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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Hopkins, Phillips, Casimiro, and Place

Date Introduced: February 27, 2026

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-61. Prompt processing of claims.

(a) A healthcare entity or health plan operating in the state shall pay all complete claims for covered healthcare services submitted to the healthcare entity or health plan by a healthcare provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within ~~thirty (30)~~ fourteen (14) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have ~~thirty (30)~~ fourteen (14) calendar days from receipt of the claim to notify in writing the healthcare provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No healthcare entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) A healthcare provider or policyholder may seek review of a claim that has been denied in part or in whole within sixty (60) days of receipt of denial. The payor shall bear the burden of establishing legitimacy of denial.

(d) If the denial of a claim is overturned, the payor shall remit the full amount due on the

claim and an administrative penalty, established by the secretary of the executive office of health and human services (EOHHS), reflecting the costs incurred by the healthcare provider.

~~(c)~~(e) Any claim that is resubmitted by a healthcare provider or policyholder shall be treated by the healthcare entity or health plan pursuant to the provisions of subsection (a) of this section.

~~(d)~~(f) A healthcare entity or health plan that fails to reimburse the healthcare provider or policyholder after receipt by the healthcare entity or health plan of a complete claim within the required timeframes shall pay to the healthcare provider or the policyholder who submitted the claim, in addition to any reimbursement for healthcare services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the healthcare provider or the policyholder.

~~(e)~~(g) Exceptions to the requirements of this section are as follows:

(1) No healthcare entity or health plan operating in the state shall be in violation of this section for a claim submitted by a healthcare provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The healthcare entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The healthcare entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No healthcare entity or health plan operating in the state shall be in violation of this section for any claim: (i) Initially submitted more than ninety (90) days after the service is rendered, or (ii) Resubmitted more than ninety (90) days after the date the healthcare provider received the notice provided for in subsection (b) of this section; provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the healthcare provider and were not caused by the healthcare provider.

(3) No healthcare entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No healthcare entity or health plan operating in the state shall be obligated under this section to pay interest to any healthcare provider or policyholder for any claim if the director of business regulation finds that the entity or plan is in substantial compliance with this section. A healthcare entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A healthcare entity or health plan that is found to be

in substantial compliance with this section shall thereafter submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A healthcare entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the healthcare entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~(h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) A bill or invoice for covered services; (ii) A line item of service; or (iii) All services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the healthcare entity or health plan receives the claim whether via electronic submission or as a paper claim.

(3) "Healthcare entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in § 23-17.13-2(2) [repealed], that operates a health plan.

(4) "Healthcare provider" means an individual clinician, either in practice independently or in a group, who provides healthcare services, and otherwise referred to as a non-institutional provider.

(5) "Healthcare services" include, but are not limited to, medical, mental health, substance abuse, dental, and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a healthcare entity that provides for the delivery of healthcare services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish healthcare services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Policyholder" means a person covered under a health plan or a representative designated by that person.

(8) "Substantial compliance" means that the healthcare entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in subsections (a) and (b) of this section.

~~(g)~~(i) Any provision in a contract between a healthcare entity or a health plan and a healthcare provider that is inconsistent with this section shall be void and of no force and effect.

(j) Failure of a healthcare entity or healthcare plan to comply with this section shall constitute a violation subject to penalty as determined by the secretary of the EOHHS.

(k) The secretary of the EOHHS shall promulgate rules, regulations, and penalty schedules

necessary to carry out the provisions of this section.

SECTION 2. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-52. Prompt processing of claims.

(a) A healthcare entity or health plan operating in the state shall pay all complete claims for covered healthcare services submitted to the healthcare entity or health plan by a healthcare provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within ~~thirty (30)~~ fourteen (14) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have ~~thirty (30)~~ fourteen (14) calendar days from receipt of the claim to notify in writing the healthcare provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No healthcare entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) A healthcare provider or policyholder may seek review of a claim that has been denied in part or in whole within sixty (60) days of receipt of denial. The payor shall bear the burden of establishing legitimacy of denial.

(d) If the denial of a claim is overturned, the payor shall remit the full amount due on the claim and an administrative penalty, established by the secretary of the executive office of health and human services (EOHHS), reflecting the costs incurred by the healthcare provider.

~~(c)~~(e) Any claim that is resubmitted by a healthcare provider or policyholder shall be treated by the healthcare entity or health plan pursuant to the provisions of subsection (a) of this section.

~~(d)~~(f) A healthcare entity or health plan that fails to reimburse the healthcare provider or policyholder after receipt by the healthcare entity or health plan of a complete claim within the required timeframes shall pay to the healthcare provider or the policyholder who submitted the claim, in addition to any reimbursement for healthcare services provided, interest that shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the healthcare provider or the policyholder.

