MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

February 20, 2026

VIA ELECTRONIC DELIVERY
Senator Beidle
Chair, Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: Opposing SB 494 to Protect Independent Medical Practices

On behalf of the Maryland Patient Care and Access Coalition ("MPCAC"), we respectfully ask that the Senate Finance Committee ("Committee") oppose SB 494 because of our concerns about its potential impact on independent medical practices. We share the Committee's concerns about provider consolidation but believe that SB 494, as currently written, would have the unintended consequence of accelerating the very consolidation it seeks to address—and would do so at the expense of the independent physician practices that serve as a vital competitive counterbalance to Maryland's highly consolidated hospital and insurance markets. We ask that the Committee allow stakeholders, including independent physician practices, to work with legislators and other interested parties outside of session to refine this bill in a manner that addresses legitimate concerns about consolidation while protecting the viability of independent medicine as a critical access point for health care services for Maryland patients.

The bill's focus on physician practices and ambulatory surgery centers is of particular relevance to MPCAC, given the leading role MPCAC has played as the voice of independent medicine in the State over the last 20 years. MPCAC's mission is to promote and protect the high-quality, cost-efficient care furnished to patients in Maryland in the independent medical practice setting. Since 2004, MPCAC has represented independent medical practices who care for hundreds of thousands of patients each year in the fields of gastroenterology, medical oncology, orthopedic surgery, radiation oncology, urology, and other specialties. MPCAC's members recognize that to remain independent, we must continue to grow our practices and capabilities. We believe that health policy in the State needs to be shaped in such a way that ensures a robust community of independent medical practices delivering care alongside health systems, academic medical centers, and vertically-integrated payor/provider models ("pay-viders"), which is why it is so important that any legislation that shifts the competitive balance of Maryland's health care market, as SB 494 would, is done responsibly and with great care.

This letter sets forth our concerns with SB 494 and is organized into two sections. First, we provide an overview of the current landscape of Maryland's health care market, its high levels of hospital and insurer consolidation, the economic pressures facing independent physician practices, and the critical role these practices play in providing cost-effective, high-quality care to Marylanders. Second, we explain why we believe the transaction review process proposed in SB 494 would inadvertently harm independent practices by creating regulatory burdens and approval risks that only Maryland's dominant hospitals and insurers can afford to bear, thereby accelerating—rather than curbing—the very consolidation the bill seeks to address. Because we are concerned with both the current state of the market and the material change transaction review process, we believe the best path forward is to take the time out of session to include MPCAC and other stakeholders in the process of formulating policy solutions that promote competition and access to health care services—something that has not happened to date with respect to this bill.

The Current Landscape of Maryland's Health Care Market

Independent physician practices represent a shrinking but critical component of Maryland's health care delivery system. They provide high-quality, patient-centered care at a lower cost than hospital-based providers, making them indispensable to Maryland's efforts to control health care expenditures. Declining reimbursement,[1] physician workforce shortages,[2] and ever-climbing costs and compliance requirements have created an environment in which independent physician practices must either find a way to grow their way to success and remain independent or concede to acquisition by a health system or insurance company. These harsh economic realities have pushed many of these practices into employment by hospitals and pay-viders, a particularly concerning trend for Maryland where these care settings are already highly consolidated.

Hospital market concentration in Maryland far exceeds the national average. According to the Hilltop Institute's report to the Maryland Health Care Commission ("MHCC") this past December (the "Hilltop Report"), since 2020, the State has not had a hospital that isn't affiliated with a health system.[3] Furthermore, of the 18 health systems in the State, just four academic health systems account for the majority of our hospitals: Johns Hopkins Health System, LifeBridge (affiliated with George Washington University), Medstar (affiliated with Georgetown University), and The University of Maryland Medical System.[4] Such high levels of concentration mean that

[1] Since 2001, Medicare reimbursement rates for health care services furnished on an inpatient basis at hospitals, in hospital outpatient centers, and in skilled nursing facilities have increased by approximately 70 percent. Reimbursement for physicians has increased at a fraction of that rate – just 10 percent – which is actually down 30 percent when adjusted for inflation. *Medicare physician payment is not keeping up with inflation*, American Medical Association (Apr. 2023), available at https://www.ama-assn.org/system/files/medicare-updates-inflation-chart-cumulative.pdf.

[2] Maryland is projected to be short more than 1,000 doctors by 2030, and 35.8% of physicians in Maryland are currently within retirement age. *Maryland Physician Shortage Facts*, Cicero Institute (February 15, 2024), available at https://ciceroinstitute.org/research/maryland-physician-shortage-facts/.

[3] Mouslim, M. & Henderson M., *Insurer and provider concentration in Maryland*, The Hilltop Institute, UMBC (December 5, 2025), at ii (the "Hilltop Report").

[4] The Hilltop Report, at 37.

Marylanders have limited options when seeking hospital-based care, and independent practices must compete against entities with massive economies of scale and substantial market power. Consolidation by hospitals has also resulted in a considerable increase in the cost of care. Moreover, literature cited in the Hilltop Report claims vertical integration into the hospital setting increases the cost of care from 14% to 47%.[5] With this data in mind, it is critical that legislation designed to address consolidation not inadvertently drive physicians who care for patients in independent medical practices into the hospital setting.

