HOUSE BILL 1450

J5 6lr2040

By: **Delegate S. Johnson**
Introduced and read first time: February 13, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Health Insurance – Coordination of Benefits – Carrier Responsibilities and Retroactive Denials of Reimbursement

FOR the purpose of requiring, if a claim is submitted to a carrier and is subject to coordination of benefits with another payor, the carrier to identify certain payors, identify the amounts payable by certain payors, and coordinate benefits with certain payors; altering the time period in which a carrier may retroactively deny reimbursement subject to coordination of benefits with another carrier; and generally relating to coordination of benefits by health insurance carriers.

BY adding to
Article – Insurance
Section 15–1005.1
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1008
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

15–1005.1.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" HAS THE MEANING STATED IN § 15–1008 OF THIS SUBTITLE.

(3) "PAYOR" MEANS A CARRIER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, OR THE MEDICARE PROGRAM.

(B) IF A CLAIM IS SUBMITTED TO A CARRIER AND IS SUBJECT TO COORDINATION OF BENEFITS WITH ANOTHER PAYOR, THE CARRIER SHALL BE RESPONSIBLE FOR:

(1) IDENTIFYING THE PRIMARY AND SECONDARY PAYORS;

(2) IDENTIFYING THE AMOUNTS PAYABLE BY EACH PAYOR; AND

(3) COORDINATING ITS BENEFITS WITH THE BENEFITS OF THE OTHER PAYORS BY DETERMINING THE ORDER OF PAYMENTS AND ENSURING THAT COMBINED PAYMENTS DO NOT EXCEED 100% OF THE TOTAL CLAIM.

(C) EACH CARRIER SHALL SUBMIT AN ANNUAL REPORT ON ITS ACTIVITIES UNDER THIS SECTION TO THE COMMISSIONER IN THE FORM REQUIRED BY THE COMMISSIONER.

15–1008.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization;

(v) a managed care organization, as defined in § 15–101 of the Health – General Article; or

(vi) any other person that provides health benefit plans subject to regulation by the State.

(3) "Code" means:

(i) the applicable current procedural terminology (CPT) code, as adopted by the American Medical Association;

(ii) if for a dental service, the applicable code adopted by the American Dental Association; or

(iii) another applicable code under an appropriate uniform coding scheme used by a carrier in accordance with this section.

(4) "Coding guidelines" means those standards or procedures used or applied by a payor to determine the most accurate and appropriate code or codes for payment by the payor for a service or services.

(5) "Health care provider" means a person or entity licensed, certified or otherwise authorized under the Health Occupations Article or the Health – General Article to provide health care services.

(6) "Reimbursement" means payments made to a health care provider by a carrier on either a fee–for–service, capitated, or premium basis.

(b) This section does not apply to an adjustment to reimbursement:

(1) made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract; or

(2) made as part of a two–sided incentive arrangement that complies with § 15–113 of this title.

(c) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) **SUBJECT TO ITEM (II) OF THIS PARAGRAPH, MAY ONLY RETROACTIVELY DENY REIMBURSEMENT FOR SERVICES SUBJECT TO COORDINATION OF BENEFITS WITH ANOTHER CARRIER DURING THE 9–MONTH PERIOD AFTER THE DATE ON WHICH THE CARRIER PAID THE HEALTH CARE PROVIDER;**

(II) may only retroactively deny reimbursement for services subject to coordination of benefits with **[**another carrier,**]** the Maryland Medical Assistance Program**[**,**]** or the Medicare Program during the 18–month period after the date that the carrier paid the health care provider; and

[(ii)**] (III)** except as provided in **[**item (i)**] ITEMS (I) AND (II)** of this paragraph, may only retroactively deny reimbursement during the 6–month period after the date that the carrier paid the health care provider.

(2) (i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits by a carrier that is not a managed care organization, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) Except as provided in subsection (e) of this section, a carrier that does not comply with the provisions of subsection (c) of this section may not retroactively deny reimbursement or attempt in any manner to retroactively collect reimbursement already paid to a health care provider.

(e) (1) The provisions of subsection (c)(1) of this section do not apply if a carrier retroactively denies reimbursement to a health care provider because:

(i) the information submitted to the carrier was fraudulent;

(ii) the information submitted to the carrier was improperly coded and the carrier has provided to the health care provider sufficient information regarding the coding guidelines used by the carrier at least 30 days prior to the date the services subject to the retroactive denial were rendered;

(iii) the claim submitted to the carrier was a duplicate claim; or

(iv) for a claim submitted to a managed care organization, the claim was for services provided to a Maryland Medical Assistance Program recipient during a time period for which the Program has permanently retracted the capitation payment for the Program recipient from the managed care organization.

(2) Information submitted to the carrier may be considered to be improperly coded under paragraph (1) of this subsection if the information submitted to the carrier by the health care provider:

(i) uses codes that do not conform with the coding guidelines used by the carrier applicable as of the date the service or services were rendered; or

(ii) does not otherwise conform with the contractual obligations of the health care provider to the carrier applicable as of the date the service or services were rendered.

(f) If a carrier retroactively denies reimbursement for services as a result of coordination of benefits under provisions of subsection (c)(1)(i) **OR (II)** of this section, the health care provider shall have 6 months from the date of denial, unless a carrier permits a longer time period, to submit a claim for reimbursement for the service to the carrier, Maryland Medical Assistance Program, or Medicare Program responsible for payment.

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