HOUSE BILL 639

C3 6lr0405

By: **Delegates Kelly, Frick, Jalisi, Korman, Lam, Reznik, ~~and Waldstreicher~~ Waldstreicher, Hill, Hammen, Angel, Barron, Bromwell, Cullison, Hayes, Kipke, Krebs, McDonough, McMillan, Miele, Morgan, Morhaim, Oaks, Pena–Melnyk, Pendergrass, Rose, Saab, Sample–Hughes, West, and K. Young**

Introduced and read first time: February 4, 2016
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 9, 2016

CHAPTER ______

1 AN ACT concerning

2 **Health Insurance – Provider Claims – Payment by Credit Card ~~– Prohibited~~ or**
3 **Electronic Funds Transfer Payment Method**

4 FOR the purpose of ~~prohibiting~~ authorizing an insurer, nonprofit health service plan, or
5 health maintenance organization ~~from paying~~, under certain circumstances, to pay
6 certain claims for reimbursement submitted by certain providers of health care
7 services using a credit card or electronic funds transfer payment method that
8 imposes a fee or similar charge; requiring the acceptance by a certain provider or the
9 provider's designee of a certain payment method to apply to certain claims; defining
10 a certain term; and generally relating to the payment by insurers, nonprofit health
11 service plans, and health maintenance organizations of claims for reimbursement
12 submitted by health care providers.

13 BY repealing and reenacting, with amendments,
14 Article – Insurance
15 Section 15–1005
16 Annotated Code of Maryland
17 (2011 Replacement Volume and 2015 Supplement)

18 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
19 That the Laws of Maryland read as follows:

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

1 **Article – Insurance**

2 15–1005.

3 (a) In this section, "clean claim" means a claim for reimbursement, as defined in
4 regulations adopted by the Commissioner under § 15–1003 of this subtitle.

5 (b) To the extent consistent with the Employee Retirement Income Security Act
6 of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health
7 service plan, or health maintenance organization that acts as a third party administrator.

8 (c) Except as provided in § 15–1315 of this title and subsection **[**(h)**]** **(I)** of this
9 section, within 30 days after receipt of a claim for reimbursement from a person entitled to
10 reimbursement under § 15–701(a) of this title or from a hospital or related institution, as
11 those terms are defined in § 19–301 of the Health – General Article, an insurer, nonprofit
12 health service plan, or health maintenance organization shall:

13 (1) mail or otherwise transmit payment for the claim in accordance with
14 this section; or

15 (2) send a notice of receipt and status of the claim that states:

16 (i) that the insurer, nonprofit health service plan, or health
17 maintenance organization refuses to reimburse all or part of the claim and the reason for
18 the refusal;

19 (ii) that, in accordance with § 15–1003(d)(1)(ii) of this subtitle, the
20 legitimacy of the claim or the appropriate amount of reimbursement is in dispute and
21 additional information is necessary to determine if all or part of the claim will be
22 reimbursed and what specific additional information is necessary; or

23 (iii) that the claim is not clean and the specific additional information
24 necessary for the claim to be considered a clean claim.

25 ~~**(D) (1) IN THIS SUBSECTION, "CREDIT CARD" MEANS ANY CARD OR**~~
26 ~~**OTHER DEVICE ISSUED BY A CREDIT CARD ISSUER FOR THE USE OF THE**~~
27 ~~**CARDHOLDER IN OBTAINING MONEY, GOODS, SERVICES, OR ANYTHING OF VALUE ON**~~
28 ~~**CREDIT.**~~

29 ~~**(2) AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH**~~
30 ~~**MAINTENANCE ORGANIZATION MAY NOT PAY A CLAIM UNDER SUBSECTION (C) OF**~~
31 ~~**THIS SECTION OR A PORTION OF A CLAIM UNDER SUBSECTION (F) OF THIS SECTION,**~~
32 ~~**USING A CREDIT CARD.**~~

1 (D) (1) (I) IN THIS SUBSECTION, "CREDIT CARD" MEANS A CREDIT,
2 DEBIT, PREPAID, OR STORED–VALUE CARD USED TO MAKE A PAYMENT THROUGH A
3 PRIVATE CARD NETWORK.

4 (II) "CREDIT CARD" INCLUDES A METHOD OF PAYMENT TO A
5 PROVIDER WHERE NO PHYSICAL CARD IS PRESENTED.

6 (2) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH
7 MAINTENANCE ORGANIZATION MAY PAY A CLAIM UNDER SUBSECTION (C) OF THIS
8 SECTION, OR A PORTION OF A CLAIM UNDER SUBSECTION (F) OF THIS SECTION,
9 USING A CREDIT CARD OR AN ELECTRONIC FUNDS TRANSFER PAYMENT METHOD
10 THAT IMPOSES ON THE PROVIDER A FEE OR SIMILAR CHARGE TO PROCESS THE
11 PAYMENT IF:

12 (I) THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR
13 HEALTH MAINTENANCE ORGANIZATION NOTIFIES THE PROVIDER IN ADVANCE OF
14 THE PAYMENT THAT:

15 1. A FEE OR SIMILAR CHARGE ASSOCIATED WITH THE
16 USE OF THE CREDIT CARD OR ELECTRONIC FUNDS TRANSFER PAYMENT METHOD
17 WILL APPLY; AND

18 2. THE PROVIDER WILL NEED TO CONSULT THE
19 PROVIDER'S MERCHANT PROCESSOR OR FINANCIAL INSTITUTION FOR THE SPECIFIC
20 RATES;

21 (II) THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR
22 HEALTH MAINTENANCE ORGANIZATION OFFERS THE PROVIDER AN ALTERNATIVE
23 PAYMENT METHOD THAT DOES NOT IMPOSE A FEE OR SIMILAR CHARGE ON THE
24 PROVIDER; AND

25 (III) THE PROVIDER OR THE PROVIDER'S DESIGNEE ELECTS TO
26 ACCEPT PAYMENT OF THE CLAIM OR A PORTION OF THE CLAIM USING THE CREDIT
27 CARD OR ELECTRONIC FUNDS TRANSFER PAYMENT METHOD.

