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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

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

The Maryland House of Delegates
6 Bladen Street, Room 241
Annapolis, Maryland 21401
410-841-3883
800-492-7122 *Ext.* 3883
Bonnie.Cullison@house.maryland.gov

Written Testimony in Support of House Bill 1367:
Establishing the Commission on Re–Imagining Health Care in Maryland

Good afternoon, Chair Beidle Vice Chair Hayes and honorable members of the Senate Finance Committee. Thank you for this opportunity to present HB 1367 Establishing the Commission on Re–Imagining Health Care in Maryland.

The health care infrastructure within the State of Maryland currently stands at a precipice, necessitating a fundamental evaluation of its delivery models, financial sustainability, and equity outcomes. House Bill 1367 (HB 1367) proposes the establishment of a Commission on Re–Imagining Health Care, a body tasked with envisioning a comprehensive health care system that is entirely patient-centered, integrated across somatic and behavioral disciplines, and agile enough to evolve alongside the needs of its residents.[1] This legislative initiative emerges in response to a systemic failure where, despite high expenditures, the state faces outcomes that often pale in comparison to other developed nations.[1] The current landscape is characterized by a "health care divide" where rural residents face life expectancies up to seven years shorter than those in affluent suburban areas, and where one in three Marylanders skips necessary medications due to prohibitive costs.[1]

Maryland in a Global Context:
Spending Levels, Structural Cost Drivers, and the Fiscal Imperative for Reform

Total health care expenditures in Maryland reached approximately $69.5 billion in 2020. This translates to an astounding $11,482 for every man, woman, and child across a population of roughly 6.25 million residents.[29] If Maryland were evaluated as a standalone nation, its per-person spending would rival that of the most expensive health systems globally.

International comparisons provide critical context. The United States spends approximately $12,555 per capita (USD PPP) on health care, or 16.6% of GDP, the highest share among comparable peer nations.[30] By contrast, other advanced economies sustain universal or near-universal systems at significantly lower cost.

Country	Health spending per capita (USD PPP)	Health spending as % of GDP
United States	$12,555	16.6% (OECD)[30]
Switzerland	$8,049	11.3% (OECD)[30]
Germany	$8,011	12.7% (OECD)[30]
Netherlands	$6,729	10.2% (OECD)[30]
France	$6,630	12.1% (OECD)[30]
Sweden	$6,438	10.7% (OECD)[30]
Australia	$6,372	9.6% (OECD)[30]
Canada	$6,319	11.2% (OECD)[30]
New Zealand	$6,061	11.2% (OECD)[30]
United Kingdom	$5,493	11.3% (OECD)[30]

Compared to similarly wealthy nations, the United States spends 4 to 6 percentage points more of our GDP on health care.[30] More recent OECD-based data estimate U.S. per-capita spending at $13,432 in 2023, compared to an average of $7,393 across comparable nations, a difference of approximately $6,039 per person annually.[31]

Applied to Maryland's population, that international spending gap represents the equivalent of $37.7 billion annually (6,039 × 6.25M). A more conservative benchmark reinforces the point. If Maryland's per-capita spending were aligned with the Netherlands, $6,729 per person[30], this would amount to a difference of $4,753 per resident and would scale to approximately $28.8 billion saved annually.[29,30] And while Maryland cannot simply import another country's financing model, the data demonstrate that it is possible to deliver healthcare access at dramatically lower spending levels as a share of national income. More importantly, it demonstrates that we are missing a piece of the puzzle.

Evidence indicates that excess U.S. spending is not primarily driven by higher utilization of services. A cross-national analysis published in *JAMA* found that the United States does not consistently use more health care services than peer nations; rather, its spending is largely attributable to higher prices and administrative costs.[32] This divergence was found to be due primarily to price levels and system complexity, not greater clinical volume.[32]

Administrative Fragmentation as a Primary Cost Driver

Administrative spending represents one of the most measurable structural differences between the U.S. and peer systems. A 10-country comparative study found that administrative expenditures account for a conservative estimate of 8% of total health spending with other sources citing as much as 30% of health spending in the United States, compared to 1–3% in other high-income countries.[33,36] More granular sector analysis published in peer-reviewed literature estimates that administration constitutes nearly one-third of total U.S. health expenditures, roughly twice the share observed in Canada.[34]

