HOUSE BILL 739

J5, J4 6lr2039

By: **Delegate Martinez**
Introduced and read first time: February 3, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Health Insurance – Prompt Payment of Claims – Requirements

FOR the purpose of requiring insurers, nonprofit health service plans, and health maintenance organizations to send certain notices in a certain manner; requiring that certain refusals to reimburse by insurers, nonprofit health service plans, and health maintenance organizations be considered denials of all or part of certain claims; requiring insurers, nonprofit health service plans, and health maintenance organizations to pay or refuse to reimburse all or part of certain claims if certain information is not provided within a certain number of days; and generally relating to prompt payment requirements for health insurance claims.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1005
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

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

Article – Insurance

15–1005.

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

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health 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.

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

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

(2) **[**send**] MAIL OR E–MAIL** a notice of receipt and status of the claim that states:

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

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

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

(D) A REFUSAL TO REIMBURSE ALL OR PART OF A CLAIM FOR REIMBURSEMENT UNDER SUBSECTION (C)(2)(I) OF THIS SECTION SHALL BE CONSIDERED A DENIAL OF ALL OR PART OF THE CLAIM.

[(d)**] (E)** (1) (i) In this subsection, "credit card" means a credit, debit, prepaid, or stored–value card used to make a payment through a private card network.

(ii) "Credit card" includes a method of payment to a provider where no physical card is presented.

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

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

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

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

(ii) the insurer, nonprofit health service plan, or health maintenance organization offers the provider an alternative payment method that does not impose a fee or similar charge on the provider; and

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

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

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

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

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

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

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

(i) **1.** mail or otherwise transmit payment for any undisputed portion of the claim in accordance with this section; and

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

(II) IF THE PROVIDER DOES NOT SEND THE REQUESTED ADDITIONAL INFORMATION WITHIN 30 DAYS, COMPLY WITH SUBSECTION (C)(1) OR (2)(I) OF THIS SECTION.

(3) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(iii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall**:**

(I) comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information**; OR**

(II) IF THE PROVIDER DOES NOT SEND THE REQUESTED ADDITIONAL INFORMATION WITHIN 30 DAYS, COMPLY WITH SUBSECTION (C)(1) OR (2)(I) OF THIS SECTION.

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

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

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

(iii) 2.5% after the 120th day.

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

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

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

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

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

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

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

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

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.