2024-03-08 SB 1103 (Support).pdf
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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

March 5, 2024

The Honorable Pamela Beidle
Chairwoman, Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Re: Senate Bill 1103 – Hospitals and Related Institutions – Outpatient Facility Fees - **Support**

Dear Chairwoman Beidle:

The Office of the Attorney General (OAG) respectfully urges the Health and Government Operations Committee to give Senate Bill 1103 a favorable report. If enacted into law, Senate Bill 1103 would provide individuals with the information they need to make informed decisions about where to obtain affordable health care. By expanding the existing statutory notice requirement and requiring the Health Services Cost Review Commission to convene a group to study the impact of facility fees on the health care systems in Maryland, Senate Bill 1103 will align Maryland with current best practices around the nation in the crucial areas of consumer choice and health care affordability.

Facility Fee Notice for All Outpatient Services

Hospitals are able to charge patients a facility fee for services provided by any healthcare provider it employs and at any facility it owns, even if the patient never sets foot in the hospital. During the 2020 legislative session, the Maryland General Assembly passed the Facility Fee Right to Know Act (FFRKA), Md. Code Ann., Health-Gen. §19-349.2 (2020 Md. Laws, Chs. 365, 366), after hearing from and about countless consumers who were surprised to receive a large

hospital bill for services like routine eye examinations, EKGs, and MRIs. The FFRKA requires hospitals that charge outpatient facility fees to provide patients with a written notice containing specified information, including if a facility charges a facility fee. During deliberations on the FFRKA, OAG proposed that the notice requirement should apply to all outpatient services; however, the notice requirement that was included in the final statute was limited only to "clinic services", inexplicably leaving consumers in the dark with relation to a wide variety of other outpatient services. Senate Bill 1103 would change that.

Since the enactment of FFRKA, the OAG's Health Education and Advocacy Unit (HEAU) has continued to hear from consumers who have received hospital bills that are often triple or quadruple the cost of what a provider would bill for the same services simply because of the addition of an undisclosed facility fee. The fact that HEAU continues to receive these types of complaints from consumers illustrates the need to expand the FFRKA to better protect consumers. Too often, patients are unaware that (1) a regular provider/doctor visit that takes place in a place other than their regular doctor's office is in fact taking place at what is considered "a hospital" and (2) that they may be billed by both the provider and the hospital for the services rendered. Patients consistently complain they should be given this information when they make their appointment so they can decide for themselves whether to see the provider "at the hospital" or at another location where a facility fee is not charged.

Definition of "Hospital"

In addition to expanding the provisions of the FFRKA to require notice for all hospital outpatient services, Senate Bill 1103 alters the definition of "hospital" for purposes of the required notice to include out-of-state hospitals that are operating outpatient facilities in the State and charging facility fees. Out-of-state actors should not be allowed to dodge the protections Maryland puts into place for outpatients by claiming they are not subject to our laws when they are operating within our State and are treating Maryland consumers.

Expanding the provisions of the FFRKA to **all** hospital outpatient services and to **all** hospitals that offer outpatient services means that less consumers will be surprised by large, unexpected facility fees and will be armed with the knowledge to make informed health care decisions by receiving:

- a notice regarding a separate facility fee charge;
- the amount or estimate and range of fees they may be charged;
- information about seeing the provider at a location without facility fees; and
- material about the availability of financial assistance for eligible consumers.

Facility Fee Study

OAG supports the proposition that, at a minimum, consumers have the right to know about a facility fee upfront so they can make an informed choice about where to receive their outpatient health care services. While this notice offers some consumer protections, it does not address the fact that hospital outpatient facility fees are increasing costs for both consumers and employers by rising out-of-pocket costs and insurance premiums. This notice does not address the fact that carriers are

responding to these increased costs by, in turn, increasing cost-sharing for services provided in hospital outpatient settings. This notice also does not address the fact that as more provider offices become regulated spaces, consumers have fewer facility-fee-free locations to obtain care. These are concerns that simply cannot be ignored.

Senate Bill 1103 requires the Maryland Health Services Cost Review Commission, in consultation with various stakeholders and subject matter experts in all areas of the health care system, to (1) study the impact of facility fees on health equity, access to care, and the cost of health care services, and (2) report their findings and recommendations to the General Assembly. This comprehensive study will include review of the impact of facility fees on consumers, employers, providers, hospitals, and insurers; the interaction of outpatient facility fees with Maryland's Total Cost of Care model obligations to the federal government; and efforts by other states, federal regulatory agencies, and national advocacy organizations related to the regulation of facility fees.

