by the House, including the provision requiring the Maryland Medical Advisory Committee to establish a workgroup to study the transition to a fee-for-service (FFS) delivery model for all Medicaid services.

HB 1112 comes at a critical time for the 1.7 million Marylanders who rely on Medicaid.¹ The Maryland Department of Health is projecting unprecedented federal cuts to Medicaid—potentially approaching 20 percent of the state's Medicaid current funding.² In this environment, Maryland must carefully manage costs while preserving beneficiaries' access to quality care. HB 1112 establishes a workgroup to study adopting a FFS model, which would likely increase state savings on Medicaid.

Since 1996, most Maryland Medicaid recipients have received coverage through managed care organizations (MCOs).³ MCOs are private insurance plans that receive a fixed, per-member fee from the state to cover necessary care for enrollees. Even with federal and state oversight, this system can create incentives for companies to undertreat or deny care to recipients to maximize profits.⁴ In contrast, under the FFS model, the state reimburses

¹ The Hilltop Institute, Maryland Medicaid Dataport, *Medicaid Enrollment*, https://hilltopinstitute.org/public-dataport/#pac_dtm_child_3.

² Danielle Brown, *Health official warns that future Medicaid cuts could lead to \$2.7 billion loss in federal funding*, Maryland Matters (January 29, 2026), <https://marylandmatters.org/2026/01/29/health-official-warns-that-future-medicaid-cuts-could-lead-to-2-7-billion-loss-in-federal-funding/>.

³ Some populations receive services through FFS, including those on Medicaid services waivers, rare and expensive case management and the community first choice programs.

⁴ Three of Maryland's nine MCO parent companies are in the top 20 of the S&P Fortune 500. UnitedHealthcare Community Plan parent company, United Healthcare is #3; Aetna Better Health of Maryland's parent company, CVS Health, is #6; Wellpoint's parent company, Elevance Health, is #15. All three MCOs had prior authorization denial rates above 27%.

providers directly for each service provided. Connecticut's Medicaid program transition from MCO to FFS delivery in 2011. A recent study found that Connecticut now spends 14 percent less per enrollee than the Northeastern average while maintaining access to care comparable to national benchmarks.⁵

DRM strongly recommends that the workgroup also evaluate how a FFS model would affect Medicaid recipients' access to timely, quality care. MCOs nationwide, including in Maryland, have concerning high rates of prior authorization denials, which can delay or prevent access to medically necessary care.⁶ Although recipients are entitled to an internal appeal and a Medicaid fair hearing when denied services, only about 11 percent of prior authorization denials are appealed nationwide.⁷ In Maryland, the MCO appeals process is often slow and complex, frequently taking months, or even up to a year, for recipients to obtain approval for medically necessary services. When appeals are pursued, a substantial share of denials are overturned: for five Maryland MCOs, over 50 percent of appeals are overturned in favor of the recipient.⁸

For these reasons, DRM requests a favorable report on HB 1112 as amended by the House. Thank you for your consideration of this bill.

Contact: Daria Pugh, Esq. at DariaP@DisabilityRightsMD.org or (443) 692-2487.

⁵ Connecticut Department of Social Services, *Medicaid Landscape Analysis*, https://portal.ct.gov/dss/home/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf (December 2024).

⁶ Christi Grimm, Inspector General, Department of Health and Human Services Office of Inspector General, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*, <https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicare-managed-care/> (July 17, 2023); Maryland Department of Health, *Medicaid Managed Care Organization Grievances, Appeals, & Denials Focused Review Report Measurement Year 2024*, (<https://health.maryland.gov/mmcp/healthchoice/Documents/MY2024-Grievance-Appeals-Denials-Annual-Report.pdf>), (July 2025).

⁷ *Id.*

⁸ Maryland Department of Health, *Medicaid Managed Care Organization Grievances, Appeals, & Denials Focused Review Report Measurement Year 2024*, (<https://health.maryland.gov/mmcp/healthchoice/Documents/MY2024-Grievance-Appeals-Denials-Annual-Report.pdf>), (July 2025) (Jai Medical Systems, Inc. at 78%, MedStar Family Choice, Inc. at 71%, CareFirst Community Health Plan at 66%, UnitedHealthcare Community Plan at 53% and Kaiser Permanente of the Mid-Atlantic States, Inc. at 52%).

HB 1112 Testimony_ Donna Ticknor_ 03.23.2026.pdf.p

Uploaded by: Donna Ticknor

Position: FAV

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

Hearing Date: 03/25/2026

Position: FAV

From: Donna Ticknor, MD; Anne Arundel County, District 33B

Date: 03/23/2026

Dear Madam Chair and Members of the Health Committee:

My name is Dr. Donna Ticknor and I live in District 33 B. I have been a Maryland resident for 28 years. I practice medicine throughout the State of Maryland and have been a practicing physician for over 25 years.

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.

We 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. Maryland 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 using 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.

