BeneSys™ Navigator

FROM THE CEO

Keeping a finger on the pulse of benefit administration

by Ed Wolyniec, CEO

For those of us in the world of plan administration (both TPAs and Self-Administered Fund offices), 2021 is shaping up to be a potentially busy year from a legislative and regulatory standpoint. The Consolidated Appropriations Act, 2021 (CAA), passed in late 2020, is affecting health plans in a number of ways. In his excellent article on page 2, BeneSys in-house counsel and Chief Compliance Officer Matt Morbello discusses the CAA's key provisions and their impact on health plans. Definitely worth a read.

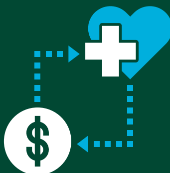
In other news, BeneSys conducted its first ever direct client satisfaction survey in December. Thank you to all who responded. We've acted on your feedback by (1) passing along positive comments to individuals you identified as doing a great job, and (2) providing specific suggestions to the managers or supervisors in areas where improvement is needed. Our goal is to be the best TPA in the business, and your feedback is what really matters in our efforts to get there. We plan to send out the client satisfaction survey annually and would appreciate your continued participation.

As always, feel free to contact me directly at ed.wolyniec@benesys.com with feedback on how we can better serve you and your members. •

YEAR IN REVIEW | 2020 by the numbers

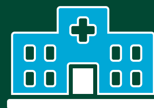
Last year was a busy one at BeneSys. The following stats show just how much our dedicated specialists were able to accomplish on behalf of our clients.

1,707,583
service calls taken.



Over
$5 billion
in contributions received and allocated.

3,300,584



medical,

dental and

vision claims processed.

$40 billion
in assets reconciled monthly.

169,223
new enrollments and/or enrollment changes processed.

More than
23,000
pension applications and estimates processed,

including over
2,500
in special COVID-19 hardship applications.

COMPLIANCE

New legislation brings new challenges for health plans

by Matthew Morbello, CCO

Matthew Morbello, JD, is chief compliance officer and in-house counsel for BeneSys Inc.

The bipartisan Consolidated Appropriations Act, 2021 (CAA) — one of the largest spending bills ever and reportedly the longest bill ever passed by Congress — was enacted on Dec. 27, 2020. While most of the bill deals with budget appropriations and coronavirus-related spending, the CAA also includes the most significant package of health-care-related provisions since the Affordable Care Act. These provisions will require coordination among a health plan's administrator, consultant, and counsel in the coming months. Following are a few highlights, as well as our initial thoughts.

Surprise medical billing

- The CAA includes the first serious federal effort to curb surprise medical billing by out-of-network providers. Beginning in 2022, providers generally cannot balance bill Participants for out-of-network services provided at in-network facilities. This also applies to out-of-network air ambulance services, but not ground ambulance services.
- Beginning with the 2022 plan year, health plans must apply in-network cost sharing to out-of-network emergency services, non-emergency services provided by an out-of-network provider at an in-network facility, and air ambulance services. A Participant's cost-sharing payments for these services must count toward the health plan's in-network deductible and out-of-pocket maximums as if the services were provided in-network.
- Out-of-network providers working at in-network facilities can balance bill in some cases if the patient is provided 72 hours' notice, if the patient receives a good-faith cost estimate, and if the Participant gives his or her written consent. However, consent is not permitted if there is no in-network provider available in the facility, or if the care is for unforeseen or urgent services or is for "ancillary services" (anesthesiology, pathology, radiology, etc.) not typically selected by the patient.
- Disputes over out-of-network claims can be resolved via binding arbitration. Arbitration can be initiated by a health plan or provider as early as 30 days after the initial payment or denial. The binding arbitration is "baseball arbitration," with the arbitrator choosing one side's proposal and the loser paying the costs of arbitration. The arbitrator will consider the median in-network rate for the service, but not usual and customary charges or Medicare rates, or the out-of-network provider's billed charges.

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Our thoughts: While the CAA appears to address the classic problem of a patient being balance billed by an out-of-network anesthesiologist working at an in-network hospital, it does not stop other out-of-network providers from balance billing Participants for non-emergency services provided at out-of-network facilities. The arbitration provision was a significant win for out-of-network providers but is designed to incentivize settlements between health plans and providers. Health plans will need to determine their risk tolerance and be prepared to evaluate cases and decide whether to settle or risk an adverse arbitral award.

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Administrators will need to work with health plans to ensure that advance EOBs contain the required information and are delivered timely.