These costs include what researchers define as "billing and insurance-related" (BIR) expenses:

1. Claims submission and adjudication
2. Prior authorization processing
3. Denial management and appeals
4. Insurance marketing and underwriting
5. Multi-payer compliance documentation

Private insurance overhead alone averages approximately 17% of premiums, compared to far lower administrative margins in public systems and single-payer models.[35] This is precisely the reason why a reassessment of our current system is necessary. While many OECD countries operate with centralized or standardized claims processing structures that significantly reduce duplicative administrative staffing, Maryland's system relies on unnecessarily burdensome fragmentation at a systemic level. While it does not directly improve clinical quality, it consumes substantial financial and workforce resources.

For Maryland, this distinction is critical. While the state has historically demonstrated leadership through its all-payer hospital rate-setting system, it remains embedded in a national financing structure that is characterized by unnecessary multi-payer complexity and administrative duplication. Systemic inefficiencies outside inpatient care, particularly in pharmaceutical pricing, and insurance administration continue to exert an upward cost pressure. This commission would serve to examine these burdensome arrangements. It creates an opportunity for Maryland to, once again, lead in making history.

The Fiscal Implications for Maryland

As Maryland transitions from the TCOC and AHEAD models, fiscal margins narrow further. The state must achieve savings targets while maintaining hospital solvency and addressing workforce deficits. In this context, incremental adjustments to reimbursement formulas will not resolve systemic cost drivers rooted in administrative complexity and price dispersion.

The Commission is, in part, intended to quantify where Maryland's system aligns with global best practices and where it diverges. The Commission proposed under House Bill 1367 provides a vehicle for disciplined, evidence-based examination of these structural factors. By explicitly analyzing:

1. International spending benchmarks (10–12% GDP vs. 16.6% in the U.S.)[30]
2. Per-capita expenditure gaps exceeding $6,000 annually[31]
3. Administrative cost shares ranging from 1–3% abroad vs. 8-30% or more domestically[33]
4. Sector-level estimates attributing up to one-third of U.S. spending to administrative functions[34]

At present, Maryland invests nearly $70 billion annually in health care.[29] That investment equals roughly the size of the state's entire annual operating budget. The question before policymakers is not whether Maryland can afford systemic examination, but whether it can sustain current spending trajectories without structural reform.

House Bill 1367 provides the structured forum necessary to align Maryland's financing architecture with evidence-based models of cost containment, integration, and equity. These inefficiencies are not marginal, they are systemic. A Commission empowered to examine global payment alignment, regulatory simplification, and administrative harmonization is therefore not aspirational policy but necessary fiscal stewardship.

The Structural Imperative for Systemic Re-Imagination

The primary impetus for HB 1367 is the recognition that the existing health care architecture in Maryland is fragmented and increasingly unable to withstand modern pressures. The bill outlines a vision for a system that is not only financially sustainable but also designed to ensure that health care quality and access are stronger than the current framework.[1] This requirement for "re-imagining" is driven by a series of cascading crises, including a historic physician shortage, the skyrocketing cost of prescription drugs, and a complex transition from the Total Cost of Care (TCOC) model to the federal States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model.

The Commission is mandated to study the role of the worker's compensation program within an integrated system and how high deductibles and limited networks deter care.[1] The necessity of such a study is underscored by data showing that high-deductible health plans (HDHPs) are associated with a 9% relative reduction in office visits for chronic conditions, as patients delay care to avoid upfront costs.[5] Furthermore, the state faces a critical workforce deficit; Maryland currently meets only 28.74% of its primary care needs, a figure that places it among the lowest-performing states in terms of practitioner density.[6]

Maryland Physician Workforce and Health Professional Shortage Area (HPSA) Data

Metric	**2024–2025 Statistic**
Percentage of Primary Care Needs Met	28.74% [6]
Practitioners Needed to Remove HPSA Designations	284 [6]
Projected Physician Shortage by 2030	1,052 [7]
Physicians within Retirement Range	35.8% [7]
Counties with HPSA Designations	22 of 24 [7]

The analysis of these figures indicates that workforce growth is failing to keep pace with the demand generated by an aging population and the increased prevalence of chronic disease. By 2030, the United States is projected to face a shortage of over 120,000 physicians, and Maryland's share of this deficit 1,052 doctors will be exacerbated by the fact that over one-third of the state's active physicians are nearing retirement.[7] This aging workforce is most prevalent in the capital region and among surgical specialties, suggesting that without the strategic intervention proposed in HB 1367, access to high-level specialized care will continue to erode.[7]