On average, MCOs take 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 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 choose from a unified statewide network of Medicaid providers.

Connecticut has found that a simplified, unified Medicaid system has helped draw physicians into the program. When there is less time-consuming paperwork and bureaucratic, clinicians are

more likely to choose to serve Medicaid patients. Decreasing clinically inappropriate insurance denials and the administrative burden that takes away time from directly treating patients will reduce the Moral Injury that drives clinicians away from participating in Medicaid programs and also leaving the healthcare profession.

<https://pnhp.org/understanding-moral-injury-in-health-care/>

<https://pnhp.org/removing-the-middlemen-from-medicaid/>

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, however, 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.

Currently, Maryland Medicaid programs struggle to enroll an adequate number of mental health clinicians, especially psychiatrists and specialized mental health clinicians. By simplifying the process of using one state-run Medicaid program, it will reduce the cost and the administrative burden to solo mental health clinicians and small mental health clinics and encourage more participation. It will also reduce the number of unnecessary prior authorizations and profit-driven mental health care denials. This improves the care and choice of Medicaid recipients.

We owe it to our children, our seniors, healthcare workers, and our most vulnerable residents to move expeditiously to explore this option. The 9 or 10 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 "work requirements."

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 this amendment and reclaim the revenue we need to respond to the harm of federal budget cuts.

Thank you.

Respectfully submitted,

Donna Ticknor, MD

Riva, Maryland, Anne Arundel County, District 33B

Licensed to practice medicine in Maryland and DC

ABPN Board-certified Adult Psychiatry

APA/MPS member and fellow

Progressive Maryland Healthcare Taskforce Member
Physicians for a National Health Plan, MD/DC chapter member
Committee to Protect Health Care, advocate member
Committee to Protect Public Mental Health, Vice Chair

HB1112 FAV Spillane testimony.pdf

Uploaded by: John Spillane

Position: FAV

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.

John Spillane
6110 43rd St
Hyattsville, MD 20781

2026 MdAPA HB 1112 Senate Side.pdf

Uploaded by: Michael Paddy

Position: FAV



To: Senate Finance Committee

Bill: House Bill 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability

Date: March 23, 2026

Position: Favorable

The Maryland Academy of Physician Assistants strongly supports House Bill 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability. The bill expands the scope of the Health Insurance Coverage Protection Commission to study ways to stabilize and reduce costs in Maryland's individual and small group health insurance markets. The bill directs the Commission to analyze options such as creating a public insurance option, merging insurance markets, adjusting regulations for managed care organizations, and forming interstate purchasing agreements. It also requires evaluation of strategies to lower prescription drug costs, strengthen reinsurance programs, and support Federally Qualified Health Centers.

Physician assistants support the bill because it directs a commission to study ways to stabilize the health insurance market, which could lead to more affordable and predictable coverage for their patients. More stable insurance markets can reduce gaps in coverage and improve continuity of care, making it easier for PAs to manage treatment plans without frequent disruptions due to insurance changes. The bill also promotes examination of strategies to control prescription drug costs and support safety-net providers, which aligns with many PAs' goals of improving access and reducing financial barriers to care. Finally, by evaluating market reforms and potentially strengthening risk pools, the bill could help ensure that more patients are insured and able to seek care from PAs when needed.

We ask for a favorable report. If any additional information would be helpful, please contact Michael Paddy at mpaddy@policypartners.net.

Senate Testimony.pdf

Uploaded by: Michael Santome

Position: FAV

To: Senate Finance Committee

Hearing Date: Wednesday, March 25th

Bill: HB 1112 - Health Insurance Coverage Protection Commission

Position: FAVORABLE

Dear Madam Chair and Members of the Committee:

My name is Michael Santome, and I am a healthcare professional residing in Bel Air, Harford County. I am writing to urge a favorable report on HB 1112.

As a Nurse Case Manager working with a team of frontline clinicians, we see the cracks in our healthcare system every single day. The 2025 Budget Reconciliation Act threatens to reduce federal Medicaid funding drastically over the next decade, putting our most vulnerable patients, such as children, the elderly, and those with disabilities, at extreme risk. We cannot simply accept cuts to patient care; we must identify new sources of revenue and eliminate bureaucratic waste.

The sponsor amendment for HB 1112 empowers the state to study transitioning away from our current reliance on middleman Managed Care Organizations (MCOs) in favor of a direct payment, fee-for-service model. Current estimates show that Maryland could save up to \$521 million annually by making this transition. MCOs currently take roughly 13 cents of every Medicaid dollar for overhead and profits, whereas the state would only need about 3 cents to administer the program directly.

But beyond the massive financial savings, we need this transition for the sake of patient safety and clinical integrity.

Under the current MCO model, healthcare professionals spend an exorbitant amount of time fighting administrative red tape, navigating narrow networks, and battling terrible track records of care denials. Instead of worrying if a vital medication or procedure is covered by a patient's specific MCO, a unified statewide system would allow us to actually focus on treating the patient.

