Maryland
Hospital Association

House Bill 1153- Maryland Medical Assistance Program and Health Insurance - Claims for Reimbursement - Downcoding

Position: *Support*
March 5, 2026
House Health 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 House Bill 1153. When Marylanders think they may be experiencing an emergency, they should go to the emergency department (ED) right away, not hesitate because they worry an insurer will later deny coverage on a technicality. This bill provides patients with the assurance they need to act quickly, and it supports hospitals that must treat first and worry about payment later.

Maryland's Prudent Lay Person Standard and Federal EMTALA Requirements
Maryland law is designed to ensure that emergency care is covered and reimbursed based on the symptoms as presented, by a reasonably prudent layperson, when they arrive in an ED, not on the final diagnosis. Someone experiencing crushing chest pain cannot possibly know whether they are having a heart attack or something less dangerous until a hospital conducts the necessary tests and complex clinical evaluations. The law is written so that patients do not hesitate to go to the hospital out of fear that they will be stuck with large out-of-pocket costs if the final diagnosis turns out to be less severe. The Emergency Medical Treatment & Labor Act (EMTALA) creates a parallel responsibility for hospitals. It requires clinicians to examine and stabilize anyone who comes to the ED without delay, regardless of insurance or ability to pay. Hospitals must act immediately based on the patients' symptoms, not on a diagnosis that can only be known after necessary medical tests are completed.

How Payers Underpay for Emergency Care
To understand how insurers underpay for emergency care, it is helpful to look at how medical billing works. An emergency room bill can include a wide range of itemized services. It includes the physical tools and diagnostic tests used during the visit, such as running laboratory blood work, taking X-rays, or performing a CT scan. A medical bill also includes charges for the actual "medical work" performed by the physician, nurse, or other health care practitioner. This covers their clinical expertise, the time spent evaluating complex symptoms, and the medical decision making required to keep a patient safe based on those test results.

Payers systematically reduce what they pay for emergency care by exploiting technicalities and hindsight rather than the symptoms that caused the patient to seek emergency care.

- One practice is to judge a claim by the final diagnosis instead of the symptoms at the door. Plans then lower or deny payment for the physician's work if the outcome appears

less dangerous than what the symptoms suggested. A patient who presents with crushing chest pain must receive a thorough heart-attack work-up. If testing later shows indigestion, some plans reduce or deny payment for the practitioner's work even though the evaluation was necessary because the risk was unknown at arrival.

- A second practice is to split the bill. The plan will pay for the labs and imaging that were clearly needed yet deny or reduce the portion that pays for the physician's judgment to examine the patient and decide to order and ultimately interrupt the labs and test that were already paid for. This practice is often done through artificial intelligence or automated edits without any clinician reviewing the chart.
- A third practice is when payers deny all or part of the claim and instruct the hospital to resubmit at a lower level in order to be paid. This pressures providers to accept reduced payment rather than undertake a lengthy appeal.

Although these practices differ in form, they produce the same result by leveraging administrative friction to reduce payment. Contesting a denial requires specialized staff time, clinical input, and repeated documentation, which makes appeals expensive and slow for hospitals. While the claim is tied up, the insurer retains the cash and the provider bears the carrying cost, increasing pressure to accept a reduced amount simply to resolve the account. Even if a denial is eventually reversed, the insurer has already financially benefited from the delay and from the deterrent effect that discourages providers from appealing similar claims in the future. These financial and operational incentives are why denials and downcoding strategies persist, and why a statutory fix like HB 1153 is necessary to fix these payer practices.

How This Bill Addresses Payer Practices to Reduce Payment for Emergency Care

HB 1153 would address administrative hurdles and automated practices insurers use to underpay for emergency care. These reforms apply to all payers operating in the state, including commercial carriers and managed care organizations. First, the bill defines downcoding and prohibits payers from downcoding claims using automated processes (including AI). Second, it standardizes the downcoding process by establishing certain requirements and timelines to ensure claims are not pending for long periods of time. It requires insurers to honor the same documentation and well-established coding standards that providers already follow. Furthermore, any denial or reduction in payment must now follow a review conducted by a physician in the exact same specialty. For emergency visits, that medical judgment must be based solely on the symptoms documented at the patient's arrival, strengthening Maryland's existing prudent lay-person standard. Finally, this bill strengthens reporting requirements around this practice to ensure greater transparency and accountability.

Impact on Hospitals

These practices significantly reduce the financial resources hospitals have available to deliver quality care. Systematically denying or effectively downcoding claims causes hospitals to lose millions of dollars in rightful reimbursement and requires them to expend significant resources submitting, processing, and unnecessarily contesting claims. Hospitals are now forced to hire entire teams of additional administrative staff just to deal with these systemic payer practices. Under Maryland's unique payment model, hospitals operate on fixed budgets and cannot raise

prices in response to these payer practices. Additionally, every dollar a hospital is forced to spend hiring administrative staff to fight an insurance company for rightful payment is a dollar taken directly away from patient care. Allowing insurers to withhold these funds adds insult to injury, especially as our hospitals navigate the complex transition to the AHEAD Model and brace for significant federal Medicaid cuts.

Denials are a significant and growing problem for Maryland hospitals, and the state's own data shows it. MHA's review of Health Services Cost Review Commission (HSCRC) data found total dollars tied up in denials dollars have risen 75% since FY 2021, which means more staff time spent on paperwork instead of caring for patients. In emergency departments, the impact is especially harmful. In FY 2024, **one in seven ED claims was denied—roughly 245,000 claims totaling about $77 million**. These resources are lost to denials rather than going to hiring staff, providing direct care, and reducing ED wait times.

By passing HB 1153, Maryland can ensure that health care resources are used to treat patients who need emergency care, rather than being diverted into a costly and avoidable cycle of administrative disputes.

For these reasons, we request a favorable report on HB 1153.

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