~~(e)~~(g) Exceptions to the requirements of this section are as follows:

(1) No healthcare entity or health plan operating in the state shall be in violation of this

section for a claim submitted by a healthcare provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The healthcare provider or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The healthcare entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No healthcare entity or health plan operating in the state shall be in violation of this section for any claim: (i) Initially submitted more than ninety (90) days after the service is rendered, or (ii) Resubmitted more than ninety (90) days after the date the healthcare provider received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the healthcare provider and were not caused by the healthcare provider.

(3) No healthcare entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No healthcare entity or health plan operating in the state shall be obligated under this section to pay interest to any healthcare provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A healthcare entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A healthcare entity or health plan that is found to be in substantial compliance with this section shall after this submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A healthcare entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the healthcare entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~(h) For purposes of this section, the following definitions apply:

(1) "Claim" means:

(i) A bill or invoice for covered services;

(ii) A line item of service; or

(iii) All services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the healthcare entity or health plan receives the claim whether via electronic submission or has a paper claim.

(3) "Healthcare entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor

as described in § 23-17.13-2(2), that operates a health plan.

(4) “Healthcare provider” means an individual clinician, either in practice independently or in a group, who provides healthcare services, and referred to as a non-institutional provider.

(5) “Healthcare services” include, but are not limited to, medical, mental health, substance abuse, dental, and any other services covered under the terms of the specific health plan.

(6) “Health plan” means a plan operated by a healthcare entity that provides for the delivery of healthcare services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish healthcare services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) “Policyholder” means a person covered under a health plan or a representative designated by that person.

(8) “Substantial compliance” means that the healthcare entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in § 27-18-61(a) and (b).

~~(g)~~(i) Any provision in a contract between a healthcare entity or a health plan and a healthcare provider that is inconsistent with this section shall be void and of no force and effect.

(j) Failure of a healthcare entity or healthcare plan to comply with this section shall constitute a violation subject to penalty as determined by the secretary of the EOHHS.

(k) The secretary of the EOHHS shall promulgate rules, regulations, and penalty schedules necessary to carry out the provisions of this section.

SECTION 3. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-47. Prompt processing of claims.

(a) A healthcare entity or health plan operating in the state shall pay all complete claims for covered healthcare services submitted to the healthcare entity or health plan by a healthcare provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within ~~thirty (30)~~ fourteen (14) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute the standard to all participating providers.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have ~~thirty (30)~~ fourteen (14) calendar days from receipt of the claim to notify in writing the healthcare provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No healthcare entity

or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) A healthcare provider or policyholder may seek review of a claim that has been denied in part or in whole within sixty (60) days of receipt of denial. The payor shall bear the burden of establishing legitimacy of denial.

(d) If the denial of a claim is overturned, the payor shall remit the full amount due on the claim and an administrative penalty, established by the secretary of the executive office of health and human services (EOHHS), reflecting the costs incurred by the healthcare provider.

~~(c)~~(e) Any claim that is resubmitted by a healthcare provider or policyholder shall be treated by the healthcare entity or health plan pursuant to the provisions of subsection (a) of this section.

~~(d)~~(f) A healthcare entity or health plan which fails to reimburse the healthcare provider or policyholder after receipt by the healthcare entity or health plan of a complete claim within the required timeframes shall pay to the healthcare provider or the policyholder who submitted the claim, in addition to any reimbursement for healthcare services provided, interest that shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the healthcare provider or the policyholder.

~~(e)~~(g) Exceptions to the requirements of this section are as follows:

(1) No healthcare entity or health plan operating in the state shall be in violation of this section for a claim submitted by a healthcare provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The healthcare entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The healthcare entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No healthcare entity or health plan operating in the state shall be in violation of this section for any claim: (i) Initially submitted more than ninety (90) days after the service is rendered, or (ii) Resubmitted more than ninety (90) days after the date the healthcare provider received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the healthcare provider and were not caused by the healthcare provider.

(3) No healthcare entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No healthcare entity or health plan operating in the state shall be obligated under this section to pay interest to any healthcare provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A healthcare entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A healthcare entity or health plan that is found to be in substantial compliance with this section shall after this submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A healthcare entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the healthcare entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~(h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) A bill or invoice for covered services; (ii) A line item of service; or (iii) All services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the healthcare entity or health plan receives the claim whether via electronic submission or has a paper claim.

(3) "Healthcare entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as described in § 23-17.13-2(2), that operates a health plan.

(4) "Healthcare provider" means an individual clinician, either in practice independently or in a group, who provides healthcare services, and referred to as a non-institutional provider.

(5) "Healthcare services" include, but are not limited to, medical, mental health, substance abuse, dental, and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a healthcare entity that provides for the delivery of healthcare services to persons enrolled in the plan through:

(i) Arrangements with selected providers to furnish healthcare services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Policyholder" means a person covered under a health plan or a representative designated by that person.

(8) "Substantial compliance" means that the healthcare entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in § 27-18-61(a) and (b).