When you decrease the paperwork and eliminate the bureaucratic complexity of dealing with multiple MCOs, clinicians are much more likely to accept and serve Medicaid patients.

By removing the middleman, we keep healthcare dollars at the bedside where they belong. I urge you to vote FAVORABLE on HB 1112 so we can protect our patients and our state's healthcare infrastructure.

Thank you,

Michael Santome, RN, BSN

Nurse Case Manager | Healthcare Advocate

Bel Air, Maryland

410-322-5195 | Michael.Santome87@gmail.com

HB1112 Testimony SUPPORT (FAVORABLE) Mar 25th 2026

Uploaded by: Michael Walsh

Position: FAV

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.

Michael Walsh
District 30B
walsh2.michael@gmail.com
410-353-2756

Progressive Maryland HB1112 Testimony_ Senate Fina

Uploaded by: Patty Snee

Position: FAV



March 23rd, 2026

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

Position: FAV

Dear Madam Chair and Members of the Committee:

My name is Patty Snee and I'm on the staff of Progressive Maryland where I lead our grassroots organizing and coalition building on health care issues.

I am writing to offer favorable testimony for HB1112 on behalf of Progressive Maryland, a statewide nonprofit issue advocacy organization.

Since April of last year, Progressive Maryland along with our national affiliate People's Action has been involved in the massive national effort to stop Medicaid funding cuts and the imposition of burdensome work requirements that will lead to tens of thousands of Marylanders losing Medicaid coverage.

I'm sure you're familiar with the facts and figures. The 2025 Budget Reconciliation Act reduces federal Medicaid funding by \$1 trillion over the next decade. The cuts will be particularly deep and difficult to handle 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.

We're grateful for the tireless efforts of our state health officials to mitigate the harm that the 2025 federal budget is going to inflict on our most vulnerable residents. We've been talking to and surveying our members around the state since last summer, from the Eastern Shore to Western Maryland and in some of our largest counties and cities. As you can imagine there's a great deal of fear, confusion, and anger about what's going to happen to Medicaid. One member, Jennifer, told us this:

“My son, who we fostered to adopt, was born with health problems, and he has been on Medicaid since birth in order to ensure he will always be able to get healthcare to address the conditions he was born with. If cuts are made to Medicaid, then American families may not be willing to take the financial risk of adopting kids with medical needs.”

There are just so many negative consequences with these cuts.

People want to know what the state is doing to find the revenue we need to protect enrollees and everyone who will be impacted. We tell them about what Connecticut did back in 2012 when they transitioned from using private Managed Care Organizations to a fee-for-service model to manage Medicaid. Connecticut, by all accounts, has saved \$4 billion since making the transition.

Almost to a person they say, can Maryland do that? We tell them yes, we are going to advocate for legislation that lets us follow Connecticut's lead.

The recent white paper from Physicians for A National Program estimates that our state could save up to \$521 million annually if we took this action.

How and why would this happen? 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 the support the state will need to provide to keep people enrolled.

Transitioning away from an MCO model would also simplify the lives of Medicaid enrollees who would not have to endure the stress of trying to choose a plan from multiple MCOs. The state, Medicaid enrollees, and clinicians would all benefit from a direct payment model where there is far less paperwork and bureaucratic complexity to deal with, not to mention care delays and denials.

The dollars not being funneled to MCOs can be used for people’s healthcare treatment, to fund state eligibility operations, and expand the pool of local health department navigators we need to help people keep up with the new “work requirements.”

States like Wisconsin, Rhode Island, Illinois, Minnesota and New York are also looking at the Connecticut example and considering similar legislation.

I urge you to give favorable consideration to this legislation which has unanimously passed the House chamber, and will empower this Commission to address the health insurance affordability crisis as well as the Medicaid funding crisis both in the short term and for the long haul.

Thank you.

Patty Snee
Takoma Park, Maryland

- Link to White Paper published by Physicians For A National Health Program 2025

[PNHP research paper on Removing the Middlemen from Medicaid](#)

HB1112-Senate-Testimony-RArmendariz.pdf

Uploaded by: Rebecca Armendariz

Position: FAV

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,

A handwritten signature in black ink, appearing to read 'R. Armendariz', written in a cursive style.

Rebecca Armendariz, MSW, LCSW-C
District 11B
Baltimore County, Maryland

HB1112 crossover bill - FAV - Health Insurance Cov

Uploaded by: Richard KAP Kaplowitz

Position: FAV

HB1112_CrossoverBill_RichardKaplowitz_FAV

03/25/2026

Richard Keith Kaplowitz

Frederick, MD 21703

TESTIMONY ON CROSSOVER BILL HB#1112- POSITION: FAVORABLE

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

TO: Chair Beidle, Vice Chair Hayes, and members of the Finance Committee

FROM: Richard Keith Kaplowitz

My name is Richard Keith Kaplowitz. I am a resident of District 3, Frederick County. I am submitting this testimony in support of crossover bill HB#1112, **Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability**

This bill changes the duties of the Health Insurance Coverage Protection Commission.

