ValleyHealth
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TO: Regional Business Partners

FROM: Mark H. Merrill
President and CEO

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RE: No-Network/Reference-Based Pricing "Insurance" Plans

Valley Health values your organization as a local area employer and as a member of our community. Exceptional patient care, creating a positive patient experience, and helping patients and employers get the most out of the resources they spend on healthcare are top priorities for us and we are honored to serve you and your employees. In today's environment, a patient's safety, satisfaction, and financial security depends not only on the care that is delivered, but also on the quality and reliability of their insurance coverage and benefits.

As health insurance enrollment season for 2020 begins, we want to alert you to some recent and emerging industry practices that are causing confusion and frustration for employers and patients. Over the past few years, a number of third-party vendors referred to as "Reference-Based" or "No-Network" plans have begun selling products and services to individuals and employers. These plans do not provide the same financial protection that insurance does; however, they are being marketed to employers as an opportunity to reduce health care costs. In some cases, these plans may cover physician office visits under a network arrangement that does not include hospital care, creating a false sense of security and leaving the patient at risk when hospital-based treatment or emergency care is necessary. Unfortunately, the sales pitch for these plans can be misleading or gloss over the shortcomings that leave patients vulnerable to far greater out-of-pocket costs and non-covered expenses than indicated in these plans' marketing material. This is a scenario we want to help you avoid.

Our purpose is to educate you about these Reference-Based or No-Network plans, and explain how they are managed by Valley Health so that you and your employees can make a fully-informed decision before agreeing to participate in any of these types of arrangements. Valley Health is committed to working with you and your health plan partners to make mutually beneficial network arrangements available to your employees. For the reasons discussed in the attached "Frequently-Asked Questions About Reference-Based or No-Network Plans" document, we believe adopting the practices of these plans may not be in the best interests of your company or your employees.

Thank you for your attention to this matter. If you have any questions regarding your insurance plan's coverage and benefits, the plan's participation status with Valley Health, or if you are considering changing insurance plans and would like to verify a potentially new insurance plan's participation status with Valley Health hospitals and providers, please contact our Managed Care team's information line at 540-536-6140 or managedcare@valleyhealthlink.com. Although we cannot advocate any particular health insurance plan, we can answer questions regarding coverage to help ensure you, your employees, and their families have the level of coverage you believe you are purchasing.

FAQs: "Reference Based" or "No-Network" Plans

Do these plans have relationships with health care providers that have agreed to treat my employees?

Typically, no. These plans generally do not provide the same level of protection to patients or providers that network based health insurance plans are to cover. Employers and enrollees are enticed with statements that patients can visit any physician or hospital that they choose, but the reality is that most do not have provider network arrangements or participating provider contracts with providers, either directly or through any other affiliation. This is often a surprise to employees when they present their health care ID cards expecting to have coverage.

What if the card does list a network?

In some cases, these plans have a limited network coverage, covering only physician and ancillary services, but not hospital services. Because physician offices will accept the coverage as they are participating in an established network, this limited network can lull enrollees into a false sense of security and place patients at risk of non-coverage when hospital-based treatment or emergency care is necessary. If a network is listed on the card, it should specify "hospital" coverage.

Will the employee receive a bill from the health care provider?

Yes. Health care providers will typically regard any patient enrolled in any one of these plans as "self-pay" or "out-of-network." This means that the employee will receive a bill directly from the provider, without any contractual discount amount applied

Will the plan pay the bill in full so that the employee is protected from the balance?

No. When a patient receives a bill it is forwarded to the plan and the plan unilaterally applies a "discount" on the bill, usually by reference to a public fee schedule or other benchmark, *e.g.*, payment based upon XX% of the Medicare payment amount. Because there is no provider network arrangement or participating provider contract, this payment does not constitute payment in full so the employee can become caught in the middle of a billing dispute with the plan. In the case of limited network plans, the patient may receive coverage for a physician office visit; but, be exposed to balance billing when the seek care at a hospital.

Is the patient liable for the difference between the billed amount and the plan payment?

Yes. Under contract law, the patient, not the plan, is liable to pay the billed amount. As a result, the employee is caught in the middle. And if the billing dispute is not resolved in a timely fashion by the plan or the employer, the employee's credit could be at risk.

What will the plan do if the health care provider does not accept the payment amount?

Most referenced based or no-network plans will offer some sort of advocacy or negotiation services to attempt to resolve billing disputes, but this does not remove the employee from being

involved. Rather than paying the balance owed, some of these plans may go so far as to engage an attorney to file a lawsuit against the provider on the employee's behalf, drawing the employee and health care provider into a costly and time-consuming proceeding.

Are these plans regulated by the state Bureau of Insurance?

Typically no. The Bureau of Insurance does not regulate these plans. Accordingly, there is little or no oversight of their practices, placing employers and employees at risk. In the case of limited network plans, the plan may be regulated; but, does not cover hospital rates under network arrangement, meaning the patient may not have hospital coverage.

What can I do as an Employer?

When choosing a health insurance plan, ensure you have been provided enough facts and details on what you are purchasing and what level of coverage you are providing to your employees and their families:

- Ensure that your plan has a comprehensive network of participating providers so that your employees will have options for affordable, high quality, in-network care.
- Before selecting the plan, verify that it is licensed as a health insurance plan in the state(s) where you expect your employees to most commonly seek medical care.

What can I do as an Employer? How do I know if a plan is a "Referenced Based" or "No Network" plan?

Do your homework and ask penetrating questions – considering the potential risk involved in selecting the wrong plan, the extra effort is worth the extra diligence!

- Ensure that you have a comprehensive network of participating providers so that your employees will have options for affordable, high quality, in-network care.
- Thoroughly read the all of the material provided by your broker or potential plan, ask to see the exact language that will appear on your subscribers' insurance card, and keep a copy of this material for your records.
- Check with your state's insurance regulatory authority to verify if the plan you are considering is a health insurance plan licensed in your state and is in good standing with state regulators:
    - Virginia State Corporation Commission Bureau of Insurance at https://www.scc.virginia.gov/boi/ConsumerInquiry/ or
    - West Virginia Office of the Insurance Commissioner at https://www.wvinsurance.gov/consumerservices/
- Contact the Valley Health Managed Care Team to verify the health insurance plan is participating with Valley Health providers. Although we cannot recommend a particular health insurance plan, we are happy to answer questions or verify Valley Health participates with the plan you are considering. The Valley Health Managed Care Team can be reached at 540-536-6140 or managedcare@valleyhealthlink.com.
- Considering asking advice from your financial advisor or attorney.

Are there red flags that might indicate a plan is a "Referenced Based" or "No Network" plan? Yes. Watch for the following language or terms in plan material or in the fine-print on the member card that indicates you should ask more in depth questions:

- ***"Referenced-based pricing"*** or ***"No Network"***
- A network is listed on the card with the terms ***Practitioner & Ancillary only"*** or ***"Physician & Ancillary only"*** (***"Hospital"*** is omitted).
- ***"This Plan is NOT insurance"*** or similar
- The term ***"accord & satisfaction"***
- Any language to the effect that ***"filing a claim with [or depositing checks from] the plan constitutes acceptance of the terms of the plan"*** or ***"Acceptance of this card indicates acceptance of the Plan's benefits as payment in full"***

We invite you to contact the Valley Health Managed Care Team at 540-536-6140 or managedcare@valleyhealthlink.com if you have any questions regarding the health insurance plans with which our providers expect to participate in the coming year or any other questions you might have regarding this communication.