~~(g)~~(i) Any provision in a contract between a healthcare entity or a health plan and a

healthcare provider that is inconsistent with this section shall be void and of no force and effect.

(j) Failure of a healthcare entity or healthcare plan to comply with this section shall constitute a violation subject to penalty as determined by the secretary of the EOHHS.

(k) The secretary of the EOHHS shall promulgate rules, regulations, and penalty schedules necessary to carry out the provisions of this section.

SECTION 4. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-64. Prompt processing of claims.

(a) A healthcare entity or health plan operating in the state shall pay all complete claims for covered healthcare services submitted to the healthcare entity or health plan by a healthcare provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within ~~thirty (30)~~ fourteen (14) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have ~~thirty (30)~~ fourteen (14) calendar days from receipt of the claim to notify in writing the healthcare provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No healthcare entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

(c) A healthcare provider or policyholder may seek review of a claim that has been denied in part or in whole within sixty (60) days of receipt of denial. The payor shall bear the burden of establishing legitimacy of denial.

(d) If the denial of a claim is overturned, the payor shall remit the full amount due on the claim and an administrative penalty, established by the secretary of the executive office of health and human services (EOHHS), reflecting the costs incurred by the healthcare provider.

~~(c)~~(e) Any claim that is resubmitted by a healthcare provider or policyholder shall be treated by the healthcare entity or health plan pursuant to the provisions of subsection (a) of this section.

~~(d)~~(f) A healthcare entity or health plan that fails to reimburse the healthcare provider or policyholder after receipt by the healthcare entity or health plan of a complete claim within the required timeframes shall pay to the healthcare provider or the policyholder who submitted the claim, in addition to any reimbursement for healthcare services provided, interest that shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt

of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the healthcare provider or the policyholder.

~~(e)~~(g) Exceptions to the requirements of this section are as follows:

(1) No healthcare entity or health plan operating in the state shall be in violation of this section for a claim submitted by a healthcare provider or policyholder if:

(i) Failure to comply is caused by a directive from a court or federal or state agency;

(ii) The healthcare entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(iii) The healthcare entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it.

(2) No healthcare entity or health plan operating in the state shall be in violation of this section for any claim: (i) Initially submitted more than ninety (90) days after the service is rendered, or (ii) Resubmitted more than ninety (90) days after the date the healthcare provider received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the healthcare provider and were not caused by the healthcare provider.

(3) No healthcare entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency.

(4) No healthcare entity or health plan operating in the state shall be obligated under this section to pay interest to any healthcare provider or policyholder for any claim if the director of the department of business regulation finds that the entity or plan is in substantial compliance with this section. A healthcare entity or health plan seeking that finding from the director shall submit any documentation that the director shall require. A healthcare entity or health plan that is found to be in substantial compliance with this section shall submit any documentation the director may require on an annual basis for the director to assess ongoing compliance with this section.

(5) A healthcare entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the healthcare entity or health plan is converting or substantially modifying its claims processing systems.

~~(f)~~(h) For purposes of this section, the following definitions apply:

(1) "Claim" means: (i) A bill or invoice for covered services; (ii) A line item of service; or (iii) All services for one patient or subscriber within a bill or invoice.

(2) "Date of receipt" means the date the healthcare entity or health plan receives the claim whether via electronic submission or as a paper claim.

(3) "Healthcare entity" means a licensed insurance company or nonprofit hospital or

medical or dental service corporation or plan or health maintenance organization, or a contractor as described in § 23-17.13-2(2) [repealed] that operates a health plan.

(4) "Healthcare provider" means an individual clinician, either in practice independently or in a group, who provides healthcare services, and is referred to as a non-institutional provider.

(5) "Healthcare services" include, but are not limited to, medical, mental health, substance abuse, dental, and any other services covered under the terms of the specific health plan.

(6) "Health plan" means a plan operated by a healthcare entity that provides for the delivery of healthcare services to persons enrolled in the plan through:

(i) Arrangements with selected providers to furnish healthcare services; and/or

(ii) Financial incentive for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

(7) "Policyholder" means a person covered under a health plan or a representative designated by that person.

(8) "Substantial compliance" means that the healthcare entity or health plan is processing and paying ninety-five percent (95%) or more of all claims within the time frame provided for in § 27-18-61(a) and (b).

~~(g)~~(i) Any provision in a contract between a healthcare entity or a health plan and a healthcare provider that is inconsistent with this section shall be void and of no force and effect.

(j) Failure of a healthcare entity or healthcare plan to comply with this section shall constitute a violation subject to penalty as determined by the secretary of the EOHHS.

(k) The secretary of the EOHHS shall promulgate rules, regulations, and penalty schedules necessary to carry out the provisions of this section.

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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This act would require insurers to pay electronic claims for healthcare coverage within fourteen (14) calendar days of receipt. This act would further permit healthcare providers to dispute claim denials within sixty (60) days. This act would empower the secretary of the EOHHS to establish penalties for violations of this section.

This act would take effect upon passage.

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