The Medicare Rights Center is reporting that *States Already Cutting Medicaid, Massive Federal Cuts Yet to Come*¹

The budget reconciliation bill, HR 1, [contained drastic cuts to states' Medicaid funding and coverage](#). While most of these cuts have not yet gone into effect, many states are already fearing [economic downturns or recession](#) spurred in part by rising costs and tariffs. In response, some of these states have [already started cutting Medicaid spending](#), leading to access issues for people who get vital coverage from the program. In many areas, finding Medicaid providers can be difficult. [Medicaid's payment rates are lower than Medicare's](#) or other insurance and may [drive some providers away from treating patients with Medicaid coverage](#).

The American Medical Association tracks *Trends in health care spending* and notes it is rapidly becoming increasingly expensive.²

Here in Maryland, 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. Maryland also needs to identify new sources of significant revenue to offset the federal cuts and avoid cuts in services. Other states have implemented solutions that remove the use of middlemen Managed Care Organizations (MCOs) in favor of a direct payment system or fee-for-service model. 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.

HB1112_RichardKaplowitz_FWA

¹ [https://www.medicarerights.org/medicare-watch/2025/10/02/states-already-cutting-medicaid-massive-federal-cuts-yet-to-come#:~:text=Over%20ten%20years%2C%20Medicaid%20will%20lose%20\\$930,funding%20tax%20cut%20for%20the%201%25%20which](https://www.medicarerights.org/medicare-watch/2025/10/02/states-already-cutting-medicaid-massive-federal-cuts-yet-to-come#:~:text=Over%20ten%20years%2C%20Medicaid%20will%20lose%20$930,funding%20tax%20cut%20for%20the%201%25%20which)

² <https://www.ama-assn.org/about/ama-research/trends-health-care-spending>

HB1112_RichardKaplowitz_FWA

It is estimated that 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 simplifying the system for enrollees and providers and a decrease in denials are also worth pursuing. At least seven other states are looking at this solution.

It is incumbent on Maryland to examine the problems we see now and can see coming down the road to find best practices to deal with the situation.

This bill will require the Maryland Medical Advisory Committee to form subcommittees and workgroups, as necessary, to carry out the duties of the Committee; establishing the Workgroup to Study the Adoption of a Fee-for-Service Model for all Medicaid Services to study the feasibility of implementing a direct care payment model throughout the State's Medicaid program; and requiring the workgroup to report its findings and recommendations to the Advisory Committee and certain members of the General Assembly by January 1, 2027. This mission amendment for this bill as written will alter the duties of the Health Insurance Coverage Protection Commission to require the Commission's deferral to the Maryland Medical Advisory Committee to study and make recommendations regarding individual and group health insurance market stability.

This report can guide Maryland's Governor and General Assembly in the creation of solutions to identified problems and challenges.

I respectfully urge this committee to return a favorable report on crossover bill HB#1112.

HB1112_FAV_DeMarco_MHCFA.pdf

Uploaded by: Vincent DeMarco

Position: FAV



TESTIMONY IN FAVOR OF HOUSE BILL 1112

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

Before the Senate Finance Committee

By Vincent DeMarco, President, Maryland Health Care for All

March 25, 2026

Chair Beidle, Vice-Chair Hayes, and Members of the Finance Committee, thank you for the opportunity to submit supportive testimony for HB 1112, and special thank you to Vice-Chair Cullison for sponsoring this bill. The Maryland [Health Care For All Coalition](#) brings together hundreds of faith, community, labor, health care and business groups from across the state working to achieve access to quality, affordable health care for all Marylanders. We thank this Committee for your leadership in protecting and expanding access to health care coverage in Maryland.

We are grateful that in 2025 the Maryland General Assembly and Governor Moore passed legislation to create a Health Insurance Coverage Protection Commission (HICPC) modeled on the HICPC that was created in 2017 to respond to federal threats to health care access. We applaud that HB 1112 includes identifying ways to sustain and increase premium assistance in the individual market in its list of policies that the HICPC should consider to stabilize the individual and group health insurance markets.

Maryland has enacted several successful premium assistance programs in past years. The Young Adult Health Insurance Subsidy Program established in 2022 was made permanent subject to available funding in 2025. It increases young adult enrollment which helps stabilize premiums for everybody else by bringing healthier adults into the risk pool, improves the quality of plans that young adults can afford, and improves health equity by race and ethnicity.

The State-Based Health Insurance Subsidies Program was established in 2025 and is currently helping low-to-moderate income Marylanders to continue to afford their [health coverage](#) in the individual market for plan year 2026 after their enhanced advance federal premium tax credits (ATPCs) were terminated by Congress.

Both of these programs face challenges in the coming years, and many Marylanders whose enhanced APTCs were terminated have had to drop their coverage or downgrade to plans with lower metal levels. It is critical that the HICPC study how to sustain and increase premium assistance.

