CERTIFICATION OF ENROLLMENT

# ENGROSSED SUBSTITUTE SENATE BILL 5845

Chapter 158, Laws of 2026

69th Legislature
2026 Regular Session

HEALTH CARRIERS—TIMELY PAYMENTS

EFFECTIVE DATE: June 11, 2026—Except for section 4, which takes effect January 1, 2028.

Passed by the Senate March 9, 2026
Yeas 49 Nays 0

DENNY HECK

**President of the Senate**

Passed by the House March 5, 2026
Yeas 95 Nays 0

LAURIE JINKINS

**Speaker of the House of Representatives**

Approved March 23, 2026 3:36 PM

BOB FERGUSON

**Governor of the State of Washington**

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5845** as passed by the Senate and the House of Representatives on the dates hereon set forth.

SARAH BANNISTER

**Secretary**

FILED

March 24, 2026

**Secretary of State**
**State of Washington**

# ENGROSSED SUBSTITUTE SENATE BILL 5845

AS AMENDED BY THE HOUSE

Passed Legislature - 2026 Regular Session

**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.

AN ACT Relating to modernizing and clarifying timely payment requirements for health carriers; amending RCW 48.43.600; reenacting and amending RCW 41.05.017; adding a new section to chapter 48.43 RCW; creating a new section; and providing an effective date.

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 carriers are contributing factors to the financial vulnerability for health care providers and health care facilities and impact availability of care and delay the determination of cost sharing for patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) This section applies only to claims submitted by:

(i) A health care provider or health care facility that is a participating provider or facility under a contract with a health carrier; or

(ii) An Indian health care provider as defined in RCW 43.71B.010 including those who are not contracted or participating providers.

(d) Except as provided in subsection (7)(c)(ii) of this section, nothing in this section is intended to modify or supersede payment requirements applicable to nonparticipating providers or facilities, including those governed by RCW 48.49.160.

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

(9) For purposes of this section:

(a) "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. A claim does not lose the status of "clean claim" due to issues related to carrier internal processing or systems.

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

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

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

**Sec. 4.** RCW 48.43.600 and 2025 c 227 s 7 are each amended to read as follows:

(1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within ((~~twenty-four~~)) 12 months after the date that the original payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within six months after the date the original payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(2) A carrier may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it

does so in writing to the provider within ((~~thirty~~)) 18 months after the date that the original payment was made or, in the case of mental health and substance use disorder services as defined in RCW 48.43.766, within nine months after the date the original payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

(3) A carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

(4) If a contract between a carrier and a health care provider conflicts with this section, this section ((~~shall prevail~~)) prevails. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a carrier any payment previously made to satisfy a claim.

(5) For purposes of this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(6) This section neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

(7) This section does not apply to claims for health care services provided through dental only health carriers, health care services provided under Title XVIII (medicare) of the social security act, or medicare supplemental plans regulated under chapter 48.66 RCW.

NEW SECTION. **Sec. 5.** Section 4 of this act takes effect January 1, 2028.

Passed by the Senate March 9, 2026.
Passed by the House March 5, 2026.
Approved by the Governor March 23, 2026.
Filed in Office of Secretary of State March 24, 2026.

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