28 (3) IF A PROVIDER PARTICIPATES ON A PROVIDER PANEL OF AN
29 INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE
30 ORGANIZATION, THE ACCEPTANCE BY THE PROVIDER OR THE PROVIDER'S
31 DESIGNEE OF A PAYMENT METHOD OFFERED UNDER PARAGRAPH (2)(II) OF THIS
32 SUBSECTION OR ELECTED UNDER PARAGRAPH (2)(III) OF THIS SUBSECTION SHALL
33 APPLY TO ALL CLAIMS PAID FOR BY THE INSURER, NONPROFIT HEALTH SERVICE
34 PLAN, OR HEALTH MAINTENANCE ORGANIZATION UNLESS OTHERWISE NOTIFIED BY
35 THE PROVIDER OR THE PROVIDER'S DESIGNEE.

1 **[**(d)**]** **(E)** (1) An insurer, nonprofit health service plan, or health maintenance
2 organization shall permit a provider a minimum of 180 days from the date a covered service
3 is rendered to submit a claim for reimbursement for the service.

4 (2) If an insurer, nonprofit health service plan, or health maintenance
5 organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit
6 health service plan, or health maintenance organization shall permit a provider a minimum
7 of 90 working days after the date of denial of the claim to appeal the denial.

8 (3) If an insurer, nonprofit health service plan, or health maintenance
9 organization erroneously denies a provider's claim for reimbursement submitted within the
10 time period specified in paragraph (1) of this subsection because of a claims processing
11 error, and the provider notifies the insurer, nonprofit health service plan, or health
12 maintenance organization of the potential error within 1 year of the claim denial, the
13 insurer, nonprofit health service plan, or health maintenance organization, on discovery of
14 the error, shall reprocess the provider's claim without the necessity for the provider to
15 resubmit the claim, and without regard to timely submission deadlines.

16 **[**(e)**]** **(F)** (1) If an insurer, nonprofit health service plan, or health
17 maintenance organization provides notice under subsection (c)(2)(i) of this section, the
18 insurer, nonprofit health service plan, or health maintenance organization shall mail or
19 otherwise transmit payment for any undisputed portion of the claim within 30 days of
20 receipt of the claim, in accordance with this section.

21 (2) If an insurer, nonprofit health service plan, or health maintenance
22 organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit
23 health service plan, or health maintenance organization shall:

24 (i) mail or otherwise transmit payment for any undisputed portion
25 of the claim in accordance with this section; and

26 (ii) comply with subsection (c)(1) or (2)(i) of this section within 30
27 days after receipt of the requested additional information.

28 (3) If an insurer, nonprofit health service plan, or health maintenance
29 organization provides notice under subsection (c)(2)(iii) of this section, the insurer,
30 nonprofit health service plan, or health maintenance organization shall comply with
31 subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested
32 additional information.

33 **[**(f)**]** **(G)** (1) If an insurer, nonprofit health service plan, or health
34 maintenance organization fails to pay a clean claim for reimbursement or otherwise
35 violates any provision of this section, the insurer, nonprofit health service plan, or health
36 maintenance organization shall pay interest on the amount of the claim that remains
37 unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly
38 rate of:

1 (i) 1.5% from the 31st day through the 60th day;

2 (ii) 2% from the 61st day through the 120th day; and

3 (iii) 2.5% after the 120th day.

4 (2) The interest paid under this subsection shall be included in any late
5 reimbursement without the necessity for the person that filed the original claim to make
6 an additional claim for that interest.

7 **[**(g)**]** **(H)** An insurer, nonprofit health service plan, or health maintenance
8 organization that violates a provision of this section is subject to:

9 (1) a fine not exceeding $500 for each violation that is arbitrary and
10 capricious, based on all available information; and

11 (2) the penalties prescribed under § 4–113(d) of this article for violations
12 committed with a frequency that indicates a general business practice.

13 **[**(h)**]** **(I)** (1) An insurer, a nonprofit health service plan, or a health
14 maintenance organization may suspend review of a claim for reimbursement for a
15 preauthorized or approved health care service if the insurer, nonprofit health service plan,
16 or health maintenance organization sends written notice within 30 days after receipt of the
17 claim that informs the person filing the claim, that:

18 (i) review of the claim is suspended during the second or third
19 month of a grace period under 45 C.F.R. § 156.270(d); and

20 (ii) on receipt of the payment of premium, the insurer, nonprofit
21 health service plan, or health maintenance organization is required to comply with
22 paragraph (2) of this subsection.

23 (2) Within 30 days after receipt of the payment of premium, an insurer, a
24 nonprofit health service plan, or a health maintenance organization shall comply with
25 subsection (c)(1) or (2) of this section.

26 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
27 October 1, 2016.