The information this study will provide is critical to understanding our options for reforms that might better protect consumers, reduce costs, and increase transparency. Similar studies are taking place at the state and national levels as outlined in Georgetown University's Center on Health Insurance Reforms recent report, *Protecting Patients From Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform*, (Monahan et al., July 2023).

The OAG believes all consumers are entitled to receive meaningful notice of outpatient facility fees. Consumers harmed by these fees repeatedly propose the same solutions - the State should require notification, revision, or elimination of outpatient facility fees charged by hospitals. On behalf of consumers, we ask for no further delay in providing them with the notification they have been urgently requesting and obtaining the critical information necessary for more meaningful reform. For the foregoing reasons, we ask your favorable report for SB 1103.

Sincerely,

Anthony G. Brown

Enclosures

cc: Committee Members

CRoss SB1103.pdf
Uploaded by: Catharine Ross
Position: FAV

7 March 2024

I am presenting information in favor of Senate Bill 1103. I share my experiences in hopes that Maryland legislation can be clarified to help others in similar situations in the future.

My six-year-old daughter needed an outpatient service at Mt Washington Pediatric Hospital in Baltimore in October of last year. I tried to do my due diligence. I made sure our private health insurance was accepted. I asked questions about the forms that I was signing, trying to make sure we wouldn't have any unexpected fees. When I got the bills afterwards, it turned out that the facility fee alone was nearly $4,000. With our insurance, we were responsible for 20% of that, and we ended up paying nearly $800 for the facility fee. My issue, in part, was with the high amount of the facility fee--it certainly was hard to swallow--but also that I felt I had no way of knowing this information ahead of time, so that I could make informed decisions about my daughter's care.

After doing some research I learned about facility fee disclosures--or a written estimate of the anticipated hospital charges for nonemergency services--and as near as I could tell, this was something I should be able to obtain.

So when my three-year-old son needed a brain MRI at University of Maryland Medical Center in Baltimore just last month, I tried to do things a little differently. A few days ahead of his appointment, as I was going through forms for the online check-in process, I came across this statement: "You have the right to request and receive a written estimate of the total charges for hospital nonemergency services[...]." So I started making phone calls. Looking back at my call history, it looks like I made about a dozen phone calls over a period of several days.

I was bounced around to multiple departments at UMMC, most people telling me either they had no idea what I was talking about, or someone else could help me--or actually I needed to call the office of the doctor who ordered the scan, get the procedure codes, and then talk to someone else. Finally, the day before the scan, by the end of the day I had an email with the information I had requested. In practice, the information I was told I had a "right" to felt nearly impossible to obtain.

Having a clear sense of anticipated fees ahead of time is a vital part of accessible healthcare.

Catharine Ross
Baltimore, MD

Georgetown Karen Davenport SB 1103 testimony.pdf
Uploaded by: Karen Davenport
Position: FAV

GEORGETOWN UNIVERSITY
McCourt School of Public Policy

CENTER ON HEALTH INSURANCE REFORMS

Testimony of

Karen Davenport, Senior Research Fellow

before the

Finance Committee

of the

Maryland Senate

March 8, 2024

Chairwoman Beidle and members of the Committee, my name is Karen Davenport and I am a Senior Research Fellow at the Center for Health Insurance Reforms at Georgetown University's McCourt School of Public Policy. I am pleased to be here today to share our recent research on outpatient facility fees. I hope this information will inform your deliberations on Senate Bill 1103 (SB 1103).

In recent years, health care consumers, payers, and policymakers have brought attention to the growing prevalence of hospital outpatient facility fees in the United States. As hospitals and health systems expand their ownership and control of ambulatory care practices, they frequently newly charge patients with facility fees for services delivered in these outpatient settings. Facility fees are an important element of spending on hospital outpatient services, which is one of the most rapidly rising components of health care spending.[1] The growth in the amount and prevalence of these charges is important to payers and consumers, who face greater financial exposure as insurance deductibles increase and payers develop new benefit designs that increase patients' exposure to cost-sharing, particularly in hospital outpatient settings.