Transparency provisions

- Beginning with the 2022 plan year, health plans must provide an advance explanation of benefits (EOB) when they are informed by a provider that a service has been scheduled. Health plans must then provide the advance EOB, in many cases within one business day.
  - If the provider is in-network, the advance EOB must explain the Participant's coverage and the provider's contract rate for the services.
  - If the provider is out-of-network, the advance EOB must explain the health plan's and Participant's shares of the cost for the services as of the date of the advance EOB (including the Participant's remaining annual deductible or out-of-pocket maximum) and how to find an in-network provider.
- Also beginning with the 2022 plan year, health plans have to offer in-network price comparison guidance by telephone and on a website via a tool that allows Participants to compare their expected share of costs from different providers. The website also must make available a provider directory database with contact information.
- Prior to the CAA, PPO networks did not share provider-specific cost or quality of care information with health plans. The CAA generally prohibits such restrictions, effective immediately.

Our thoughts: Administrators will need to work with health plans to ensure that advance EOBs contain the required information and are delivered timely. This essentially means processing a claim both before and after a service and will be a challenge. Self-insured health plans will need to work with their PPOs to ensure that previously confidential and proprietary price information is accessible to health plans and Participants.

Mental Health Parity compliance

The CAA requires that health plans report a detailed analysis demonstrating compliance with the Mental Health Parity and Addiction Equity Act's non-quantitative treatment limitations. The CAA requires health plans to perform an analysis and be prepared to provide it to governmental agencies upon request as early as Feb. 10, 2021. Federal agencies will select at least 20 health plans each year for review and will issue a compliance program guidance document within 18 months of the CAA's effective date.

Our thoughts: Health plans should talk to their professionals now about how to complete the analysis. Depending on how a health plan handles benefits for mental health and substance abuse disorders, it may be necessary to work with several professionals and vendors to obtain the required information and compile a report.

Continuity of care provisions

Beginning with the 2022 plan year, if a provider leaves a network, and a Participant is already receiving treatment for a serious and complex condition, pregnant, receiving inpatient care, terminally ill or scheduled for non-elective surgery, the health plan must continue to cover services as though the provider remains in-network for 90 days following notice of the provider's removal from the network.

Our thoughts: Health plans will need to ensure that the PPO and claims administrator are able to re-price and pay claims at the in-network rate for up to 90 days after the provider has left the network. PPOs should be asked how they intend to communicate this notice with health plans and their administrators. Health plans should ensure that affected Participants are informed as soon as possible of their provider's status and the potential impact on their cost sharing. •

This article is provided for informational purposes only and does not constitute legal advice. Readers should consult with their own legal counsel before acting on any of the information presented.

TECH NEWS

A step ahead of cyber hackers

Cybersecurity is a big concern these days, and major breaches — like the hacking of SolarWinds, reported late last year — are headline news. BeneSys takes cybersecurity and data security very seriously. We strengthened our compliance team by hiring another full-time person last year, we routinely conduct IT audits, and this year we will once again hire an external firm to conduct IT penetration testing to verify that our tools and processes are effectively protecting your data. Taking proactive steps like these helps us stay ahead of cyber hackers and keep vital data secure.

EXPANSION

BeneSys and BPA of Wisconsin join forces

BeneSys announced in January that it has joined forces with Benefit Plan Administration of Wisconsin Inc. (BPA) to form a single entity. The combined businesses will operate under the BeneSys name.

"Both companies are well known within the Taft-Hartley space as quality providers," says BeneSys CEO Ed Wolyniec. "The combined entity will have even greater resources to increase quality and capabilities as well as improve service and technology for our clients."

BPA brings with it four service locations in Wisconsin, giving BeneSys an expanded presence in the Upper Midwest and no overlap with its 20-plus offices across the country. BPA President Mark Traino and Vice President Jim Hoppe have joined the BeneSys executive team as senior vice presidents reporting to Ed.

"The Taft-Hartley and overall benefit administration space continues to grow in terms of complexity, requirements for ongoing investment, and technology refreshes and enhancement," Ed says. "Leveraging our combined resources will allow us to respond to changing market conditions while remaining high-quality, reliable partners to our clients."

With more than 220 clients representing over 480 multiemployer trust funds across the U.S., BeneSys serves more than 500,000 plan Participants and their dependents. •

PAUL S. HOWELL

Now part of the BeneSys executive team, BPA of Wisconsin execs Mark Traino (center) and Jim Hoppe (right) meet with BeneSys CEO Ed Wolyniec at BPA's headquarters in Milwaukee.

ABOUT BENESYS

BeneSys has been providing Taft-Hartley trust fund administration and IT services since 1979. Our dedicated specialists understand the nuances of Taft-Hartley benefit plans, and our software system, BenefitDriven, is designed to give our clients and their plan Participants the most efficient tools for self-administering trust fund accounts.

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New office opens in Denver

Our newest benefit office is open for business in Denver, giving plan Participants in the region access to walk-in services provided by four knowledgeable benefit specialists. "We're thrilled to have successfully opened our doors during a pandemic to serve the Eighth District Electricians in the area," says BeneSys President Bonnie Maraia. Located at 4704 Harlan Street, Suite 104, the new office is in Lakeside Office Park, in the Lakeside neighborhood, northwest of downtown Denver.