The Economic Barrier: Prescription Drug Costs and Medical Debt

A central pillar of the "broken" system described by advocates is the symbol of the prescription drug market. Medications account for nearly 30% of total health care expenditures in Maryland's privately insured markets.[1] The cost of life-saving drugs like insulin rose by $1,200\%$ between 1996 and 2017, forcing 30% of diabetics to ration their doses.[1] This trend is not isolated to older medications; the median annual cost for new prescription drugs reached $\$300,000$ in 2023.[1]

The Commission established by HB 1367 would work in tandem with the existing Prescription Drug Affordability Board (PDAB), which is already exploring upper payment limits for high-cost drugs like Jardiance and Farxiga.[1] These medications represent the single largest cost for the state employee health plan, with net spending doubling from $\$14.5$ million to $\$29.3$ million between 2020 and 2024.[1] The systemic failure is further highlighted by the fact that taxpayers contributed $\$870$ million toward the research and development of these specific drugs, yet they remain priced ten times higher in the United States than in other developed nations.[1]

The Impact of Medical Debt and High Deductibles on Maryland Families

Economic barriers extend beyond the pharmacy counter. In 2023, 14% of Maryland households approximately 327,600 families held unaffordable medical debt.[9] This debt is a primary driver of care avoidance and financial ruin, particularly for Black-led households, where 23% of surveyed residents reported carrying such debt.[10] The Commission is specifically tasked with investigating how high deductibles and limited networks decrease equal access to health care.[1]

In 2026, standard bronze plans in the individual market are projected to have an average deductible of $\$7,476$, while catastrophic plans will feature deductibles as high as $\$10,600$ for individuals.[11] For a family of four, these out-of-pocket maximums can reach $\$21,200$.[11] These figures suggest that many Marylanders are "underinsured," possessing a health plan that protects against catastrophic loss but provides little to no relief for routine or preventive care.

Household Medical Debt Source in Maryland	Percentage of Impacted Households
Hospital Visit Only	23% [9]
Outpatient Services Only	44% [9]
Combined Hospital and Outpatient	30% [9]
Debt from a Hospital Visit (General Poll)	53% [10]

The legislation passed in 2025, such as HB 268, attempted to mitigate this by expanding financial assistance to families earning up to 500% of the FPL and prohibiting lawsuits for debts under $500.[12] However, these are defensive measures; the Commission on Re–Imagining Health Care is required to take an offensive approach, developing a system where such debt is not the default outcome of seeking medically necessary care.[1]

The Transition to the AHEAD Model and Hospital Sustainability

Maryland stands apart as the only state with a unique all-payer hospital rate-setting system, currently managed through the TCOC model.[3] This system has successfully slowed hospital spending growth and reduced readmissions, keeping commercial hospital costs approximately 20% lower than national benchmarks.[3] However, the TCOC model is set to expire, and Maryland is transitioning to the federal AHEAD model.[3]

This transition introduces significant risk. Under AHEAD, rate-setting authority for Medicare Fee-For-Service will transition from the Maryland Health Services Cost Review Commission (HSCRC) to the federal CMMI.[13] This shift creates a potential "funding cliff" after 2027, as the federal government contemplates reducing its annual contribution of approximately $3 billion to the Maryland model.[3] The Commission must determine how the state's hospitals, which are already struggling with razor-thin margins and rising labor costs, will survive this transition.[14]

Hospital Financial Health and Operational Challenges

The Maryland Hospital Association (MHA) has indicated that the average operating margin for state hospitals was just 0.3% in late 2024, a figure that is insufficient for sustaining non-profit missions or making necessary capital investments.[14] Labor costs grew by 19% between 2019 and 2023, while net patient revenue grew by only 14.2% .[14] This imbalance is compounded by a 55% increase in losses related to physician coverage, as hospitals struggle to recruit specialists in areas like anesthesia and radiology.[14]

Hospital Operational Metric	**Maryland Statistic (2024)**
Average Operating Margin	0.3% [14]
Payer Denials (Total Dollar Value)	$\$1.39$ Billion [14]
Average Age-of-Plant (Maryland)	13.2 Years [14]
Average Age-of-Plant (National)	12.3 Years [14]
Growth in Labor Costs (2019–2023)	19% [14]