Policymakers across the country and in Congress have begun to respond to this problem. Between November 2022 and April 2023, my colleagues and I examined laws and regulations on outpatient facility fees in 11 study states—Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas, and Washington—and conducted more than 40 qualitative interviews with stakeholders and experts.[2] We continue to delve into this issue and are currently in the midst of assessing laws and regulations in the remaining 40 states. Our full 2023 report is available on our website.[3]

Background

Facility fees are the charges institutional health care providers, such as hospitals, bill for providing outpatient health care services. Hospitals submit these charges separately from the professional fees physicians and certain other health care practitioners, such as nurse practitioners, physician assistants, and physical therapists, charge to cover their time and expenses. In general, public and private payers pay more in total when patients receive services in a hospital—including, importantly, hospital-owned outpatient departments—instead of an independent physician's office or clinic.

This payment differential both encourages and exacerbates the effects of vertical integration in the U.S. health care system, as hospitals and health systems acquire physician practices and

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[1] *2021 Health Care Cost and Utilization Report*. (2023, Apr. 1). Health Care Cost Institute. Retrieved May 12, 2023, from https://healthcostinstitute.org/images/pdfs/HCCI_2021_Health_Care_Cost_and_Utilization_Report.pdf.

[2] Monahan, C.H., Davenport, K., Swindle, R. Protecting Patients from Unexpected Outpatient Facility Fees: State on the Precipice of Broader Reform. (2023, Jul.). Georgetown University, Center on Health Insurance Reforms.

[3] See https://chir.georgetown.edu/state-facility-fee-project/.

other outpatient health care providers.[4] When a hospital acquires or otherwise affiliates with a practice, ambulatory services provided at the practice can generate a second bill, the facility fee, on top of the professional fees the health professionals charge. As hospitals expand their control over more outpatient practices, they can also exert greater power in their negotiations with commercial health insurers and extract even higher payments.

This growth in outpatient facility fees drives up overall health care spending, resulting in higher premiums. Our research also suggests that insurance benefit designs are increasing consumers' direct exposure to these charges. Rising deductibles appear to be one factor. However, even when a consumer has met their insurance deductible, a separate facility fee from the hospital on top of a professional bill may trigger additional cost-sharing obligations for the consumer, such as a separate co-insurance charge on the hospital bill. Insurers also may require higher cost-sharing for hospital-based care than for office-based care, resulting in higher out-of-pocket costs than consumers otherwise anticipate for their outpatient care.

Consumers may question why they receive a hospital bill for a run-of-the-mill visit to the doctor. Hospitals maintain that these charges cover the extra costs they incur and services they provide—such as round-the-clock staffing, nursing and other personnel costs, and security—even though individual patients may not pose any additional costs or use the hospital's services. In contrast, payers and a range of policy experts view facility fee billing as a way hospitals leverage their market power and take advantage of the United States' complex and opaque payment and billing systems to increase revenue.

State Efforts to Regulate Outpatient Facility Fees

States are at the forefront of tackling outpatient facility fee billing in the commercial market. Our analysis of the laws and regulations in 11 study states demonstrates the range of reforms available (see Table 1). Specifically, we identify five types of reforms: (1) hospital reporting requirements; (2) consumer disclosure requirements; (3) out-of-pocket cost protections; (4) prohibitions on facility fees; and (5) provider transparency requirements. Notably, since the publication of our report, Colorado and Maine have created commissions or task forces to study the scope and impact of facility fee bills on consumers and outpatient cost trends. These studies have been charged with providing state policymakers with recommendations for further reforms, reflecting how health care provider consolidation and escalating health care costs continue to pressure consumers and challenge policymakers.[5] Similarly, Section 2 of SB 1103 requires the

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[4] Galarraga, J., Mutter, R., & Pines, J.M. Costs Associated with Ambulatory Care Sensitive Conditions Across Hospital Settings. (2015, Feb.). Academic Emergency Medicine. Retrieved May 13, 2023, from https://pubmed.ncbi.nlm. nih.gov/25639774; Capps, C., Dranove, D., & Ody, C. The Effects of Hospital Acquisitions of Physician Practices on Prices and Spending. (2018, Apr. 22). Journal of Health Economics. Retrieved May 13, 2023, from https://pubmed. ncbi.nlm.nih.gov/29727744/; Cooper, Z., Craig, S., Gaynor, M., Harish, N.J., Krumholz, H.M., & Van Reenan, J. Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-2014. (2019, Feb.). Health Affairs. Retrieved May 13, 2023, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424.

[5] See Colorado Department of Health Care Policy and Financing Hospital Facility Fee Steering Committee website: https://hcpf.colorado.gov/hospitalfacilityfeesteeringcommittee; Task Force to Evaluate the Impact of Facility Fees on Patients, Maine Office of Policy and Legal Analysis. January 2024 report: https://mainelegislature.org/doc/10648.

