
SENATE BILL 5683

State of Washington

69th Legislature

2025 Regular Session

By Senators Slatter, Frame, Nobles, and Valdez

Read first time 02/06/25. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to health carrier transparency of payment
2 timeliness of claims submitted by health care providers and health
3 care facilities; adding a new section to chapter 48.43 RCW; adding a
4 new section to chapter 74.09 RCW; adding a new section to chapter
5 41.05 RCW; and creating a new section.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 NEW SECTION. **Sec. 1.** (1) The legislature finds that timeliness
8 of payment and administrative burden related to obtaining payment
9 from health insurance carriers, health plans, and managed care
10 organizations are contributing factors to the financial vulnerability
11 for health care providers and health care facilities, and the care
12 available for patients is negatively impacted due to delays in
13 payment.

14 (2) It is the intent of the legislature to increase transparency
15 regarding timeliness of claims payment by health insurance carriers,
16 health plans, and managed care organizations by requiring carriers to
17 report to the office of the insurance commissioner and the health
18 care authority metrics related to timeliness of payment and for the
19 office of the insurance commissioner and the health care authority to
20 report the information in a public manner.

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

3 (1) By January 1, 2027, and annually thereafter, each carrier
4 shall report to the commissioner the following data related to the
5 carrier's claims payment timeliness for the prior plan year:

6 (a) The total number of claims submitted for items and services
7 furnished to individuals enrolled in plans administered by the
8 carrier by providers of services and suppliers with which the carrier
9 has a contract with respect to furnishing such items and services;

10 (b) The total number of claims described in (a) of this
11 subsection that were determined to be clean claims and the total
12 number of claims that were determined not to be clean claims;

13 (c) The total number of claims described in (a) of this
14 subsection for which itemized billing or additional information is
15 requested by the carrier;

16 (d) The average days, and total range of days, between the date
17 on which providers of services and suppliers submitted additional
18 information or documents requested by the carrier for purposes of
19 processing and paying claims described in (c) of this subsection and
20 the date on which the carrier notified the providers of services and
21 suppliers of the carrier's determination for such claims;

22 (e) The average days, and total range of days, between the date
23 of submission of claims described in (a) of this subsection
24 determined to be clean claims and the date on which the provider of
25 services or supplier received from the carrier full payment of such
26 claims;

27 (f) The average days, and total range of days, between the date
28 of submission of claims described in (a) of this subsection
29 determined to not be clean claims and the date on which the provider
30 of services or supplier received from the carrier full payment of
31 such claims;

32 (g) The percentage of all claims described in (a) of this
33 subsection, if any, fully paid by the carrier within 30 days of the
34 date of submission of the claim; and

35 (h) Such other information as specified by the commissioner.

36 (2) For purposes of this section, "clean claim" means a claim
37 that has no defect or impropriety, including a lack of any required
38 substantiating documentation or particular circumstances requiring
39 special treatment that prevents timely payments from being made on
40 the claim.

1 (3) By July 1, 2027, and annually thereafter, the commissioner
2 shall submit to the relevant committees of the legislature and
3 publish on a public website a report including:

4 (a) The detailed information submitted by each carrier under
5 subsection (1) of this section, including the identity of the carrier
6 submitting the information;

7 (b) A summary of the information submitted for such year by all
8 carriers under subsection (1) of this section;

9 (c) A summary of the complaints received by the commissioner
10 relating to timely payment of claims submitted during such year, by
11 the carrier; and

12 (d) An analysis on the carrier level and statewide level of
13 trends shown by such information submitted under this section.

14 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09
15 RCW to read as follows:

16 (1) By January 1, 2027, and annually thereafter, each managed
17 care organization shall report to the authority the following data
18 related to the managed care organization's claims payment timeliness
19 for the prior plan year:

20 (a) The total number of claims submitted for items and services
21 furnished to the managed care organization's enrollees by
22 participating providers and facilities;

23 (b) The total number of claims described in (a) of this
24 subsection that were determined to be clean claims and the total
25 number of claims that were determined not to be clean claims;

26 (c) The total number of claims described in (a) of this
27 subsection for which itemized billing or additional information is
28 requested by the managed care organization;