The Commission's mandate to study the "role of hospitals" and "how to balance patient-centered care and cost" is therefore a matter of survival for the state's critical health infrastructure.[1] If the state cannot maintain the financial stability of its hospitals while meeting the federal AHEAD savings targets which require a 2.66% reduction in Medicare spending by 2032 the result could be widespread service reductions or hospital closures, particularly in rural jurisdictions.[3]

Integrating Behavioral Health and Addressing the Health Care Divide

A "re-imagined" system must address the chronic underfunding and fragmentation of behavioral health services. Eight national studies conducted between 2019 and 2023 have identified Maryland's behavioral health data as among the worst in the nation for systemic inequity in access.[15] Over 325,000 residents rely on the public behavioral health system, but the workforce crisis has left the system unable to meet the growing demand for mental health and substance use care.[15]

The Commission's focus on an "integrated system of care, addressing all aspects of health, both somatic and behavioral" is vital.[1] Current models often silo these treatments, leading to poorer outcomes for patients with complex needs. The proposed integration would also examine the role of workers' compensation, a system that has traditionally operated independently of general health insurance. Research suggests that a connected payment and claims ecosystem in workers' compensation could facilitate faster return-to-work times and improve transparency for injured workers, who currently wait an average of 34 days for indemnity payments following catastrophic events.[16]

Racial and Geographic Health Disparities

The Commission is explicitly charged with eliminating barriers for all residents, a task that requires addressing the profound racial and geographic disparities in the state.[1] In Maryland, early death rates for Black residents are 5.7 times higher than for multiracial residents.[17] On the Eastern Shore, residents have life expectancies as many as seven years shorter than those in Montgomery County.[18]

Geographic Health Disparity (Maryland)	Impacted Population
Meets 100% Medically Underserved Area (MUA) Status	Caroline, Kent, Somerset, Worcester [18]
Early Death Rate Disparity (Black vs. Multiracial)	5.7x Higher [17]
Rural Counties in Maryland	18 of 24 [19]
Physician Density Deficit vs. National Average	16% Lower [2]

The Commission must synthesize recommendations from the 2025–2030 Rural Health Strategic Plan and the Office of Minority Health and Health Disparities.[19] These entities highlight that "curing disease is not enough to achieve health equity," and that addressing social drivers of health such as transportation isolation and food insecurity is essential for improving population-level outcomes.[21] Rural Marylanders often lose an entire workday to travel for a single appointment, a burden that makes preventive care functionally impossible for many families.[2]

Comparative Analysis: Successful State-Based Models

To re-imagine its own system, Maryland must look toward states like Vermont and Oregon, which have implemented ambitious all-payer and coordinated care models.

Vermont's All-Payer ACO Model

Vermont transitioned to a payment system based on value and high-quality outcomes rather than volume.[22] The model provided $9.5 million in start-up investment to assist providers with care coordination.[23] By its second performance year, Vermont saw improvements in 22 reported measures and met or exceeded five of its six population health outcome targets, including increased primary care access and reduced suicide rates.[22]

Oregon's Coordinated Care Organizations (CCOs)

Oregon's CCO model rewards quality of care through a pay-for-performance program.[24] In 2024, Oregon's CCOs collectively earned over $325 million in quality incentives.[24] The program specifically focuses on "Health Equity Plans," requiring organizations to prioritize organizational changes that embed equity in service delivery.[25] Oregon has also increased Medicaid behavioral health reimbursement rates by an average of 30% to ensure a robust provider network.[26]

Feature	Vermont All-Payer ACO	Oregon CCO Model	Maryland HB 1367 Vision
Core Focus	Value vs. Volume [22]	Quality Incentive Program [24]	Entirely Patient-Centered [1]
Integration	Somatic + Behavioral + Public Health [23]	Medical + Dental + Behavioral [26]	Somatic + Behavioral + Life Course [1]
Funding Strategy	Global Budgets & ACO scale [23]	Capitation Rates & Bonuses [26]	Financial Sustainability [1]
Equity Metric	Population-level outcomes [23]	Mandatory Health Equity Plans [25]	Eliminate barriers for all [1]

These models demonstrate that when a state aligns incentives across all payers and focuses on the social determinants of health, population health can measurably improve. HB 1367 positions Maryland to take the best elements of these successful models and adapt them to its unique regulatory environment.