Maryland Health Services Cost Review Commission to examine the scope and impact of facility fees in Maryland and the implications of reducing or eliminating these fees. This study should shed much-needed light on the incidence of facility fee billing in Maryland, particularly given Maryland's unique all-payer rate-setting system for hospital services, the impact these fees have on consumers, and possible policy responses.

For the remainder of this statement, I describe the five approaches to facility fee reform we identified in our report. Many of these reforms are complementary and states have combined multiple approaches as they seek to protect consumers from these fees and control health care costs.

1. Hospital Reporting Requirements: Disclosing How Much Hospitals Charge and Receive in Outpatient Facility Fees

   Five study states have adopted public reporting requirements to better understand how much hospitals charge and receive for outpatient care. Four states—Connecticut, Indiana, Maryland, and Washington—have enacted annual reporting requirements.

2. Consumer Disclosure Requirements: Notifying Consumers About Outpatient Facility Fee Charges

   All but two study states require health care providers—typically hospitals and hospital-owned facilities and sometimes freestanding emergency departments—and/or health insurers to notify consumers that they may be charged a facility fee in certain circumstances. For example, Connecticut and Colorado require providers to disclose certain information about their facility fee billing practices upon scheduling care, in writing before care, via signs at the point of care, and in billing statements. Upon acquiring a new practice, hospitals in these states also must notify patients that they may be charged new facility fees. Other study states also require disclosures before care is provided and/or in signage at the facility. Some states require consumers to be more proactive, requiring only that information about facility fee charges be available online or provided upon request by hospitals and/or health insurers.

   Of particular relevance to this hearing, Maryland requires hospitals to provide a pretreatment notice and a written range or estimate of facility fees for patients who schedule appointments for clinic services. SB 1103 would update this notice requirement in several ways. First, it would expand Maryland's current notice requirement to additional critical services and revenue centers, including labor and delivery, physical and occupational therapy, diagnostic, therapeutic, and interventional radiology, and laboratory services. It would also revise the current notice requirement to ensure that patients receive both a written range *and* an estimate of likely facility fees. Finally, SB 1103 would apply this revised notice requirement to all hospitals operating facilities within the state of Maryland, even if the main hospital campus is located outside the state. Currently, out-of-state systems provide outpatient care at facilities they operate within Maryland but do not provide their patients with advance notice of potential facility fees; SB 1103 will ensure that patients receiving care at these facilities are also protected by Maryland's pretreatment notice requirement.

3. Provider Transparency Requirements: Who Is Providing Care Where?

   Colorado and Massachusetts have taken steps to bring more transparency to the questions of where care is being provided and by whom. Unfortunately, existing claims data often conceal the specific location where care was provided and the extent to which hospitals and health systems own and control different health care practices across a state. This makes it challenging for payers, policymakers, and researchers to effectively monitor and respond to outpatient facility fee charges.

   Colorado requires every off-campus location of a hospital to obtain a unique identifier number (referred to as a national provider identifier or NPI) and include that identifier on all claims for care provided at the applicable location. Federal lawmakers and other states are considering similar proposals.[6] One challenge Colorado has faced, however, is tracking the affiliations between different locations, all now represented by unique NPIs. Beginning in 2024, Colorado hospitals are required to report annually on their affiliations and acquisitions, which may help address this gap. Massachusetts does not have a unique NPI requirement but maintains a provider registry that includes information on provider ownership and affiliations among other data, enabling the state to better monitor trends in consolidation and integration.

4. Out-of-Pocket Cost Protections: Limiting Consumer Charges for Facility Fees

   Two study states have adopted relatively narrow restrictions that limit consumers' exposure to out-of-pocket costs while continuing to allow hospitals to charge facility fees in at least some circumstances. Connecticut prohibits insurers from imposing a separate copayment for outpatient facility fees provided at off-campus hospital facilities (for services and procedures for which these fees are still allowed to be charged) and bars health care providers from collecting more than the insurer-contracted facility fee rate when consumers have not met their deductible. More narrowly, health care providers in Colorado will be prohibited from balance billing consumers for facility fee charges for preventive services provided in an outpatient setting beginning July 1, 2024.

5. Prohibitions on Outpatient Facility Fees: Stopping Charges Before They Happen

   Several study states have prohibited facility fee charges in some circumstances, although the scope of these laws varies significantly. Connecticut, Indiana and Maine prohibit facility fees for selected outpatient services typically provided in an office setting. Some states have more narrowly targeted facility fees for specific services, including telehealth services (Connecticut, Maryland, Ohio, and Washington), preventive services (New York), and Covid-19 related services (Maryland, Texas, and, during the public health emergency, Massachusetts).