We urge a favorable report for House Bill 1112. Thank you for your consideration.

HB1112-Testimony-Health-Insurance-Coverage-Protect

Uploaded by: Yvette Delph

Position: FAV

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

Position: FAVORABLE

To: Senate Finance Committee

Hearing Date: Thursday, March 25, 2026

Dear Chair Beidle and Members of the Senate Finance Committee:

My name is Yvette Delph and I am a retired physician living in Silver Spring, District 19. I am a member of Progressive Maryland's Health Care Task Force. I respectfully request your support of HB1112. This bill would require the Health Insurance Coverage Protection Commission to consider whether to adopt a direct payment system or fee-for-service model for all services covered by the Maryland Medical Assistance Program, or Medicaid.

According to the Department of Health (https://health.maryland.gov/mmcp/Documents/OBBBA%20One-Pager_7.11.25.pdf), will lose up to \$2.7 billion in federal funding annually when all provisions of HR 1 (One Big Beautiful Bill Act) are implemented, with the majority of funding losses incurred between July 2026 and June 2028. Tens of millions of additional dollars will be needed to implement and administer HR 1 requirements, particularly those pertaining to eligibility changes such as work requirements. Maryland needs needs urgent solutions because Medicaid is a lifeline for one in four Marylanders, including half of our children, 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. Marylanders are living in fear that they, or someone they love or care for, will lose Medicaid and the essential medical care they need.

A report recently published by Physicians for a National Health Program estimates that the establishment of a fee-for-service model for all Medicaid services would save Maryland up to \$521 million every year, based on 2023 expenditures (<https://pnhp.org/removing-the-middlemen-from-medicaid/#appendix-f>). Medicaid expenditures for 2023 published by the Maryland Department of Health (<https://health.maryland.gov/mmcp/Documents/JCRs/2025/MLRJCR9-25.pdf> Table 1), show that the nine managed care organizations providing healthcare for Medicaid enrollees in Maryland received more than \$1 billion in administrative expenses and profits, or 13 cents of every dollar they received. Maryland could administer Medicaid directly for 3 cents on the dollar.

Since Connecticut implemented such a system in 2012, it has saved \$4 billion, spends 14% lower than the Northeastern average per Medicaid enrollee, and has lower administrative spending rates compared with the average of states using a managed care model (3.8% vs 9.4%). Connecticut has also seen the number of primary care physicians who participate in Medicaid increase by 14.6% and, even without an increase in reimbursement rates, participating specialists increased by 11%. Connecticut contracts with administrative service organizations that were selected via competitive bid to provide, at the direction of the state, administrative services only. As Connecticut experienced, when bureaucratic complexity, paperwork, denials and delays of care, and provider payment delays are reduced, clinicians are more likely to choose to serve Medicaid patients, and enrollees are more satisfied with the state's Medicaid program. At least seven other states are actively working on similar legislation—Hawaii, Illinois, Minnesota, New York, Rhode Island, West Virginia, and Wisconsin—and three others are considering it.

The direct payment model would be a win-win-win solution for Medicaid patients, providers, and the state. It would help to avoid cuts to critical services that could harm Marylanders and prevent unnecessary increases in the number of residents without health insurance—while

improving efficiency, cost-effectiveness, and enrollee and provider satisfaction. It is incumbent on Maryland to examine this cost-saving alternative and how best to implement it throughout Maryland's Medicaid program.

As you consider the difficult choices you are being forced to make in the face of the HR 1 provisions, I urge you to give favorable consideration to HB1112 that will provide you with objective data on how you can optimize our Medicaid program.

Sincerely,

Yvette Delph, MBBS, DA
14907 Running Ridge Lane
Silver Spring, MD 20906

2

crossfile HB1112 Berger.pdf

Uploaded by: Zackary Berger

Position: FAV

For Senate Finance Committee
Hearing: Wednesday March 25th

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

FAV with Sponsor Amendments

Dear Madam Chair and Members of the Committee:

I am a primary care physician in Baltimore City. Many of my patients depend on Medicaid and its services. Medicaid cuts are dangerous for public health and individual health.

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.

My patients are vulnerable, with chronic conditions, and will be hurt by Medicaid cuts.

We 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 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.

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 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 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 “work requirements.” Additional benefits like simplifying the system for enrollees and providers and a decrease in denials are also worth pursuing.

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 this amendment and reclaim the revenue we need to respond to the harm of federal budget cuts.

Thank you.

Zackary Berger MD PhD
21218

MMCOA Comments on House Bill 1112.pdf

Uploaded by: Joseph Winn

Position: UNF



House Bill 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability

UNFAVORABLE
Senate Finance Committee
March 25, 2026

Thank you for the opportunity to submit testimony on House Bill 1112. The Maryland Managed Care Organization Association (MMCOA), which represents all nine Managed Care Organizations (MCOs) serving Maryland Medicaid members, respectfully requests an unfavorable report on this bill.

