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March 12, 2026

The Honorable Heather Bagnall  
Chair, House Health Committee  
240 Taylor Office Building  
Annapolis, MD 21401

**House Bill 1450 – Health Insurance – Coordination of Benefits – Carrier Responsibilities and Retroactive Denials of Reimbursement**

Dear Chair Bagnall,

The League of Life and Health Insurers of Maryland, Inc. respectfully opposes *House Bill 1450 – Health Insurance – Coordination of Benefits – Carrier Responsibilities and Retroactive Denials of Reimbursement* and urges the committee to give the bill an unfavorable report.

League members are opposed to HB 1450 because the new carrier responsibility outlined in the legislation is operationally unworkable. Section 15-1005.1 requires carriers to independently *identify* other payors, determine the amounts payable by those payors, and coordinate benefits accordingly. In practice, carriers often lack real-time access to information about what another carrier, Medicaid, or Medicare has paid or will pay. Carriers have no line of sight into the accounting of other carriers. Requiring a carrier to know what a separate, independent payor owes before processing its own claim imposes an information-gathering burden that current claims infrastructure cannot support. This will inevitably slow claims processing to the detriment of both providers and patients. The first place the information should come from is the patient who inevitably has the information at hand. The bill as written also likely raises considerable anti-trust concerns.

The 9-month coordination of benefit (COB) window in HB 1450 is arbitrary and insufficient. The bill reduces the retroactive denial window for carrier-to-carrier COB from 18 months down to 9 months. Coordination of benefits between commercial carriers is often a prolonged process. The primary carrier may not finalize its payment, and the secondary carrier may not receive the Explanation of Benefits (EOB), within 9 months due to the prolonged time providers have before they must submit a claim for payment. Compressing this window artificially prevents legitimate recovery of overpayments made in good faith, effectively forcing carriers to absorb costs they were never obligated to bear. This section has the potential to explode costs.

If carriers are forced to absorb overpayments they can no longer recover due to the shortened retroactive denial window, those costs will ultimately be passed on to policyholders through higher premiums. The bill's proponents seemingly frame it as protecting providers, but the practical effect is to socialize the cost of COB errors across the insured population in Maryland.

Section (f) of HB 1450 gives providers only 6 months from the date of a retroactive COB denial to submit a claim to the responsible payor. If a carrier denies at, say, month 8 under the new 9-month window, a provider may be time-barred from submitting to Medicare or Medicaid by that program's own filing deadlines, which are often 12 months from the date of service. The bill creates a window that sounds protective of providers but may in fact leave them without recourse in many practical scenarios, leading to disputes with carriers about who bears responsibility for the resulting gap.

For these reasons, the League urges the committee to give House Bill 1450 an unfavorable report.

Very truly yours,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal stroke extending to the right.

Matthew Celentano  
Executive Director

cc: Members, House Health Committee