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[6] While not a state in our study, Nebraska recently enacted a unique provider identifier requirement. Neb. L.B. 296 § 12 (2023).

Maine, which has the longest-standing prohibition among our study states, specifies that all services provided by a health care practitioner in an office setting must be billed on the individual provider form. This means hospitals cannot charge facility fees for office-based care, even when provided in a hospital-owned practice. We learned that some providers have narrowly interpreted this prohibition to limit facility fee charges for evaluation and management (E&M) services, but do charge facility fees for more complex procedures or, conversely, services where a physician is not directly involved at the point of care, such as infusion therapy for cancer treatment.

Indiana's recently enacted law uses the same office-setting framework and more narrowly prohibits facility fee billing for off-campus facilities owned by non-profit hospitals. Connecticut currently bars hospital-owned or -operated facilities from charging facility fees for outpatient E&M and assessment and management (A&M) services at off-campus locations. Beginning July 1, 2024, this prohibition will extend to on-campus locations as well, excluding emergency departments and certain types of observation stays.

Further Reforms and Next Steps

Beyond the state reforms we highlighted in our 2023 report, states continue to consider additional strategies for understanding and addressing hospitals' practice of charging facility fees for outpatient services. Pending legislation in Indiana, for example, would require hospitals and other health care-related entities to report corporate ownership relationships to the state Department of Health on an annual basis, while the Massachusetts Health Policy Commission's most recent report calls for the state to require site-neutral payment for ambulatory services that are commonly provided in office settings.

Thank you for the opportunity to share our findings with you. As Maryland considers strategies for further protecting consumers from unexpected facility fee charges, it continues to stand in the vanguard of this important issue.

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Source: Monahan, C.H., Davenport, K., Swindle, R. Protecting Patients from Unexpected Outpatient Facility Fees: State on the Precipice of Broader Reform. (2023, Jul.). Georgetown University, Center on Health Insurance Reforms.

SB1103 Outpatient Facility Fees EconActionFAV.pdf
Uploaded by: Marceline White
Position: FAV

Testimony to the Senate Finance Committee
SB1103 Hospitals and Related Institutions-Outpatient Facility Fees
Position: Favorable

March 8, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401
cc: Members, Senate Finance

Chair Beidle and Members of the Committee:

Economic Action Maryland (formerly the Maryland Consumer Rights Coalition) is a statewide coalition of individuals and organizations that advances economic rights and equity for Maryland families through research, education, direct service, and advocacy. Our 12,500 supporters include consumer advocates, practitioners, and low-income and working families throughout Maryland.

We are here in support of SB1103 which builds on this committee's important work passing the Facility Fee Right to Know Act (SB632) which established disclosures and reporting for hospital facility fees. SB1103 builds on that work by extending these disclosures to outpatient facilities.

This legislation is particularly important because medical debt remains a problem in Maryland. In 2023, 14% of Maryland voters had a medical bill or medical debt that they or someone in their household is unable to pay. Medical debt hit Black-led households harder, with 23% of African-Americans polled having an unaffordable medical bill[1]. Families struggle with medical debt from a variety of sources including Maryland's nonprofit hospitals, outpatient services such as physical therapy, diagnostic tests, or rehabilitative treatments, as well as private practice doctors, dentists, and other health practitioners. Patients report that 44% of medical debt comes from an outpatient visit and 30% from both outpatient visits and hospital stays[2].

Facility fees are ostensibly overhead charges for care provided in outpatient and physician office settings but the fees do not necessarily bear any relationship to the patient or setting. The facility fees vary by location as well so there is no consistency. Patients have borne the brunt of this as they face increased out-of-pocket costs as well as higher premiums from these extra charges.

SB1103 increases transparency for consumers as well as reporting of these fees. For these reasons, we support SB1103 and ask for a favorable report.

Marceline White
Executive Director

[1] September 2023 Gonzales Poll Commissioned by Economic Action Maryland (then Maryland Consumer Rights Coalition)
[2] September 2023 Gonzales Poll Commissioned by Economic Action Maryland (then Maryland Consumer Rights Coalition)

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Senate Bill 1103 - Hospitals and Related Instituti

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Position: FWA

Maryland
Hospital Association

Senate Bill 1103 - Hospitals and Related Institutions - Outpatient Facility Fees

Position: ***Support with Amendments***
March 8, 2024
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 1103 with amendments.