The Role of Practitioner Reimbursement and Shortages

HB 1367 mandates an inquiry into why low physician reimbursement rates cause practitioner shortages, particularly for specialists.[1] Maryland Medicaid's reimbursement rates were approximately 91.5% of Medicare rates as of FY 2024.[27] While Maryland ranks highest among neighboring states for Evaluation and Management (E&M) procedures, it lags in other areas.[27] For example, Medicare reimbursement rates for anesthesia services are only about one-third of commercial payment rates.[28] This disparity creates a system where providers are disincentivized from seeing the most vulnerable patients, leading to access gaps that disproportionately affect those on public plans.

The Commission will also examine models of practitioner education. The University of Maryland School of Medicine is currently expanding its class size to 200 students by 2031 to address the projected 84,000-physician national shortage.[29] However, educating more doctors is only half the solution; the state must also create an environment where these providers can afford to practice, particularly in high-need rural areas. The Rural-MD Scholars program, which provides scholarships to students committing to practice on the Eastern Shore, serves as a pilot for the type of workforce development the Commission must standardize statewide.[18]

Conclusion: A Mandate for Action

The establishment of the Commission on Re–Imagining Health Care is not a luxury; it is a clinical and economic necessity. Maryland's health care system is "teetering on the edge of collapse," burdened by costs that strip dignity from the elderly and barriers that isolate the poor.[1] The transition to the AHEAD model provides a unique window of opportunity to codify a system that prioritizes people over profit margins.

The Commission's work, concluding in 2029, will provide the legislative and regulatory roadmap for the next generation of health care in the state.[1] By addressing the physician shortage, reigning in drug costs, integrating behavioral health, and dismantling the health care divide, Maryland can move from a system of survival to one of health equity and excellence. The passage of HB 1367 will signal that Maryland puts its people first, ensuring that every resident has access to the care they need, regardless of their zip code, income, or stage of life. The time to act is now, as the cost of inaction is measured in the lives of the 1.1 million Medicare recipients predicted to die this decade because they cannot afford their medications.[1] Maryland must choose to lead.

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Planned Parenthood
Care. No matter what.
Planned Parenthood of Maryland

330 N. Howard Street
Baltimore, MD 21201
(410) 576-1400
www.plannedparenthood.org/maryland

Committee: **Senate Finance Committee**

Bill Number: **House Bill 1367 - Commission on Re-Imagining Health Care in Maryland**

Hearing Date: **March 25, 2026**

Position: **Favorable**

Planned Parenthood of Maryland (PPM) supports *House Bill 1367 - Commission on Re-Imagining Health Care in Maryland.* The bill would create a commission to study different focus areas to improve the health care system within Maryland.

We, in Maryland, are fortunate to have legislative leaders who value and promote comprehensive health care for their residents and constituents. We also recognize that there is room for improvement, especially within the context of recent changes at the federal level. This bill takes tremendous strides toward creating a health care system that works for all Marylanders by galvanizing a commission of a wide range of stakeholders in the state. We are excited that this bill promotes and acknowledges the need to study health needs across a diverse group of topics with the goal of providing Marylanders with comprehensive, affordable, and patient centric care.

Planned Parenthood of Maryland is thrilled that the state has an opportunity to study health care services throughout the state – including the "how to delineate covered health care services, such as basic, preventive, acute illness, chronic illness, and elective[.]" Many believe Planned Parenthood of Maryland to only provide crisis or emergency care – but this is wholly untrue. While we are passionate about being able to reach patients in moments of need with comprehensive, nonjudgemental, and compassionate care, we also serve thousands in preventative services such as birth control provision, cancer exams, and STI testing. As such, PPM feels as if our experience as front line health care workers for almost 100 years in Maryland will make us a strong member of the commission.

We ask for a favorable report to establish a health care system that works for ***all Marylanders***. If we can provide any additional information, please contact Vice President of Public Affairs, Erin Bradley, at erin.bradley@ppm.care.