Maryland's health insurance market is even more consolidated than the hospital market. Just two insurers—CareFirst and Kaiser—control more than 82% of the insurance markets.[6] Both of these major insurers have vertically integrated providers into their corporate structures, which further consolidates market power and reduces competition. At the same time, insurers have been able to use their dominant market shares to keep commercial provider reimbursement in Maryland among the lowest in the country, ranking the third lowest among all 50 states with only Alabama and Delaware having lower reimbursement rates as a percentage of Medicare reimbursement for professional services.[7] This disparity is not a small difference; it means that for every dollar a physician in the average state receives for a particular service, a Maryland physician receives approximately 85 cents.[8] Over time, this differential compounds, reducing the ability of independent practices to invest in new technology, recruit talented physicians, expand into underserved communities, and simply maintain their operations.

With the current state of the market reflecting dangerously high levels of consolidation, it is right to consider legislative solutions that would strengthen competition, improve access and decrease the overall cost of care. However, Maryland's problem is not that the market is rapidly consolidating such that there needs to be greater oversight but, rather, that the market has already consolidated to the point where it is difficult for all but the largest health care entities to meaningfully compete. We are concerned that the proposed material change transaction notice, review and approval process in SB 494 will further entrench the dominant positions of Maryland's hospitals and insurers by creating an onerous review process that only these dominant players can afford the risk of undertaking.

The Proposed Transaction Review Process Will Deter the Growth of Independent Practices

The material change transaction notice, review and approval process proposed by SB 494 would impose significant burdens on independent medical practices seeking to grow and remain competitive by sweeping into its scope nearly all transactions with physician practices and establishing a "pay-to-play" system in which only the entities with the most dominant market shares can survive. The bill's low revenue thresholds, lengthy notice and review periods, and broad

[5] The Hilltop Report, at 52.
[6] The Hilltop Report, at ii.
[7] The Hilltop Report, at 19-20.
[8] The national average for commercial professional reimbursement is 122% of Medicare, whereas the average in Maryland is 104% of Medicare.

(and virtually unchecked) MHCC Executive Director approval authority would create costs and risks that only the State's largest and most well-resourced entities—namely, hospital systems and major insurers—could realistically absorb. Rather than promoting competition, this framework threatens to deter the very transactions that would enable independent practices to achieve the scale necessary to survive in Maryland's already highly consolidated market.

SB 494 proposes to respond to consolidation by establishing a transaction notice, review and approval process for transactions involving health care entities, broadly defined to capture nearly all health care facilities and physician practices, in which the entity, or a new entity, has combined revenues of $10 million.[9] We are aware of only three other states with such a low threshold, and its effect would ultimately require that nearly all but the smallest transactions would trigger the notice requirement.[10]

Once the threshold for a material change transaction is met, the parties would be required to submit notice to MHCC 90 days before completing their transaction. The 90-day period begins when MHCC deems the notice "complete," a decision entirely subject to MHCC's discretion.[11] Within 30-days of providing complete notice, the Executive Director of MHCC could allow the parties to proceed after the 90-day waiting period is up or choose to subject the transaction to a comprehensive and costly "public interest" review process.[12] The standards for what the Executive Director shall consider when determining whether a transaction should be subjected to public interest review are highly ambiguous. A mere determination that the transaction is likely to have a negative impact on health care services is sufficient to warrant heightened scrutiny.[13]

If subjected to public interest review, the parties to the transaction must then wait an additional 60 days while the Executive Director completes this second-level review.[14] In conducting a public interest review, the Executive Director would be permitted to solicit public comments, the opinions of experts and consultants at the parties expense, and feedback from the employees of the entities.[15] This threatens to not only drive up the cost of transactions by requiring the parties to pay for consultants that they had no role in selecting or hiring, but it would also cloud the factual basis of the review by considering feedback from members of the public who are uninformed about the purpose for or outcome of the transaction, and worse, from competitors that would benefit if the transaction was prevented from proceeding.

At the end of the 60-day review process, the Executive Director is given the authority to approve the transaction, approve the transaction with conditions, or deny the parties from proceeding with the transaction. We are aware of only two other states, Oregon and Minnesota,

[9] SB 494 Section 19-120-3(A)(5)(I).
[10] Illinois, Indiana, and Minnesota.
[11] SB 494 Section 19-120-3(D)(1), (2).
[12] Section 19-120-3(F).
[13] Section 19-120-3(G).
[14] Section 19-120-3(H)(2).
[15] Section 19-120-3(H)(3).

where such approval power is contemplated for transactions involving physician practices and Minnesota's approval power is only applicable to transactions with a value of more than $80 million. MPCAC is most concerned about this step in the process, because after the parties have gone through the process and expense of entering into the transactions, preparing the transaction notice, and enduring the public interest review process, they then face the possibility of their transaction being rejected by MHCC. Effectively, the bill provides MHCC's Executive Director with complete control over Maryland's health care market. The costs and risks associated with this process would mean that most transactions, except those between large enough enterprises that can afford the risk, would likely be abandoned if initially subjected to public interest review. We are deeply concerned about vesting this level of discretionary authority in one individual without adequate guardrails.

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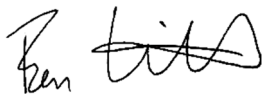
We are concerned that the proposed material change transaction review process would further entrench Maryland's consolidated health care markets, rather than foster a more competitive environment. That is why we believe that this Committee should work with MHCC and stakeholders, including independent practices, to develop legislation that promotes competition and safeguards access to high quality, cost-efficient care for Maryland patients.

We thank you for your consideration, and we would welcome the opportunity to continue this dialogue. Please reach out to MPCAC's lobbyist, Joe Bryce (jbryce@maniscanning.com), if we can be of any assistance as you refine this important legislation.

Sincerely,



Ben Lowentritt, M.D.
MPCAC President & Chairman of the Board

cc: All Senate Finance Committee Members