HOUSE BILL REPORT
ESSB 5812

As Reported By House Committee On:
Health Care
Appropriations

Title: An act relating to the prompt payment of health care claims.

Brief Description: Requiring prompt payment of health care claims.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Thibaudeau, Deccio, Wojahn, Winsley, Gardner, Prentice and Costa).

Brief History:
Committee Activity:
Health Care: 3/30/99, 4/2/99 [DPA];
Appropriations: 4/5/99 [DPA(APP w/o HC)s].

Brief Summary of Engrossed Substitute Bill
(As Amended by House Committee)

- Establishes uniform provider claim payment standards for most state-regulated health care payers.

HOUSE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended. Signed by 8 members: Representatives Cody, Democratic Co-Chair; Parlette, Republican Co-Chair; Pflug, Republican Vice Chair; Schual-Berke, Democratic Vice Chair; Alexander; Campbell; Mulliken and Ruderman.

Minority Report: Do not pass. Signed by 3 members: Representatives Boldt; Conway and Edmonds.

Staff: Bill Hagens (786-7131).

Background:

Current state law requires that all fees and medical charges accrued under the worker's compensation program be paid within 60 days. Federal law requires that Medicare providers be paid within 30 days. Other than these, there is no law that explicitly governs the timeliness of payments from insurers to health care providers. In the case of managed care organizations, the issue may be addressed in the contract between the organization and its affiliated providers.

Concern exists that the current law is insufficient and that, increasingly, payments owed health care providers by insurance entities are not being paid on a timely basis.

Summary of Amended Bill:

Time limits are established for payers of medical claims, defined to include health carriers, the health care authority, medical assistance administration, local jurisdictions that purchase medical care, and the Department of Labor and Industries, except for self-insured programs.

A clean claim is defined as the Medicare standard. Payment standards are set as follows: 95 percent of the monthly volume of clean claims to be paid within 30 days of receipt and 95 percent of the monthly volume of all claims to be paid or denied within 60 days, except as agreed to in writing by the parties on a claim-by-claim basis.

Failure to pay on time shall result in 1 percent interest owed by the payer on undenied and unpaid clean claims of more than 61 days.

The Department of Health must create a committee to study trends and issues and make recommendations regarding future legislative, regulatory, or private solutions, including electronic billings, that will promote timely and accurate payment of health claims.

No explicit enforcement provisions are included.

The insurance commissioner is prohibited from adopting rules.

Amended Bill Compared to Engrossed Substitute Bill: The definition of "clean claim" is set at Medicare standards. Enforcement provisions are removed. The insurance commissioner's rule prohibition is added. Time limit exceptions are permitted. Self-insured labor and industries programs are exempted. "Emergency medical care and transportation services" are explicitly added to the definition of "provider."

Appropriation: None.

Fiscal Note: Not requested.

Effective Date of Amended Bill: (Except for the study committee) September 1, 2000.

Testimony For: Delinquent payments from insurance companies to health care providers are a severe problem that is getting worse. It is making it increasingly difficult for some providers to maintain their core functions. Addressing the issue diverts attention from their service delivery mission. It has a negative impact on access to care.

Testimony Against: Processing claims is a complex process that does not lend itself to simple timelines. Most claims are paid on a timely basis relative to the nature of the claim. These sorts of issues are better worked out in the contract between the payer and the individual providers. Most claims are paid within 14 days.

Testified: (in support) Frank Morrison, Washington State Podiatric Medical Association; Ronald Robinson, Pacific Northwest Eye Associates; and Dr. Mark Adams, Washington State Medical Association.

(opposed) Basil Badley, Health Insurance Association of America; Mel Sorensen, Washington Physicians Service; Linda Murphy, Department of Labor and Industries; and Ken Bertrand, Group Health.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care. Signed by 32 members: Representatives Huff, Republican Co-Chair; H. Sommers, Democratic Co-Chair; Alexander, Republican Vice Chair; Doumit, Democratic Vice Chair; D. Schmidt, Republican Vice Chair; Barlean; Benson; Boldt; Carlson; Clements; Cody; Crouse; Gombosky; Grant; Kagi; Keiser; Kenney; Kessler; Lambert; Linville; Lisk; Mastin; McIntire; McMorris; Mulliken; Parlette; Regala; Rockefeller; Ruderman; Sullivan; Tokuda and Wensman.

Staff: Deborah Frazier (786-7152).

Summary of Recommendation of Committee on Appropriations Compared to Recommendation of Committee on Health Care: The exception for employers self-insured for industrial insurance is clarified. Health services billings under the industrial insurance law are removed from the "prompt pay" provisions; instead, the Department of Labor and Industries must pay at least 95 percent of the monthly

volume of proper billings for state fund claims within the current time requirement (60 days of receipt of the billing or within 60 days of claim allowance).

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect on September 1, 2000, except for Section 3, which takes effect 90 days after adjournment of session in which bill is passed.

Testimony For: Delinquent payments from insurance companies to health care providers are a severe problem that is getting worse. This makes it increasingly difficult for some providers to maintain their core functions. Addressing the issue diverts attention from their service delivery mission and it has a negative impact on access to care.

Testimony Against: None.

Testified: Mel Sorenson, Washington Physicians Service Association; Rick Wickman, Premera Blue Cross; Susie Tracy, Washington State Medical Association; Lisa Thatcher, Suzanne Mager, Labor and Industries; and Kathleen Collins, Washington Self-Insurers Association.