
ENGROSSED SUBSTITUTE SENATE BILL 5845

State of Washington

69th Legislature

2026 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Slatter, Muzzall, Chapman, Harris, Riccelli, Cleveland, Hasegawa, Krishnadasan, Nobles, and Valdez)

READ FIRST TIME 02/02/26.

1 AN ACT Relating to modernizing and clarifying timely payment
2 requirements for health carriers; reenacting and amending RCW
3 41.05.017; adding a new section to chapter 48.43 RCW; and creating a
4 new section.

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

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that timeliness
7 of payment and administrative burden related to obtaining payment
8 from health carriers are contributing factors to the financial
9 vulnerability for health care providers and health care facilities
10 and impact availability of care and delay the determination of cost
11 sharing for patients.

12 (2) It is the intent of the legislature to increase transparency
13 and accountability for claims payment timeliness by updating payment
14 standards to better reflect claims operations and provide an
15 objective and quantifiable standard.

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

18 (1)(a) Except as provided in (b) of this subsection, for health
19 care services provided to covered persons, a carrier shall pay or
20 deny a claim from a provider or facility as soon as practical, but no

1 later than 30 calendar days after the receipt of a clean claim by the
2 carrier.

3 (b) For claims that are not clean, within 21 calendar days of
4 receipt of the claim, the carrier shall send remittance advice or
5 other electronic notice to the provider or facility acknowledging the
6 date of receipt of the claim and including one of the following:

7 (i) That the carrier is denying payment on all or part of the
8 claim and the specific reason for the denial. The denial shall
9 identify the portion of the claim that is denied and the specific
10 reasons for the denial; or

11 (ii) That additional information or documentation is needed to
12 process the claim. This notice must include a request for the
13 specific information or documentation needed to process the claim.
14 The carrier shall make a good faith effort to request all information
15 or documentation needed to process the claim in a single request and
16 may not make any additional requests for information or documentation
17 for 30 calendar days after receipt of the claim.

18 (c)(i) For claims for which the carrier receives all information
19 or documentation requested by the carrier in a notice issued pursuant
20 to (b)(ii) of this subsection, the carrier shall consider the claim a
21 clean claim and shall pay or deny the claim within 30 calendar days,
22 except as agreed to in writing by the parties on a claim-by-claim
23 basis. The 30 calendar days time period does not apply until the
24 carrier receives all information or documentation requested by the
25 carrier.

26 (ii) For claims for which a provider or facility fails to submit
27 information or documentation requested under subsection (1)(b)(ii) of
28 this section within 21 calendar days of receipt of the carrier's
29 request, the carrier's obligation to pay or deny the claim under this
30 subsection is extended to 40 calendar days following the carrier's
31 receipt of requested information or documentation.

32 (d) The receipt date of a claim or additional information or
33 documentation is the date a carrier receives either written or
34 electronic notice of the claim or additional information or
35 documentation. A carrier must establish a reasonable method for
36 confirming receipt of claims and additional information or
37 documentation and responding to provider and facility inquiries about
38 claims.

39 (2)(a) A carrier shall pay interest on the amount of any claims
40 for which the carrier fails to comply with the timeline and notice

1 requirements of subsection (1) of this section. Interest shall accrue
2 on each such claim until the claim is resolved by payment, denial, or
3 the final outcome of an appeals process.

4 (b) Interest shall be assessed at the following rates and shall
5 be calculated monthly as simple interest prorated for any portion of
6 a month:

7 (i) Beginning on calendar day one and through calendar day 60
8 following a carrier's failure to comply with any notice or claim
9 settlement requirement in subsection (1)(a) or (b) of this section,
10 interest shall be assessed at the rate of one percent per month on
11 the amount of the unresolved claim.

12 (ii) Beginning on calendar day 61 following a carrier's failure
13 to comply with any notice or claim settlement requirement in
14 subsection (1)(a) or (b) of this section and until the claim is
15 resolved, interest shall be assessed at the rate of one and one-half
16 percent per month on the amount of the unresolved claim.

