

2026 -- H 7941

=====
LC004637
=====

STATE OF RHODE ISLAND

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:

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

3 **27-18-61. Prompt processing of claims.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 [necessary to carry out the provisions of this section.](#)

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

4 **27-19-52. Prompt processing of claims.**

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

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

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

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

23 ~~(e)~~[\(e\)](#) Any claim that is resubmitted by a healthcare provider or policyholder shall be
24 treated by the healthcare entity or health plan pursuant to the provisions of subsection (a) of this
25 section.

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

33 ~~(g)~~[\(g\)](#) Exceptions to the requirements of this section are as follows:

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

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

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

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

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

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

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

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

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

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

27 (1) "Claim" means:

28 (i) A bill or invoice for covered services;

29 (ii) A line item of service; or

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

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

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

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

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

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

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

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

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

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

13 (8) "Substantial compliance" means that the healthcare entity or health plan is processing
14 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
15 27-18-61(a) and (b).

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

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

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

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

24 **27-20-47. Prompt processing of claims.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (8) "Substantial compliance" means that the healthcare entity or health plan is processing
32 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
33 27-18-61(a) and (b).

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

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

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

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

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

8 **27-41-64. Prompt processing of claims.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (8) “Substantial compliance” means that the healthcare entity or health plan is processing
15 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in §
16 27-18-61(a) and (b).

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

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

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

23 SECTION 5. This act shall take effect upon passage.

=====
LC004637
=====

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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

5 This act would take effect upon passage.

=====
LC004637
=====