Medicaid is a foundational pillar of Maryland's healthcare system, providing coverage to children, pregnant women, seniors, people with disabilities, and working families. Nearly a quarter of Maryland residents—approximately 1.4 million people—rely on Medicaid for access to care. Since the creation of the HealthChoice program in 1997, Maryland has partnered with MCOs to deliver Medicaid services through a managed care model. Today, nearly 90 percent of all Medicaid and Maryland Children's Health Program (MCHP) members are served through HealthChoice.

HealthChoice is a mature, stable, and highly effective delivery system that has demonstrated its ability to scale coverage, maintain access, and operate reliably for more than 25 years, including during periods of extraordinary stress such as the COVID-19 public health emergency. Independent evaluations by the Hilltop Institute have found that managed care oversight has made measurable progress toward the State's core goals of improving access, quality, care coordination, and prevention for low-income Marylanders. These findings reinforce HealthChoice as the foundational and appropriate model for Medicaid delivery in Maryland.

Maryland's MCOs are diverse, including provider-led, health-system-led, local, and national plans. This diversity allows MCOs to align providers, payors, and State policy goals, particularly in critical areas such as primary care, behavioral health integration, maternal health, and care management for high-need populations. As Maryland advances implementation of the AHEAD Model, MCOs play a central role in strengthening primary care through enhanced payments and care management investments that support prevention and chronic disease management.

At the same time, recent federal Medicaid changes have introduced additional eligibility and renewal requirements that place many vulnerable Marylanders at risk of losing coverage. MCOs have partnered closely with the State, providers, community-based organizations, and advocates on outreach and communications efforts to help eligible individuals remain enrolled. As Maryland navigates these operational challenges, now is not the time to divert attention or resources toward studying a wholesale shift away from a managed care system that is demonstrably working.

Maryland's MCOs remain a foundational component of the State's healthcare ecosystem and are essential partners in advancing access, quality, equity, and fiscal sustainability in Medicaid. For these reasons, MMCOA respectfully requests an unfavorable report on House Bill 1112.

JMSMCO House Bill 1112 Testimony.pdf

Uploaded by: Sophia Lupinek

Position: UNF

March 25, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

House Bill 1112 - Health Insurance Coverage Protection Commission: Study on Individual and Group Health Insurance Market Stability – **UNFAVORABLE**

Dear Senator Beidle,

Thank you for the opportunity to submit testimony in opposition to House Bill 1112. I am the President and Chief Executive Officer for Jai Medical Systems Managed Care Organization, Inc. (Jai Medical Systems), one of the nine managed care organizations serving 1.3 million Marylanders enrolled in the Medicaid HealthChoice Program. Jai Medical Systems has participated in the HealthChoice Program since its inception in 1997. During our nearly 30 years of commitment to the people of Maryland, we have become known for our high quality. In fact, we are the only MCO in history to receive a 5 out of 5 rating from the National Committee for Quality Assurance for six years in a row. In addition, our health plan, as well as all managed care organizations (MCOs) in Maryland's Medicaid HealthChoice Program, have achieved *Health Plan Accreditation* and *Health Equity Accreditation from the National Committee for Quality Assurance*.

I would like to share why the current Medicaid HealthChoice Managed Care model represents a stronger, more effective delivery system than Medicaid Fee For Service (FFS) or standalone Administrative Services Organization (ASO) models and why weakening or displacing managed care would be detrimental to both beneficiaries and the State.

Maryland's Medicaid Managed Care program, as designed by the legislature, is intentionally designed to deliver coordinated, accountable, and cost-effective care to low income and medically complex populations. By placing both financial and clinical responsibility with MCOs, the State aligns incentives toward prevention, quality improvement, care coordination, and efficient use of resources. In contrast, FFS and ASO models focus primarily on paying for or administering individual services, with limited accountability for outcomes, coordination, or the total cost of care. For these reasons, Maryland relies on managed care for the vast majority of Medicaid beneficiaries while using FFS and ASO models only in targeted and complementary roles. House Bill 1112 would undermine this proven structure.

Managed Care Provides Clear Accountability for Cost and Quality

Under Maryland Medicaid Managed Care, MCOs are paid a fixed per member per month rate and are responsible for managing the full continuum of covered services. This capitated structure makes health plans directly accountable for cost control, access to care, and quality performance. By contrast, FFS reimburses providers for each service delivered, regardless of outcomes or overall value, and ASOs administer benefits *without assuming financial risk*. These models diffuse accountability and limit the State's ability to drive performance improvement.

In addition, Managed care allows the State to set clear expectations through contracts, enforce performance standards, and require corrective action when plans fail to meet quality or access requirements; tools that are far more effective than retrospective oversight alone.

