Testimony
Date February 20, 2026
HB 971
Maryland Medical Advisory Committee - Duties and Workgroup to Study the Adoption of a Fee-For Service Model for All Medicaid Services

FAV

Dear Madam Chair and Members of the Committee:

My name is Megan Essaheb and I live in Cheverly, MD and I'm the director of federal affairs at People's Action. People's Action's Care Over Cost campaign organizes people whose private health insurer refuses to pay for the care they need.

Everyone deserves high quality health care when and where we need it. Yet, in the richest in the world, you can lose everything if you – or a loved one – gets sick or injured. Working people are facing an affordability crisis that for many is exacerbated by rising health care costs; about 25 million people in the US still have no form of health insurance.[1] Having insurance doesn't guarantee that you can use it - an additional 44 million people in the US are "underinsured" with high copays and out of pocket costs. Moreover, insurance companies are delaying and denying health care a whopping 850 million times a year.[2] All while corporations like Unitedhealth Group make tens of billions in profits annually while paying their executives tens of million in pay and stocks. Much of this money comes from Americans' tax dollars through privatized Medicaid and Medicare.

Our health care system was already broken before President Trump signed into law, H.R.1 the "One Big Beautiful Bill Act" (the Act), which makes the largest transfer of wealth from poor and working people to the rich in U.S. history. While our communities face soaring healthcare, housing, utilities, and food costs, Trump and Congress prioritized handouts to billionaire donors and corporations. In order to pay for handouts to the rich and mass deportations, Congress cut close to a trillion dollars from Medicaid and SNAP/Food Stamps in order to give tax cuts to billionaires and the ultra-rich.

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

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[1] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
[2] https://www.wsj.com/health/healthcare/health-insurance-denials-fight-back-70a1328e?gaa_at=eafs&gaa_n=ASWzDAhUsVDljsTBDWKyf4tlYtl6zZZQnYJHOdkbVto3FNdVPzZOcoKDfC--2m5dMFw%3D&gaa_ts=68dafb0c&gaa_sig=qxQm681GRsDUnyqdr6hcqbJklY0wEROuZLS3iThuqlI0nnP6d_2g9hKEYNxPQCwQTSGBU5ZA62z8JdsBy6aoGg%3D%3D

their family will lose Medicaid and the essential medical care they need. Home care services for people with disabilities and the elderly may be hit particularly hard.

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 identify new sources of significant revenue to offset the federal cuts and avoid cuts in services.

Ending Medicaid Managed Care and reinstituting state run fee-for-service would be a win-win for Maryland. It would improve care and recoup funds that are being wasted on administration costs and profiteering and the quality of care provided by Maryland Medicaid. Government run fee-for-service programs like traditional Medicare and Medicaid programs reduce red tape for doctors offices and increase the time they can spend on caring for patients.

HB 971 would 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 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. 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.

Many of the sickest patients already receive Medicaid fee-for-service from the state because the private insurers won't cover them, so we have some processes in the state already.

We owe it to our Maryland 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.

At least five other states are actively working on similar legislation - Minnesota, Hawaii, Illinois, Wisconsin and West Virginia and two others are considering.

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.

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