5812-S.E AMH HC H2630.1

ESSB 5812 - H COMM AMD
By Committee on Health Care

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that there is a need for a consistent and enforceable claims payment standard for the provision of health care services by health care facilities and providers to enrollees of carrier health plans and enrollees and beneficiaries of public programs.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) For the purposes of this section:

(a) "Payer" means any group or individual disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor regulated under chapter 48.44 RCW, a health maintenance organization regulated under chapter 48.46 RCW, self-insured entities subject to the jurisdiction of the state of Washington, the department of labor and industries operating under Title 51 RCW, except as authorized under RCW 51.14.020, the department of social and health services operating under chapter 74.09 RCW, and the Washington state health care authority as established pursuant to chapter 41.05 RCW and as authorized pursuant to chapter 70.47 RCW.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this law.

(c) "Provider" means "health care facility" or "facility," "health care provider" or "provider" as defined in RCW 48.43.005, and services licensed under chapter 18.73 RCW.

(2)(a) For health services provided to covered persons, a payer shall pay providers as soon as practical but subject to the following minimum standards: (i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the

responsible payer or agent; and (ii) ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible payer or agent, except as agreed to in writing by the parties on a claim-by-claim basis. Denial of a claim must be communicated to the provider and must include the reason the claim was denied.

(b) The receipt date of a claim is the date the responsible payer or its agent receives either written or electronic notice of the claim.

(3) Any payer failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the payer meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The payer shall add the interest payable to the amount of the unpaid claim without the necessity of the provider submitting an additional claim. Any interest paid under this section shall not be applied by the payer to an enrollee's deductible, copayment, coinsurance, or any similar obligation of the enrollee.

(4) This section does not apply to claims where there is substantial evidence of fraud or misrepresentation by providers or patients, or instances where the payer has not been granted access to information under the provider's control.

(5) Providers and payers are not required to comply with this section if the failure to comply is occasioned by an act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency; or the result of a strike, lockout, or other labor dispute.

(6) The insurance commissioner is prohibited from adopting rules regarding this section.

NEW SECTION. **Sec. 3.** The department of health shall establish a committee composed of three representatives from payers, three representatives from providers, and one representative from the department of health. The committee shall study trends and issues and make recommendations regarding future legislative, regulatory, or private solutions, including electronic billings, that will promote timely and accurate payment of health claims.

Sec. 4. RCW 51.36.080 and 1998 c 245 s 104 are each amended to read as follows:

(1) All fees and medical charges under ((~~this title~~)) chapter 51.14 RCW shall conform to the fee schedule established by the director and shall be paid within sixty days of receipt by the department of a proper billing in the form prescribed by department rule or sixty days after the claim is allowed by final order or judgment, if an otherwise proper billing is received by the department prior to final adjudication of claim allowance. The department shall pay interest at the rate of one percent per month, but at least one dollar per month, whenever the payment period exceeds the applicable sixty-day period on all proper fees and medical charges.

Beginning in fiscal year 1987, interest payments under this subsection may be paid only from funds appropriated to the department for administrative purposes.

Nothing in this ((~~section~~)) subsection may be construed to require the payment of interest on any billing, fee, or charge if the industrial insurance claim on which the billing, fee, or charge is predicated is ultimately rejected or the billing, fee, or charge is otherwise not allowable.

(2) Payment for claims for nonself-insured medical charges shall comply with the provisions set forth in section 2 of this act.

(3) In establishing fees for medical and other health care services under this title, the director shall consider the director's duty to purchase health care in a prudent, cost-effective manner without unduly restricting access to necessary care by persons entitled to the care. With respect to workers admitted as hospital inpatients on or after July 1, 1987, the director shall pay for inpatient hospital services on the basis of diagnosis-related groups, contracting for services, or other prudent, cost-effective payment method, which the director shall establish by rules adopted in accordance with chapter 34.05 RCW.

((~~(2)~~)) (4) The director may establish procedures for selectively or randomly auditing the accuracy of fees and medical billings submitted to the department under this title.

NEW SECTION. **Sec. 5.** Sections 1, 2, and 4 of this act take effect September 1, 2000.

NEW SECTION. **Sec. 6.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

Correct the title.

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