2025 -- H 5561

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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. 2025

A N A C T

RELATING TO BUSINESSES AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE AND DISCIPLINE

Introduced By: Representative Arthur J. Corvese

Date Introduced: February 26, 2025

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Section 5-37-5.1 of the General Laws in Chapter 5-37 entitled "Board of Medical Licensure and Discipline" is hereby amended to read as follows:

5-37-5.1. Unprofessional conduct.

The term “unprofessional conduct” as used in this chapter includes, but is not limited to, the following items or any combination of these items and may be further defined by regulations established by the board with the prior approval of the director:

(1) Fraudulent or deceptive procuring or use of a license or limited registration;

(2) All advertising of medical business that is intended or has a tendency to deceive the public;

(3) Conviction of a felony; conviction of a crime arising out of the practice of medicine;

(4) Abandoning a patient;

(5) Dependence upon controlled substances, habitual drunkenness, or rendering professional services to a patient while the physician or limited registrant is intoxicated or incapacitated by the use of drugs;

(6) Promotion by a physician or limited registrant of the sale of drugs, devices, appliances, or goods or services provided for a patient in a manner as to exploit the patient for the financial gain of the physician or limited registrant;

(7) Immoral conduct of a physician or limited registrant in the practice of medicine;

(8) Willfully making and filing false reports or records in the practice of medicine;

(9) Willfully omitting to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record, medical or other reports as required by law;

(10) Failing to furnish details of a patient's medical record to succeeding physicians, healthcare facility, or other healthcare providers upon proper request pursuant to § 5-37.3-4;

(11) Soliciting professional patronage by agents or persons or profiting from acts of those representing themselves to be agents of the licensed physician or limited registrants;

(12) Dividing fees or agreeing to split or divide the fees received for professional services for any person for bringing to or referring a patient;

(13) Agreeing with clinical or bioanalytical laboratories to accept payments from these laboratories for individual tests or test series for patients;

(14) Making willful misrepresentations in treatments;

(15) Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program, or aiding or abetting unlicensed persons in the practice of medicine;

(16) Gross and willful overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered, or willfully making or assisting in making a false claim or deceptive claim or misrepresenting a material fact for use in determining rights to health care or other benefits;

(17) Offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine;

(18) Professional or mental incompetency;

(19) Incompetent, negligent, or willful misconduct in the practice of medicine, which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subsection;

(20) Failing to comply with the provisions of chapter 4.7 of title 23;

(21) Surrender, revocation, suspension, limitation of privilege based on quality of care provided, or any other disciplinary action against a license or authorization to practice medicine in another state or jurisdiction; or surrender, revocation, suspension, or any other disciplinary action relating to a membership on any medical staff or in any medical or professional association or

society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as described in this chapter;

(22) Multiple adverse judgments, settlements, or awards arising from medical liability claims related to acts or conduct that would constitute grounds for action as described in this chapter;

(23) Failing to furnish the board, its chief administrative officer, investigator, or representatives, information legally requested by the board;

(24) Violating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board;

(25) Cheating on or attempting to subvert the licensing examination;

(26) Violating any state or federal law or regulation relating to controlled substances;

(27) Failing to maintain standards established by peer-review boards, including, but not limited to: standards related to proper utilization of services, use of nonaccepted procedure, and/or quality of care;

(28) A pattern of medical malpractice, or willful or gross malpractice on a particular occasion;

(29) Agreeing to treat a beneficiary of health insurance under title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., "Medicare Act," and then charging or collecting from this beneficiary any amount in excess of the amount or amounts permitted pursuant to the Medicare Act;

(30) Sexual contact between a physician and patient during the existence of the physician/patient relationship;

(31) Knowingly violating the provisions of § 23-4.13-2(d); or

(32) Performing a pelvic examination or supervising a pelvic examination performed by an individual practicing under the supervision of a physician on an anesthetized or unconscious female patient without first obtaining the patient's informed consent to pelvic examination, unless the performance of a pelvic examination is within the scope of the surgical procedure or diagnostic examination to be performed on the patient for which informed consent has otherwise been obtained or in the case of an unconscious patient, the pelvic examination is required for diagnostic purposes and is medically necessary.

(33) Failing to submit medical bills to a health insurer, based solely on the reason that the bill may arise from third-party claim or incident, other than a workers' compensation claim pursuant

to chapter 33 of title 28.

SECTION 2. 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)(1) A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) 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.

(2) No health care entity or health plan shall deny a claim for payment of any medical bill, based solely on the reason that the bill may have arisen from a third-party claim or incident, other than a workers' compensation claim pursuant to chapter 33 of title 28.

(b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care 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 health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim.

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

(d) A health care entity or health plan which fails to reimburse the health care provider or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the claim, in addition to any reimbursement for health care 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 health care provider or the policyholder.

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

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

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

(ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in

compliance with a court-ordered plan of rehabilitation; or

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

(2) No health care 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 health care 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 health care provider and were not caused by the health care provider.

(3) No health care 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 health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care 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 health care entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which 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 health care 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 health care entity or health plan is converting or substantially modifying its claims processing systems.

(f) 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 health care entity or health plan receives the claim whether via electronic submission or as a paper claim.

(3) "Health care 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], which operates a health plan.

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

(5) "Health care 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 health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care 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 health care 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) Any provision in a contract between a health care entity or a health plan and a health care provider which is inconsistent with this section shall be void and of no force and effect.

SECTION 3. 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)(1) 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) 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.

(2) No health care entity or health plan shall deny a claim for payment of any medical bill, based solely on the reason that the bill may have arisen from a third-party claim or incident, other than a workers' compensation claim pursuant to chapter 33 of title 28.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have thirty (30) 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) 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) 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) 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) 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) 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.

SECTION 4. 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)(1) 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) 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.

(2) No health care entity or health plan shall deny a claim for payment of any medical bill, based solely on the reason that the bill may have arisen from a third-party claim or incident, other than a workers' compensation claim pursuant to chapter 33 of title 28.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have thirty (30) 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) 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) 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) 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) 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) 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.

SECTION 5. 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)(1) 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) 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.

(2) No health care entity or health plan shall deny a claim for payment of any medical bill, based solely on the reason that the bill may have arisen from a third-party claim or incident, other than a workers' compensation claim pursuant to chapter 33 of title 28.

(b) If the healthcare entity or health plan denies or pends a claim, the healthcare entity or health plan shall have thirty (30) 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) 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) 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) 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) 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) 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.

SECTION 6. This act shall take effect upon passage.

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LC001604
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO BUSINESSES AND PROFESSIONS -- BOARD OF MEDICAL LICENSURE AND DISCIPLINE

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This act would prohibit healthcare providers and health plans from denying the payment of a medical bill, solely because the bill may have arisen from a third-party claim.

This act would take effect upon passage.

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