HB1367 crossover bill - FAV - Commission on Re-Ima

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Position: FAV

HB1367_Crossover_Bill_Richard Kaplowitz_FAV 03/25/2026
Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON CROSSOVER BILL HB#1367-
POSITION: FAVORABLE

Commission on Re-Imagining Health Care in Maryland

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#1367, **Commission on Re-Imagining Health Care in Maryland**

A comprehensive healthcare system improves patient outcomes through early disease detection, proactive prevention, and integrated care for physical and mental needs. It reduces long-term costs, lowers hospital readmissions, and enhances quality of life by managing chronic conditions effectively. Key advantages include holistic care, increased access to specialists, and streamlined, patient-centered services. [1]

Core Benefits of a Comprehensive Healthcare System

- **Proactive Prevention and Early Detection**
- **Improved Patient Outcomes and Quality of Life**
- **Increased Efficiency and Reduced Costs**
- **Continuity of Care**
- **Expanded Access and Specialized Services**
- **Reduced Burden on Emergency Services**
- **Better Resource Management**

Maryland can and should study a re-imagining of Health Care to codify what is the current state of health care in Maryland and how we can create better and more comprehensive health care for residents of Maryland and our health care providers.

This bill will meet that charge by establishing a Commission on Re-Imagining Health Care to envision and make recommendations regarding establishing a comprehensive health care system in the State; and requiring the Commission to submit a preliminary report by December 1, 2027, and a final report of the Commission's findings and recommendations to the Governor and the General Assembly by December 1, 2029.

This data will guide any actions to be taken to make these changes happen.

I respectfully urge this committee to return a favorable report on crossover bill HB#1367.

[1] Google AI Search "benefits of a comprehensive health care system"

Anne Arundel County _FAV_HB1367 Senate Crossover.p
Uploaded by: Tom Ni
Position: FAV

ANNE ARUNDEL COUNTY
MARYLAND
County Executive Steuart Pittman

March 25, 2026

House Bill 1367
Commission on Re-Imagining Health Care in Maryland

Senate Finance Committee

Position: FAVORABLE

Anne Arundel County **SUPPORTS** House Bill 1367 – Commission on Re-Imagining Health Care in Maryland. This Bill creates a "Commission on Re–Imagining Health Care" to envision and make recommendations regarding establishing a comprehensive healthcare system in the State.

The promotion and protection of public health must be a top priority for all levels of government. Health is not only a fundamental human right; it is a prerequisite to all other progress. Without a healthy thriving community at its core, any other policy initiative, from economic development to education, is ultimately compromised and futile. Our current healthcare system is both complex and fragmented, failing to deliver the high-quality care our residents deserve. We need a patient-centered comprehensive healthcare system that addresses all aspects of health, both somatic and behavioral, at every stage of life. We need a financially sustainable system that provides affordable and equitable care to all residents. We need a resilient system that builds a strong healthcare provider network, embraces innovation, and provides education and development that will prepare our practitioners to address both current and future healthcare needs.

As federal commitment and support remains uncertain, Maryland must take responsibility and create a comprehensive state-level system to deliver the best healthcare to all Marylanders. This Bill will mark the first step towards that goal by creating a commission bringing together stakeholders to carefully examine all aspects of the current system and envision the blueprint of our future healthcare system. For all of these reasons, I respectfully request a **FAVORABLE** report on House Bill 1367.

Steuart Pittman
County Executive

Ethan Hunt, Director of Government Affairs Phone: 410-222-3687 Email:exhunt23@aacounty.org

HB1367_FAV_DeMarco_MHCFA.pdf
Uploaded by: Vincent DeMarco
Position: FAV

TESTIMONY IN FAVOR OF HOUSE BILL 1367

Commission on Re-Imagining Health Care in Maryland

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 1367. Special thank you to Vice-Chair Cullison and Speaker Peña-Melnyk 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. Though we have accomplished much, there is much more to do to achieve our common goal of quality, affordable health care for all Marylanders. HB 1367 sets up a smart process to achieve this goal. We especially appreciate that the proposed Commission looks beyond health care coverage to work on how to make sure Marylanders in fact are healthy. We look forward to working with the new Commission to make this happen. We urge a favorable report for House Bill 1367. Thank you for your leadership and consideration.