SB 1103 makes several changes to the statute governing the required disclosure notice hospitals must provide to patients for outpatient facility fees. The bill significantly broadens the definition of "outpatient facility fee" beyond hospital-based clinic services, as the law requires now. This broader definition was rejected by the General Assembly in 2020 when it passed the Facility Fee Right-to-Know Act. The bill was focused on hospital-based clinics as the issue was driven by the confusion patients may experience when visiting physician offices on a hospital campus, particularly in space that is outside of the hospital's main building. It is in these hospital-based clinics where some patients may not know their visit is taking place "at the hospital" and that they will be billed by both the health care provider and the hospital for the visit. These same concerns are largely not present with other kinds of hospital outpatient services.

Implementing the current notice requirement was a very large undertaking for Maryland hospitals, requiring a tremendous amount of time and resources. The definition proposed under SB 1103 is extremely broad and would include any regulated outpatient facility fee charged by a hospital. This would include observation, outpatient surgery, imaging, laboratory, and a host of other services. Not only would hospitals be unable to comply with the law's notice requirements in many instances (such as when the services are unscheduled), it will likely further confuse patients and may unintentionally encourage people to not seek essential medical care.

Given the bill requires the Health Services Cost Review Commission (HSCRC), in consultation with stakeholders, to study and make recommendations on the use of hospital facility fees in Maryland, making such a significant change to the definition of "outpatient facility fee" is premature. The study's requirements are detailed and comprehensive and will enable better informed decision making. It will also allow time to determine the impact of the federal No Surprises Act on further facility fee disclosure proposals.

The hospital field recommends that no additional changes be made to the current law governing hospital outpatient facility fees until the conclusion of the comprehensive study by HSCRC.

For more information, please contact:
Pegeen Townsend, Consultant
Ptownsend@mhaonline.org

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Uploaded by: State of Maryland (MD)
Position: FWA

maryland
health services
cost review commission

March 8, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

RE: Senate Bill 1103 - Hospitals and Related Institutions - Outpatient Facility Fees – Letter of Support with Amendment

Dear Chair Beidle and Committee Members:

The Health Services Cost Review Commission (HSCRC) respectfully submits this Letter of Support with Amendments on Senate Bill 1103, "Hospitals and Related Institutions - Outpatient Facility Fees." HSCRC's support is focused on the study portion of the bill.

HSCRC is willing to conduct the study required by SB 1103. The requirements of this study are complicated and will require substantial analytical and research skills and resources. HSCRC requests flexibility in procurement laws to be able to quickly acquire resources to support HSCRC staff in this work. An accelerated procurement process will allow for a more thorough study. The recommendations resulting from this study will inform effective policy making that benefits consumers in the future.

Thank you for your consideration of this amendment. If you have any questions or if I may provide you with any further information, please do not hesitate to contact me at 410-991-7422 or deborah.rivkin@maryland.gov, or Jon Kromm, Executive Director, at jon.kromm@maryland.gov.

Sincerely,

Deborah R Rivkin

Deborah Rivkin
Director, Government Affairs

Attachment: Amendment

Amendment 1:

Page 1, after line 14, insert the following:

BY repealing and reenacting, with amendments,
Article – State Finance and Procurement
Section 11–203(a)(1)(xviii) and (xix)
Annotated Code of Maryland (2023 Replacement Volume)

Page 6, after line 28, insert the following:

Article –State Finance and Procurement

11-203

(a) Except as provided in subsection (b) of this section, this Division II does not apply to:

(1) procurement by:

(xviii) the Department of Natural Resources, for negotiating or entering into grants, agreements, or partnerships with nonprofit entities related to conservation service opportunities; ~~and~~

(xix) the State Archives for preservation, conservation, proper care, restoration, and transportation of fine art or decorative art that is:

1. in the custody of the Commission on Artistic Property; and

2. owned by or loaned to the State; **AND**

(XX) THE HEALTH SERVICES COST REVIEW COMMISSION TO IMPLEMENT SECTION 3 OF SENATE BILL 1103 (2024).

SECTION 3. AND BE IT FURTHER ENACTED, THAT:

Page 8, line 16, strike " insert "SECTION 3." and insert "SECTION 4."

Page 8, line 17, insert after the period the following: "**SECTIONS 2 AND 3 OF THIS ACT, AT THE END OF JUNE 30, 2026, WITH NO FURTHER ACTION REQUIRED BY THE GENERAL ASSEMBLY, SHALL BE ABROGATED AND OF NO FURTHER FORCE AND EFFECT.**"