FINAL BILL REPORT
SHB 1616

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Synopsis as Enacted

Brief Description: Concerning the charity care act.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Simmons, Cody, Bateman, Valdez, Davis, Macri, Slatter, Pollet and Taylor; by request of Attorney General).

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

Background:

Each hospital must develop, implement, and maintain: (1) a charity care policy to enable persons below the federal poverty level (FPL) to access appropriate, hospital-based medical services; and (2) a sliding fee schedule for determining discounts for qualifying patients. "Charity care" is defined as medically necessary hospital care provided to indigent persons to the extent that they are unable to pay for the care or the deductibles or coinsurance amounts required by a third-party payer.

The charity care standards require that a patient whose family income is at or below 100 percent of the FPL must receive charity care for the full amount of hospital charges, unless third-party coverage applies. Under Department of Health regulations, a patient whose family income is from 101 to 200 percent of the FPL qualifies for discounts based on the hospital's sliding fee schedule. Hospitals may classify a person whose family income is over 200 percent of the FPL as indigent based on the person's financial circumstances.

Summary:

The requirements that: (1) hospitals develop, implement, and maintain a sliding fee schedule for providing charity care; (2) the Department of Health develop guidelines for the development of sliding fee schedules; and (3) persons with incomes below 100 percent of

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the federal poverty level (FPL) receive charity care for the full amount of hospital charges are replaced with new charity care policy standards. The new minimum standards for hospital charity care policies categorize hospitals into two different groups, each with different standards.

The first category includes: (1) hospitals owned or operated by a health system that owns or operates three or more acute care hospitals in Washington; (2) acute care hospitals with over 300 licensed beds located in the most populous county in the state; and (3) acute care hospitals with over 200 licensed beds located in a county with at least 450,000 residents on Washington's southern border. For hospitals in this category, the minimum standards require patients and their guarantors whose income is:

- not more than 300 percent of the FPL, adjusted for family size, be deemed charity care patients for the full amount of their portion of the hospital charges;
- between 301 percent and 350 percent of the FPL, adjusted for family size, be entitled to a 75 percent discount for the full amount of their portion of the hospital charges; and
- between 351 percent and 400 percent of the FPL, adjusted for family size, be entitled to a 50 percent discount for the full amount of their portion of the hospital charges.

The second category includes all hospitals that do not meet the criteria for the first category. For these hospitals, the minimum standards require patients and their guarantors whose income is:

- not more than 200 percent of the FPL, adjusted for family size, be deemed charity care patients for the full amount of their portion of the hospital charges;
- between 201 percent and 250 percent of the FPL, adjusted for family size, be entitled to a 75 percent discount for the full amount of their portion of the hospital charges; and
- between 251 percent and 300 percent of the FPL, adjusted for family size, be entitled to a 50 percent discount for the full amount of their portion of the hospital charges.

A hospital may reduce the amount of the discount, except for patients receiving the full amount of their charges, by giving consideration to the existence, availability, and value of a person's assets. If a hospital considers assets, it must maintain a policy regarding such asset consideration and corresponding discounts, and make it publicly available. A hospital policy may not consider certain monetary assets, any equity in a primary residence, retirement plans other than 401(k) plans, any prepaid burial contract or burial plot, any life insurance policy with a value of $10,000 or less, and one motor vehicle, as well as a second motor vehicle if it is needed for employment or medical purposes. With regard to monetary assets, a hospital may not consider the first $5,000 of monetary assets for an individual, $8,000 for a family of two, and $1,500 for each additional family member. A hospital may not impose procedures that are an unreasonable burden on the responsible person. Information requests to verify assets are limited to information that is reasonably necessary and readily available, and may not be used to discourage applications. When considering monetary assets, one current account statement is sufficient for asset verification. If

documentation for an asset is not available, a written and signed statement from the party must be considered adequate. The hospital may not use asset information for collection activities.

A hospital's charity care policy must include procedures for identifying patients who may be eligible for health care coverage through public medical assistance programs or the Washington Health Benefit Exchange. The hospital must actively assist patients in applying for any available coverage, including retroactive coverage through medical assistance programs. If the hospital determines that the patient or the patient's guarantor qualifies for retroactive health care coverage through medical assistance programs, the hospital is not obligated to provide charity care if the patient or the guarantor fails to make reasonable efforts to assist the hospital in applying for the coverage. Hospitals may not adopt application procedures for charity care or for assistance in applying for retroactive medical assistance coverage that place an unreasonable burden on the patient or guarantor with respect to physical, mental, intellectual, or sensory conditions, as well as language barriers. It is declared to be an unreasonable burden to require a patient to apply for coverage that the patient is obviously or categorically ineligible for or has been determined to be ineligible for within the prior 12 months.

The requirement that hospitals develop, implement, and maintain a charity care policy to enable persons below the FPL to access appropriate, hospital-based medical services is changed to apply to indigent persons accessing charity care, rather than persons below the FPL accessing hospital-based medical services. The term "indigent person" is defined as a patient, or the patient's guarantor, who qualifies for charity care based on the FPL, adjusted for family size and who has exhausted any third-party coverage. In addition to applying to hospitals, the term "charity care" is expanded to also apply to health care provided to indigent persons at a clinic affiliated with a hospital.

The Office of the Insurance Commissioner (Office), in consultation with the Washington Health Benefit Exchange, must study how increasing eligibility for charity care may impact enrollment in health plans with high deductibles. By November 1, 2026, the Office must submit a report to the health care committees of the Legislature on enrollment trends in health plans with high deductibles between January 1, 2023, and June 30, 2026.

The new charity care standards only apply to care provided on or after July 1, 2022, and care provided before that date is governed by the section as it previously existed.

Votes on Final Passage:

House	63	33	
Senate	31	17	(Senate amended)
House	65	33	(House concurred)

Effective: June 9, 2022