17 (c) Any interest paid under this subsection shall be the
18 carrier's responsibility and not be applied by the carrier to a
19 covered person's deductible, copayment, coinsurance, or any similar
20 obligation of the covered person.

21 (d) The carrier shall add the interest payable to the amount of
22 the unpaid claim and may not require or request the provider or
23 facility to submit an additional claim.

24 (e) For any claim for which the carrier failed to comply with the
25 requirements of subsection (1)(a) or (b) of this section that is
26 unresolved for more than 90 calendar days, the carrier may be subject
27 to an administrative penalty as determined by the commissioner in
28 rule. In developing the appropriateness of an administrative penalty,
29 the commissioner shall consider whether a carrier has engaged in a
30 pattern of violations of subsection (1)(a) or (b) of this section.

31 (3) The requirements of this section do not apply to claims for
32 which a carrier has documented evidence of fraud or material
33 misrepresentation by providers, facilities, or covered persons,
34 supported by claims review, data analysis, audit activities, or
35 patterns thereof.

36 (4) Providers, facilities, and carriers are not required to
37 comply with the requirements of this section if the failure to comply
38 is occasioned by any act of God, bankruptcy, act of a governmental
39 authority responding to an act of God or other emergency,

1 cybersecurity attack, declaration of a natural disaster, or the
2 result of a strike, lockout, or other labor dispute.

3 (5) Health carriers are responsible for compliance with the
4 provisions of this chapter and are responsible for the compliance of
5 any person or organization acting on behalf of or at the direction of
6 the carrier or acting pursuant to carrier standards or requirements
7 concerning the coverage of, payment for, or provision of health care
8 services. A carrier may not offer as a defense to a violation of any
9 provision of this chapter that the violation arose from the act or
10 omission of a participating provider or facility, network
11 administrator, claims administrator, health care benefit manager, or
12 other person acting on behalf of or at the direction of the carrier,
13 or acting pursuant to carrier standards or requirements under a
14 contract with the carrier rather than from the direct act or omission
15 of the carrier.

16 (6) Nothing in this section limits any existing authority of the
17 office of the insurance commissioner under this title to oversee and
18 enforce carrier compliance with applicable statutes and rules.

19 (7)(a) The requirements of this section apply to health plans
20 filed or renewed on or after January 1, 2027.

21 (b) This section applies only to health carriers offering health
22 plans subject to regulation by the commissioner and to health plans
23 offered through the public employees' benefits board and school
24 employees' benefits board programs. This section does not apply to
25 medicaid managed care plans administered under chapter 74.09 RCW.

26 (c) This section applies only to claims submitted by a health
27 care provider or health care facility that is a participating
28 provider or facility under a contract with a health carrier. Nothing
29 in this section is intended to modify or supersede payment
30 requirements applicable to nonparticipating providers or facilities,
31 including those governed by RCW 48.49.160.

32 (8) The commissioner may adopt rules to implement this section.

33 (9) For purposes of this section:

34 (a) "Clean claim" means a claim that has no defect or
35 impropriety, including any lack of any required substantiating
36 documentation, or particular circumstances requiring special
37 treatment that prevents timely payments from being made on the claim.
38 A claim does not lose the status of "clean claim" due to issues
39 related to carrier internal processing or systems.

1 (b) "Remittance advice" means a written or electronic
2 communication issued by a carrier to a provider that explains the
3 outcome of claim adjudication and includes, at a minimum, the amount
4 paid, any amounts denied or adjusted, and the reason codes and
5 explanations supporting the carrier's payment determination.

6 **Sec. 3.** RCW 41.05.017 and 2025 c 389 s 3 and 2025 c 171 s 2 are
7 each reenacted and amended to read as follows:

8 Each health plan that provides medical insurance offered under
9 this chapter, including plans created by insuring entities, plans not
10 subject to the provisions of Title 48 RCW, and plans created under
11 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,
12 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,
13 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128,
14 48.43.780, 48.43.435, 48.43.815, 48.200.020 through 48.200.280,
15 48.200.300 through 48.200.320, 48.43.440, 48.43.845, 48.43.732,
16 section 2 of this act, and chapter 48.49 RCW.

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