Further, MCOs are held accountable to their spending and must ensure that at least 85% of the dollars they receive are spent on direct member care. This medical loss ratio rule ensures that care is provided by MCOs and that in the event that an MCO spends less than 85% of its dollars on care, the State of Maryland and the federal government receive a refund from the MCO for the percentage below 85%. It is our understanding the Maryland Medicaid Managed Care program is the only program within the Maryland government that has such protection as part of its contract process.

Managed Care Enables Stronger Care Coordination

Managed care is built around primary care, prevention, and coordination across providers and care settings. MCOs are contractually required to manage referrals, transitions of care, chronic conditions, and high-risk populations. FFS lacks built-in incentives for coordination, often resulting in fragmented care and duplicative services. ASO models focus primarily on utilization management and administrative functions rather than whole person care. Effective care coordination under managed care reduces avoidable emergency department visits, unnecessary hospitalizations, and preventable complications; improving outcomes while controlling costs.

Further, the benefits of Medicaid managed care extend beyond what can be easily measured in short-term cost analyses. The most meaningful savings produced by the Program are realized in the lives of Marylanders who receive timely preventive care that identifies and treats serious conditions before they become catastrophic. Under managed care, routine screenings occur, chronic conditions are managed early, and diseases such as hepatitis C are identified and treated before they progress to irreversible harm. These are not abstract savings; they represent people who avoid advanced illness, invasive procedures, and life-altering outcomes. By preventing avoidable suffering and preserving health, managed care not only improves lives today, but also spares the State the far greater costs associated with late-stage disease and complex interventions in the future.

Managed Care Supports Predictable and Sustainable State Spending

Capitated payments under managed care provide budget predictability and shift utilization risk away from the State. This allows Maryland to manage Medicaid expenditures responsibly while maintaining comprehensive benefits. Under FFS, increased utilization directly translates into higher State spending, regardless of whether services are appropriate or effective. ASO models retain this utilization risk while adding another layer of administrative cost. Managed care is therefore essential to Maryland's long term fiscal sustainability and its ability to invest in quality improvement and innovation.

Managed Care Improves Member Navigation and Access

MCOs are responsible for helping members navigate the healthcare system, including selecting providers, understanding benefits, obtaining referrals, and resolving access issues. This creates a clear point of accountability for beneficiaries who need assistance. In contrast, FFS provides little to no support for care navigation, and ASOs generally do not offer member-facing services. As a result, beneficiaries, particularly those with complex medical or social needs are often left to navigate an already complex system on their own. In addition, managed care improves access

to appropriate care through extensive provider networks which are superior to Medicaid FFS. These MCO networks reduce access barriers for vulnerable populations while meeting or exceeding state network adequacy requirements that do not exist within the FFS model.

Managed Care is a Resilient Model

The current managed care model protects the State and beneficiaries from the risks inherent in a single-point-of-failure system, such as is the case with a FFS model. Maryland's own experience underscores this risk. In December 2021, the Maryland Department of Health experienced a cybersecurity incident that required certain State systems to be taken offline as a precaution, resulting in widespread disruptions to FFS Medicaid claims processing, eligibility verification, and other administrative functions. During this period, many FFS recipients experienced service difficulties while providers experienced payment delays because claims could not be accepted or processed through State systems.

In contrast, recipients enrolled in MCOs did not experience any service disruption while payments from HealthChoice managed care organizations to providers continued uninterrupted. This incident illustrates how a centralized FFS infrastructure concentrates operational risk at the State level, allowing system failures whether due to cyber incidents, technology outages, or administrative disruptions to have immediate and statewide consequences. By contrast, Maryland's Managed Care model distributes operational responsibility across multiple accountable organizations, creating resilience, continuity of payments, and stability of access for beneficiaries even when State systems experience disruptions.

Appropriate but Limited Role of Fee for Service and ASO Models

Maryland appropriately continues to use FFS and ASO arrangements for specific purposes, such as certain carved out services, long term services and support, and federally required populations. These models serve targeted needs but were never intended to function as the primary Medicaid delivery system. Expanding or substituting these models for comprehensive managed care would weaken accountability, fragment care, and expose the State to unnecessary financial risk.

Managed Care Oversight and Fraud Detection

The current Medicaid managed care model helps safeguard the Program from fraud, waste, and abuse. One of the core functions of managed care is the prevention, identification, and reporting of potential fraud and/or abuse. MCOs conduct ongoing claims review and member utilization review to identify fraud in real-time. In addition, as part of the provider credentialing process, MCOs conduct pre-contractual site visits to verify the legitimacy and operational capacity of the entity. When potential fraud, waste, and abuse is identified, MCOs are required to report such findings to the Maryland Department of Health and the Office of Inspector General in accordance with applicable federal and state requirements.

Maryland Medicaid Managed Care 1115 Waiver and Budget Neutrality

The Medicaid Managed Care program in Maryland is externally validated by the Centers for Medicare and Medicaid Services (CMS). The HealthChoice Program exists under an 1115 waiver that has been approved by CMS and is reviewed and validated every five (5) years. CMS approves Section 1115 waivers based on their capacity to advance Medicaid objectives, specifically improving care, health equity, access, and quality while remaining *budget neutral*. Budget neutrality requires that the waiver must not increase federal spending; rather *costs must be equal to or lower than what they would have been without the waiver*.

