Dartmouth-Hitchcock Health

Policy Title	Uninsured Patient Discount Policy - Revenue Management Division	Policy ID	181
Keywords	financial, assistance, uninsured, discount, patient		
Department	Revenue Management Division (RMD)		

I. Purpose of the Policy

Ensures that uninsured patients are not charged any more than amounts generally billed to individuals who have insurance covering such care.

This policy is compliant with NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2009 and will be changed periodically as needed to maintain compliance.

II. Policy Scope

For purposes of this policy the "uninsured discount" applies to healthcare services provided at Dartmouth-Hitchcock Health (D-HH) uninsured patients or for services generally covered by insurance but that are non-covered for a particular service.

III. Definitions

Coinsurance: The percentage of healthcare cost shared between the insurance company and the insured as defined by the insured's policy.

Co-payment: A fixed fee that subscribers to a medical plan must pay for their use of specific medical services covered by the plan.

Deductible: The amount that an insured person must pay, as defined by their insurance policy, before the insurance company will pay for medical expenses.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare.

Package Service: Services that are elective to the patient, non-covered by insurance companies, and that are already discounted by D-HH from gross charges and require pre-payment; for example, cosmetic services.

Pre-Payment Service: Services that are not medically necessary and require payment by the patient prior to the service being provided.

Uninsured: The patient has no insurance or third-party assistance to help with meeting his/her payment obligations.

Uninsured Discount: The discount is based on the "look-back Medicare fee for service plus private payors" method as described under applicable regulations implementing sections 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustment. The discount does not apply to any copay, coinsurance, deductibles, prepayment, or packaged services which already reflect any required discount, or to services classified as non-

covered by all insurance companies. The discount is calculated annually and is adjusted accordingly at the start of the fiscal year.

Dartmouth-Hitchcock Health: For purposes of this policy Dartmouth-Hitchcock Health System Members (D-HH) are Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mt. Ascutney Hospital and Health Center, New London Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH). All other hospitals in New Hampshire and Vermont are considered Non-Member facilities.

As of May 11, 2019, this policy applies to Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, Alice Peck Day Memorial Hospital, and Cheshire Medical Center.

As of October 2020, this policy also applies to New London Hospital.

IV. Policy Statement

D-HH accepts from uninsured patients, as payment in full, an amount no greater than that generally billed and received by D-HH for patients covered by health insurance. D-HH applies an uninsured discount against the total gross charges prior to billing a patient who is a U.S. citizen. This discount does not apply to any copayments, co-insurance, deductible amounts, pre-payment, or package services which already reflect any required discount, or to services classified as non-covered by all insurances. Patients who do not have U.S. citizenship and are seeking non-emergent services are not eligible for the uninsured discount.

Patient's refusing to declare citizenship, do not qualify for the uninsured discount.

501(r) AGB Percentage calculation methodology:

IRS regulations under Section 1.501(r)-5, Limitations on Charges, requires hospital facilities to calculate their "amounts generally billed to patients who have insurance" (AGB) percentage. Hospital facilities are allowed to use the look-back method to base the AGB percentage on the claims of Medicare fee-for-service plus all private health insurers, or on Medicare alone. These regulations further state that health insurance plans administered by private health insurers under Medicare Advantage should be treated as plans of private health insurers and not Medicare fee-for-service.

D-HH sites referenced above have chosen to base their respective AGB percentage calculations using a look-back method on the claims of Medicare fee-for-service plus all private health insurers. Using a consistent 12-month look-back period year over year, gross charges for Medicare fee-for-service and all private payors are compiled, along with the net patient service revenue for these same categories. The AGB percentage is calculated as follows:

$$\text{Effective Collection Rate Percentage} = \frac{\text{Total Medicare FFS \& Private Payors Net Patient Service Revenue}}{\text{Total Medicare FFS \& Private Payors Gross Charges}}$$

AGB Percentage = 100% - Effective Collection Rate Percentage

V. References - N/A

Responsible Owner:	Finance Division Corporate	**Contact(s):**	Kimberly Mender
Approved By:	Board of Trustees; Chief Officer - Finance; Committee on Policy Support (COPS); Office of Policy Support - Organizational Policies Only; Kays, Kieran; Mender, Kimberly; Naimie, Tina; Ten Haken, Jean; Willbarger, Kathryn	**Version #**	7
Current Approval Date:	10/13/2020	**Old Document ID:**	RMD 0081
Date Policy to go into Effect:	10/13/2020		
Related Polices & Procedures:	Financial Assistance for Healthcare Services Policy		
Related Job Aids:			