

HOUSE BILL 729

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By: **Delegate Hill**

Introduced and read first time: January 30, 2020

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Payment of Clean Claims – Time Limit**

3 FOR the purpose of reducing the number of days after the receipt of certain claims or
4 certain information under certain circumstances within which an insurer, a
5 nonprofit health service plan, or a health maintenance organization is required to
6 mail or otherwise transmit certain payments or send certain notices; altering a
7 requirement that an insurer, a nonprofit health service plan, or a health
8 maintenance organization pay certain interest on a certain amount of a claim under
9 certain circumstances; and generally relating to the payment of claims for
10 reimbursement by an insurer, a nonprofit health service plan, or a health
11 maintenance organization.

12 BY repealing and reenacting, with amendments,
13 Article – Insurance
14 Section 15–1005
15 Annotated Code of Maryland
16 (2017 Replacement Volume and 2019 Supplement)

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

19 **Article – Insurance**

20 15–1005.

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

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

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 (c) Except as provided in § 15–1315 of this title and subsection (i) of this section,
2 within [30] 3 days after receipt of a claim for reimbursement from a person entitled to
3 reimbursement under § 15–701(a) of this title or from a hospital or related institution, as
4 those terms are defined in § 19–301 of the Health – General Article, an insurer, nonprofit
5 health service plan, or health maintenance organization shall:

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

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

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

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

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

18 (d) (1) (i) In this subsection, “credit card” means a credit, debit, prepaid, or
19 stored–value card used to make a payment through a private card network.

20 (ii) “Credit card” includes a method of payment to a provider where
21 no physical card is presented.

22 (2) An insurer, a nonprofit health service plan, or a health maintenance
23 organization may pay a claim under subsection (c) of this section, or a portion of a claim
24 under subsection (f) of this section, using a credit card or an electronic funds transfer
25 payment method that imposes on the provider a fee or similar charge to process the
26 payment if:

27 (i) the insurer, nonprofit health service plan, or health maintenance
28 organization notifies the provider in advance of the payment that:

29 1. a fee or similar charge associated with the use of the credit
30 card or electronic funds transfer payment method will apply; and

31 2. the provider will need to consult the provider’s merchant
32 processor or financial institution for the specific rates;

33 (ii) the insurer, nonprofit health service plan, or health maintenance
34 organization offers the provider an alternative payment method that does not impose a fee

1 or similar charge on the provider; and

2 (iii) the provider or the provider's designee elects to accept payment
3 of the claim or a portion of the claim using the credit card or electronic funds transfer
4 payment method.

5 (3) If a provider participates on a provider panel of an insurer, a nonprofit
6 health service plan, or a health maintenance organization, the acceptance by the provider
7 or the provider's designee of a payment method offered under paragraph (2)(ii) of this
8 subsection or elected under paragraph (2)(iii) of this subsection shall apply to all claims
9 paid for by the insurer, nonprofit health service plan, or health maintenance organization
10 unless otherwise notified by the provider or the provider's designee.

11 (e) (1) An insurer, nonprofit health service plan, or health maintenance
12 organization shall permit a provider a minimum of 180 days from the date a covered service
13 is rendered to submit a claim for reimbursement for the service.

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

18 (3) If an insurer, nonprofit health service plan, or health maintenance
19 organization erroneously denies a provider's claim for reimbursement submitted within the
20 time period specified in paragraph (1) of this subsection because of a claims processing
21 error, and the provider notifies the insurer, nonprofit health service plan, or health
22 maintenance organization of the potential error within 1 year of the claim denial, the
23 insurer, nonprofit health service plan, or health maintenance organization, on discovery of
24 the error, shall reprocess the provider's claim without the necessity for the provider to
25 resubmit the claim, and without regard to timely submission deadlines.

26 (f) (1) If an insurer, nonprofit health service plan, or health maintenance
27 organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit
28 health service plan, or health maintenance organization shall mail or otherwise transmit
29 payment for any undisputed portion of the claim within [30] 3 days of receipt of the claim,
30 in accordance with this section.

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

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

36 (ii) comply with subsection (c)(1) or (2)(i) of this section within [30]
37 3 days after receipt of the requested additional information.

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

6 (g) (1) If an insurer, nonprofit health service plan, or health maintenance
7 organization fails to pay a clean claim for reimbursement or otherwise violates any
8 provision of this section, the insurer, nonprofit health service plan, or health maintenance
9 organization shall pay interest on the amount of the claim that remains unpaid [30] 3 days
10 after receipt of the initial clean claim for reimbursement at the monthly rate of:

11 (i) 1.5% from the [31st] 4TH day through the 60th day;

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

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

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

17 (h) An insurer, nonprofit health service plan, or health maintenance organization
18 that violates a provision of this section is subject to:

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

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

23 (i) (1) An insurer, a nonprofit health service plan, or a health maintenance
24 organization may suspend review of a claim for reimbursement for a preauthorized or
25 approved health care service if the insurer, nonprofit health service plan, or health
26 maintenance organization sends written notice within 30 days after receipt of the claim
27 that informs the person filing the claim, that:

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

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

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

1 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
2 October 1, 2020.