Conclusion

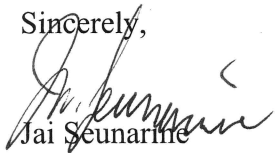
Jai Medical Systems is proud to serve in the Maryland HealthChoice Program as the only Minority Business MCO, and we are proud of the local jobs that we have provided to the people of our community. Medicaid managed care is a stronger and more effective delivery system because it aligns incentives with outcomes, establishes clear accountability for cost and quality, enhances care coordination, and supports predictable and responsible state budgeting. These core features are essential to serving complex, high-need populations while maintaining fiscal discipline.

In closing, the HealthChoice Program has been evaluated, refined, and overseen for decades through CMS waiver approvals, actuarial certifications, quality audits, network adequacy reviews, and performance reporting. As a result, the value of managed care in Medicaid is well established and not speculative.

Maryland's own experience demonstrates that managed care is best positioned to meet the clinical, operational, and fiscal demands of a modern Medicaid program. Undermining this proven structure would weaken accountability, fragment care, and expose the State to unnecessary financial and operational risk. House Bill 1112 would move Maryland in the wrong direction by calling into question a system that is working as intended. For these reasons, I respectfully urge the Committee to issue an unfavorable report on House Bill 1112.

Thank you for your consideration.

Sincerely,



Jai Seunarine
President and Chief Executive Officer

cc: Members, Senate Finance Committee

HB 1112 - MIA - LOI - FIN

Uploaded by: Marie Grant

Position: INFO

WES MOORE
Governor

ARUNA MILLER
Lt. Governor

MARIE GRANT
Acting Commissioner

JOY Y. HATCHETTE
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Date: March 25, 2026

Bill # / Title: House Bill 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability

Committee: Senate Finance Committee

Position: Letter of Information

The Maryland Insurance Administration (“MIA”) appreciates the opportunity to provide a letter of information for House Bill 1112.

The bill would amend the duties of the Health Insurance Coverage Protection Commission (“Commission”) established last year to require the Commission to study and make recommendations regarding individual and group health insurance market stability including, but not limited to:

- merging the individual and small group markets to stabilize risk and expand the base,
- pooling purchasing power across states,
- ways to control prescription drug costs,
- whether to establish a multiyear reinsurance stability fund,
- whether to reinstate the Maryland Health Insurance Plan;
- whether the pooling of state, county, and local government purchasers to combine buying power will result in better rates and quality alignment within the State
- and identifying ways to sustain and increase premium assistance in the individual market.

The topics set forth in this bill for the Commission to explore will aid in the group’s mission to protect consumer access to affordable health coverage. The study and resulting recommendations are intended to help the Commission and the State identify policy options to address longer term affordability in our health care markets.

The bill broadens the focus of the Commission, which is already supported by the MIA in terms of staffing and participation. The MIA intends to make meaningful contributions to the existing and new study requirements to help ensure individual and group health insurance market stability.

For the reasons set forth above, the MIA thanks the Committee for the opportunity to provide additional information. Please feel free to let us know if we can be of any further assistance.

HB 1112-FIN-MDH-LOI.docx (2).pdf

Uploaded by: Meghan Lynch

Position: INFO



DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

March 25, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: House Bill 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability - Letter of Information

Dear Chair Beidle and Committee Members:

The Maryland Department of Health (the Department) respectfully submits this letter of information for House Bill (HB) 1112 - Health Insurance Coverage Protection Commission - Study on Individual and Group Health Insurance Market Stability. Among other provisions, amendments to HB 1112 require the Commission to study whether a fee-for-service (FFS) model should be adopted for all services delivered by the Maryland Medical Assistance Program.

Shifting to a new model of care, from HealthChoice managed care program to a FFS model would be a substantial undertaking by the Department. Operating a FFS program puts the entire administrative burden on the state and it would require significant increase in state operating staff. The state would also bear the full financial risk of providing services to enrollees. The overall success of benefits delivery through a FFS program is dependent on the in-house capabilities of the state, with respect to quality, operations, and controlling cost. The Department anticipates robust financial investments in staffing and systems would be required to support expansion of day-to-day operations at this scale.

In the HealthChoice model, the State's current model, the nine participating managed care organizations (MCOs) are at financial risk for the medical services delivered. The Department pays MCOs capitation payments set at a fixed monthly rate per member, therefore, the MCOs are responsible for any administrative and benefits costs that exceed the capitated payments. MCOs also provide essential outreach and care management for participants, and will be key in reaching members about changes to Medicaid under H.R. 1.

If you would like to discuss this further, please do not hesitate to contact Meghan Lynch, Director of Government Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary of Health