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Health and Government Operations Committee

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THE MARYLAND GENERAL ASSEMBLY

ANNAPOLIS, MARYLAND 21401

HB 0917 – Health Insurance – Retroactive Denial of Reimbursement

Chair Bagnall, Vice Chair Cullison, and Members of the Health Committee,

HB 0917 seeks to reform the process by which health insurance carriers retroactively deny reimbursement to health care providers by narrowing the window for retroactive denials, increasing transparency requirements, and ensuring that clinical justifications are considered before reimbursement is rescinded.

A health insurance retroactive denial is a practice by which insurer claws back, in part or whole. a payment previously made to a provider for a rendered covered service. The covered service may have been pre-authorized and reasons for retroactive denials include non-payment of premium during grace period, post-payment insurance audits, changes in eligibility, discovery of a change in qualifications for coverage, and identification of other insurance.

Maryland allows for retroactive denial within six months of when the claim was originally paid, except for Medicare and Maryland Medical Assistance Program where payments can be reversed as far out as eighteen months, due to Center for Medicaid and Medicare rules allowing federal claw-backs from the state which must then be passed on. Providers are generally informed of a retroactive deny with a demand for return in full of deduction of future claims' payments if the money is not returned.

Current uncertainty regarding retroactive denials, particularly those occurring months after a service has been rendered and paid recovered, creates significant financial instability for Maryland health care providers. HB917 shortens the non-CMS window for retroactive denials from six months to three months, thereby giving providers greater financial predictability. It also requires carriers to provide a written explanation with supporting documents and calculations, to help ensure that denials are based on clear data and clinical information data and not opaque administrative missteps.

Importantly, **HB917** requires due process in the clinical review period and clear criteria under which the retroactive denial can be granted, ensuring, for instance, that the denial is not based on the outcome of a service. This requirement honors the prospective clinical judgment of the provider and prevents the unfair use of hindsight to determine the necessity of a particular service. Instead, a carrier must engage in a meaningful conversation with the health care provider to understand the rationale and totality of circumstances at the time the care was delivered.

Finally, **HB917** emphasizes education and prevention, requiring carriers to train/educate providers regarding billing standards and compliance. This provision seems to be what is causing the insurers particular angst, so we will submit an amendment clarifying that a written, electric, or online document explaining how claw-backs can be avoided, appealed, and managed. By conditioning certain retroactive denials on the prior provision of this training or education, the bill shifts the focus from punitive financial recovery to collaborative administrative accuracy, thus saving both the provider and insurer redundant and costly delays and redundancies.

HB917 establishes a more transparent and predictable insurance framework that allows providers to focus on patient care rather with greater financial predictability.

I urge a favorable report.

Terri L. Hill, M.D.