SENATE BILL REPORT
SB 5683

As Reported by Senate Committee On:
Health & Long-Term Care, February 21, 2025

Title: An act relating to health carrier transparency of payment timeliness of claims submitted by health care providers and health care facilities.

Brief Description: Concerning health carrier transparency of payment timeliness of claims submitted by health care providers and health care facilities.

Sponsors: Senators Slatter, Frame, Nobles and Valdez.

Brief History:
Committee Activity: Health & Long-Term Care: 2/20/25, 2/21/25 [DPS-WM].

Brief Summary of First Substitute Bill

- Requires carriers to submit data to the Office of the Insurance Commissioner related to the timeliness of claims payments.
- Requires health plans offered to public employees and managed care organizations to submit data to the Health Care Authority related to the timeliness of claims payments.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5683 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Orwall, Vice Chair; Muzzall, Ranking Member; Bateman, Chapman, Christian, Harris, Holy, Riccelli, Robinson and Slatter.

Staff: Greg Attanasio (786-7410)

Background: Office of the Insurance Commissioner (OIC) regulations requires carrier's

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set forth a schedule for the prompt payment of amounts owed by the carrier to a provider or facility in the provider or facility contract. Contract terms must include penalties for a carrier's failure to abide by that schedule. Payment timelines are subject to the following minimum standards:

- 95 percent of the monthly volume of clean claims must be paid within 30 days of receipt; and
- 95 percent of the monthly volume of all claims must be paid or denied within 60 days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis.

Any carrier failing to pay claims within these standards shall pay interest on undenied and unpaid clean claims more than 61 days old until the carrier meets the standard. Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision.

"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.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (First Substitute): By January 1, 2027, and annually thereafter, each carrier shall report to OIC the following data related to the carrier's claims payment timeliness for the prior plan year:

- the total number of claims submitted;
- the total number of claims determined to be clean claims, and the total number of claims that required additional information;
- the average days and range of days between providers submitting additional information on claims and the carrier finalizing the claim;
- the average days and range of days it took to pay a clean claim and claims that needed additional information; and
- the percentage of all claims that were paid within 30 days.

By July 1, 2027, and annually thereafter, OIC must submit a report with the following information:

- the information submitted by each carrier;
- a summary of complains received by OIC related to timely payments; and
- an analysis of any trends in the data.

By January 1, 2027, and annually thereafter, each health plan offered to public employees and each managed care organization (MCO) shall report to the Health Care Authority (HCA) the following data related to the plan's or MCO's claims payment timeliness for the prior plan year:

- the total number of claims submitted;
- the total number of claims determined to be clean claims, and the total number of claims that required additional information;
- the average days and range of days between providers submitting additional information on claims and the carrier finalizing the claim;
- the average days and range of days it took to pay a clean claim and claims that needed additional information; and
- the percentage of all claims that were paid within 30 days.

By July 1, 2027, and annually thereafter, HCA must submit a report with the following information:
- the information submitted by each plan and MCO;
- a summary of complains received by HCA related to timely payments; and
- an analysis of any trends in the data.

Appropriation: None.

Fiscal Note: Requested on February 16, 2025.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on First Substitute: PRO: Delayed payments make it harder to provide care. We need better data to better understand hospital finances. OIC collects similar data on prior authorization already. One third of claims take more than 90 days to be paid. Claims needing additional documentation are being denied at higher rate. High dollar claims can be delayed significantly. Even after denials are overturned, payment continues to be delayed.

OTHER: This bill would not capture all payers. Two million citizens get insurance from plans not regulated by the state.

Persons Testifying: PRO: Senator Vandana Slatter, Prime Sponsor; Jane Beyer, Office of the Insurance Commissioner; Lisa Thatcher, Washington State Hospital Association; Adam Dittemore, EvergreenHealth.

OTHER: Jennifer Ziegler, Association of Washington Health Care Plans.

Persons Signed In To Testify But Not Testifying: No one.