HOUSE BILL 1464

J5 6lr2041

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

A BILL ENTITLED

AN ACT concerning

Health Insurance – Third–Party Administrators – Verification of Eligibility

FOR the purpose of requiring third–party administrators of plans that provide health benefits to develop a process through which a health care provider can request information to determine the eligibility of an enrollee and the administrator can respond to a request in a timely manner; prohibiting certain carriers from retroactively denying reimbursement to a provider who used a certain process to confirm an enrollee was eligible for certain services; and generally relating to third–party administrators.

BY adding to
Article – Insurance
Section 8–310.1
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

8–310.1.

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

AN ADMINISTRATOR OF A PLAN THAT PROVIDES HEALTH BENEFITS SHALL DEVELOP A STREAMLINED PROCESS THROUGH WHICH:

(1) A HEALTH CARE PROVIDER CAN REQUEST WHETHER AN ENROLLEE IS ELIGIBLE TO RECEIVE A COVERED HEALTH CARE SERVICE UNDER THE PLAN; AND

(2) THE ADMINISTRATOR CAN RESPOND IN A TIMELY MANNER TO ANY ELIGIBILITY REQUEST MADE UNDER ITEM (1) OF THIS SECTION.

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) 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) except as provided in item (i) 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 **IF:**

(1) THE CARRIER DOES NOT COMPLY WITH SUBSECTION (C) OF THIS SECTION; OR

(2) BEFORE PROVIDING THE SERVICE, THE HEALTH CARE PROVIDER INQUIRED IN GOOD FAITH ABOUT THE ENROLLEE'S ELIGIBILITY UNDER § 8–310.1

OF THIS ARTICLE AND RECEIVED CONFIRMATION FROM THE THIRD–PARTY ADMINISTRATOR THAT THE ENROLLEE WAS ELIGIBLE FOR THE SERVICE, REGARDLESS OF THE ENROLLEE'S ACTUAL ELIGIBILITY STATUS.

(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) 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.