29 (d) The average days, and total range of days, between the date
30 on which providers of services and suppliers submitted additional
31 information or documents requested by the managed care organization
32 for purposes of processing and paying claims described in (c) of this
33 subsection and the date on which the managed care organization
34 notified the providers of services and suppliers of the managed care
35 organization's determination for such claims;

36 (e) The average days, and total range of days, between the date
37 of submission of claims described in (a) of this subsection
38 determined to be clean claims and the date on which the provider of

1 services or supplier received from the managed care organization full
2 payment of such claims;

3 (f) The average days, and total range of days, between the date
4 of submission of claims described in (a) of this subsection
5 determined to not be clean claims and the date on which the provider
6 of services or supplier received from the managed care organization
7 full payment of such claims;

8 (g) The percentage of all claims described in (a) of this
9 subsection, if any, fully paid by the managed care organization
10 within 30 days of the date of submission of the claim; and

11 (h) Such other information as specified by the authority.

12 (2) For purposes of this section, "clean claim" means a claim
13 that has no defect or impropriety, including a lack of any required
14 substantiating documentation or particular circumstances requiring
15 special treatment that prevents timely payments from being made on
16 the claim.

17 (3) By July 1, 2027, and annually thereafter, the authority shall
18 submit to the relevant committees of the legislature and publish on a
19 public website a report including:

20 (a) The detailed information submitted by each managed care
21 organization under subsection (1) of this section, including the
22 identity of the managed care organization submitting the information;

23 (b) A summary of the information submitted for such year by all
24 managed care organizations under subsection (1) of this section;

25 (c) A summary of the complaints received by the authority
26 relating to timely payment of claims submitted during such year, by
27 the managed care organization; and

28 (d) An analysis on the managed care organization level and
29 statewide level of trends shown by such information submitted under
30 this section.

31 NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05
32 RCW to read as follows:

33 (1) By January 1, 2027, and annually thereafter, each health plan
34 offered to public employees, retirees, and their covered dependents
35 under this chapter shall report to the authority the following data
36 related to the health plan's claims payment timeliness for the prior
37 plan year:

1 (a) The total number of claims submitted for items and services
2 furnished to the health plan's enrollees by participating providers
3 and facilities;

4 (b) The total number of claims described in (a) of this
5 subsection that were determined to be clean claims and the total
6 number of claims that were determined not to be clean claims;

7 (c) The total number of claims described in (a) of this
8 subsection for which itemized billing or additional information is
9 requested by the health plan;

10 (d) The average days, and total range of days, between the date
11 on which providers of services and suppliers submitted additional
12 information or documents requested by the health plan for purposes of
13 processing and paying claims described in (c) of this subsection and
14 the date on which the health plan notified the providers of services
15 and suppliers of the health plan's determination for such claims;

16 (e) The average days, and total range of days, between the date
17 of submission of claims described in (a) of this subsection
18 determined to be clean claims and the date on which the provider of
19 services or supplier received from the health plan full payment of
20 such claims;

21 (f) The average days, and total range of days, between the date
22 of submission of claims described in (a) of this subsection
23 determined to not be clean claims and the date on which the provider
24 of services or supplier received from the health plan full payment of
25 such claims;

26 (g) The percentage of all claims described in (a) of this
27 subsection, if any, fully paid by the health plan within 30 days of
28 the date of submission of the claim; and

29 (h) Such other information as specified by the authority.

30 (2) For purposes of this section, "clean claim" means a claim
31 that has no defect or impropriety, including a lack of any required
32 substantiating documentation, or particular circumstances requiring
33 special treatment that prevents timely payments from being made on
34 the claim.

35 (3) By July 1, 2027, and annually thereafter, the authority shall
36 submit to the relevant committees of the legislature and publish on a
37 public website a report including:

38 (a) The detailed information submitted by each health plan under
39 subsection (1) of this section, including the identity of the health
40 plan submitting the information;

1 (b) A summary of the information submitted for such year by all
2 health plans under subsection (1) of this section;

3 (c) A summary of the complaints received by the authority
4 relating to timely payment of claims submitted during such year, by
5 the health plan; and

6 (d) An analysis on the health plan level and statewide level of
7 trends shown by such information submitted under this section.

--- **END** ---