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March 3, 2026

Delegate Heather Bagnall
Chair, House Health Committee
241 Taylor House Office Building
Annapolis, Maryland 21401

RE: HB 1153 – Claims for Reimbursement – Downcoding

Dear Chair Bagnall:

On behalf of America's Health Insurance Plans (AHIP), we appreciate the opportunity to provide our concerns with HB 1153, legislation which would prohibit health insurers from engaging in claims accuracy initiatives, even though this targeted practice is limited to a small subset of outlier physicians that are out of step with their peers.

Health plans are committed to ensuring providers are reimbursed fairly and accurately and to protecting patients from unjustified costs. As part of their efforts to advance quality and affordability, health plans work to ensure submitted codes accurately reflect the complexity of care delivered and identify via statistical analyses outlier physician practices that are not following coding guidelines or meeting clinical criteria and have demonstrated patterns of overbilling, or "upcoding."

Providers are using AI to maximize billing in a way that is not always justified. Audits conducted by the Centers for Medicare Medicaid Services (CMS) and the Office of the Inspector General (OIG) have consistently found evidence of billing for higher-level codes without sufficiently meeting clinical criteria.

Upcoding by providers represents billions of dollars in unnecessary health care spending that leads to higher health insurance premiums, as documented by evidence spanning over a decade:

- Medicare inappropriately paid $6.7 billion for claims for Evaluation and Management (E/M) services in 2010 that were incorrectly coded and/or lacking documentation, representing 21% of Medicare payments for E/M services that year.[4]
- Studies have estimated that increases in upcoding of diagnosis-related coding at hospitals in 2019 was associated with $14.6 billion in hospital payments, including $5.8 billion from private health plans, $4.6 billion from Medicare, and $1.8 billion from Medicaid.[5]
- Between 2002-2012, upcoding cost publicly funded programs an estimated $11billion, highlighting this practice as a driver of waste, fraud, and unnecessary spending in the U.S. health system.[6]

To that end, the following HB 1153 provisions raise significant concerns:

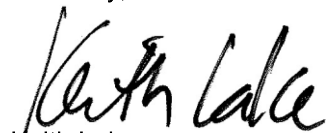
- **Proposed Insurance Article § 15–1005.1(B)(1)**
- **Proposed Insurance Article §15–1005.1(B)(2)**
- **Proposed Insurance Article §15–1005.1(B)(3)**
- **Proposed Insurance Article §15–1005.1(B)(4)**
- **Proposed Insurance Article §15–1005.1(C) and (D)**
- **Proposed Insurance Article §15–1005.1(F)**

Prohibiting health plans from adopting programs to ensure that billing codes submitted match the care a patient actually received will make these financial impacts worse, not better. It undermines insurers' ability to prevent abuse, thus forcing them to pay inflated or incorrect claims, while encouraging

inaccurate billing practices by providers. This raises overall health care spending and increases premiums for employers and consumers.

For the reasons described above, AHIP respectfully opposes HB 1153 and respectfully urges the House Health Committee not to move the bill forward.

Sincerely,



Keith Lake
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AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.