2600 St. Paul Street Baltimore, MD 21218
www.healthcareforall.com
Phone (410)235-9000 Fax (410)235-9000

HB1367 - Senate_FWA_MACHC_Comm. Re-Imagining Healt
Uploaded by: Christine Krone
Position: FWA

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

Senate Finance Committee
March 25, 2026
House Bill 1367 – *Commission on Re-Imagining Health Care in Maryland*
POSITION: SUPPORT WITH AMENDMENT

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 supports House Bill 1367 with amendment.

FQHCs are the experts in delivering high-quality care under the most challenging circumstances. By federal mandate, they provide comprehensive primary, behavioral, and dental health services regardless of a patient's ability to pay. As the Commission seeks to "re-imagine" a system that reduces health disparities, it must include the providers who currently operate on the front lines of those disparities.

Therefore, MACHC would like to respectfully request the inclusion of Federally Qualified Health Centers (FQHCs) as formal members of the Commission on Re-Imagining Health Care. FQHCs serve as the primary care backbone for Maryland's most vulnerable populations, and their unique perspective is required to ensure the Commission's recommendations are both equitable and actionable.

Rural FQHCs are centers that navigate provider shortages, transportation barriers, and the "digital divide" in telehealth. A rural representative will ensure the Commission addresses the "healthcare deserts" prevalent on the Eastern Shore and in Western Maryland.

Urban FQHCs manage high patient volumes in environments with concentrated social determinants of health, including housing instability and food insecurity. An urban representative will provide insight into integrating social services with clinical care in densely populated corridors.

FQHCs operate under a unique federal Prospective Payment System (PPS) and receive HRSA Section 330 grant funding. Any state-level "re-imagining" of health care finance that does not account for these federal structures risks destabilizing the very centers that keep thousands of Marylanders out of emergency rooms. Having FQHC leadership at the table ensures that new state models complement, rather than conflict with, federal support.

If the goal of House Bill 1367 is to create a system that is "patient-centered" and "equitable," the Commission must include the only provider type required by law to have a patient-majority governing board. FQHCs are the literal voice of the community in the healthcare space.

To re-imagine health care without the input of the state's primary safety-net providers is to plan in a vacuum. We strongly urge the adoption of this amendment to ensure that the Commission's vision is grounded in the lived experience of Maryland's community-based health providers.

For more information call:
Christine K. Krone
Danna L. Kauffman
410-244-7000

2026 Sign-on Letter HB 1367 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FWA

Committee:	**Senate Finance Committee**
Bill:	**House Bill 1367 – Commission on Re-Imagining Health Care in Maryland**
Hearing Date:	**March 25, 2026**
Position:	**Support with Amendment**

Our organizations support *House Bill 1367 – Commission on Re-Imagining Health Care in Maryland* to establish a commission to develop a long-term vision for Maryland's healthcare system. Our organizations include:

American College of Nurse Midwives- Maryland
Health Care for the Homeless
Maryland Academy of Physician Assistants
Maryland Assembly on School-Based Health Care
Maryland Community Health System
Maryland Dental Action Coalition
National Council on Alcoholism and Drug Dependence

Maryland should be looking beyond the immediate crisis of addressing the rapid-fire changes in our healthcare landscape because of federal changes. We support a process, as contemplated by this legislation, to develop a comprehensive vision of a healthcare system centered on the needs of our communities. We suggest an amendment that would enhance the Commission's ability to achieve this goal by engaging federally qualified health centers, behavioral health programs, and school-based health centers on the Commissions work through a representative. These providers form the backbone of the healthcare system for our underserved communities and should be included:

On page 3 after line 23, add "A REPRESETNATIVE OF A COMMUNITY HEALTH CENTER"

Thank you for the consideration of this amendment. We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or aciekot@policypartners.net.

Senate Finance HB1367 Written Testimony Bhagat.pdf
Uploaded by: Santi Bhagat
Position: FWA

WRITTEN TESTIMONY

House Bill 1367 — Commission on Reimagining Healthcare in Maryland

Maryland General Assembly, Senate Finance Committee

Position: FAVORABLE WITH AMENDMENT

Submitted by: Santi KM Bhagat, MD, MPH

Capacity: Founder and President, Physician-Parent Caregivers (PPC); Creator,The Invisible Wave

Date: March 2026

I. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Amendment Request

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

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

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

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

Respectfully submitted,

Santi KM Bhagat, MD, MPH
Founder and President, Physician-Parent Caregivers
Founder, The Invisible Wave | invisiblewave.org