S-1201.1

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--- END ---