BeneSys™ Navigator

FROM THE CEO

Your partner in the trust fund world

by Ed Wolyniec, CEO

"While I believe the BeneSys team has made good on our commitments, ultimately it is your opinion that matters."

Welcome to the first edition of the *BeneSys Navigator*! We've created this quarterly publication to keep you updated on events and news in this trust fund world in which we all operate. We chose the name *Navigator* purposefully, with the aspiration of providing pertinent information to help you as you make decisions on operating your trusts.

Delivering service through uncharted waters

For leaders and decision-makers everywhere, 2020 has truly been a challenging year. While we may have found ourselves saying words to that effect in the past, the COVID-19 pandemic has tested us in ways we probably could not have imagined.

At BeneSys, we responded by focusing on continuing to deliver quality service with minimal interruption for you and your Participants. Like most organizations, we had to quickly pivot to a work-from-home paradigm for the majority of our employees. This meant leveraging previous and new investments in computer, phone and networking equipment to ensure that our employees had the necessary tools to deliver on our service commitments to you and your Participants.

Tell us how we're doing

While I believe the BeneSys team has made good on our commitments, ultimately it is your opinion that matters. With that in mind, I'm pleased to announce that we will be launching an annual customer satisfaction survey in October 2020. This brief electronic survey will be emailed to you. Thank you in advance for participating.

In the meantime, if you have feedback that you'd like to share, no need to wait for the survey to let us know. Please contact me directly at ed.wolyniec@benesys.com.

Thank you for the privilege of being your TPA partner! •

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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COVID-19 tests: Diagnosing the latest coverage requirements

by Matthew Morbello, CCO

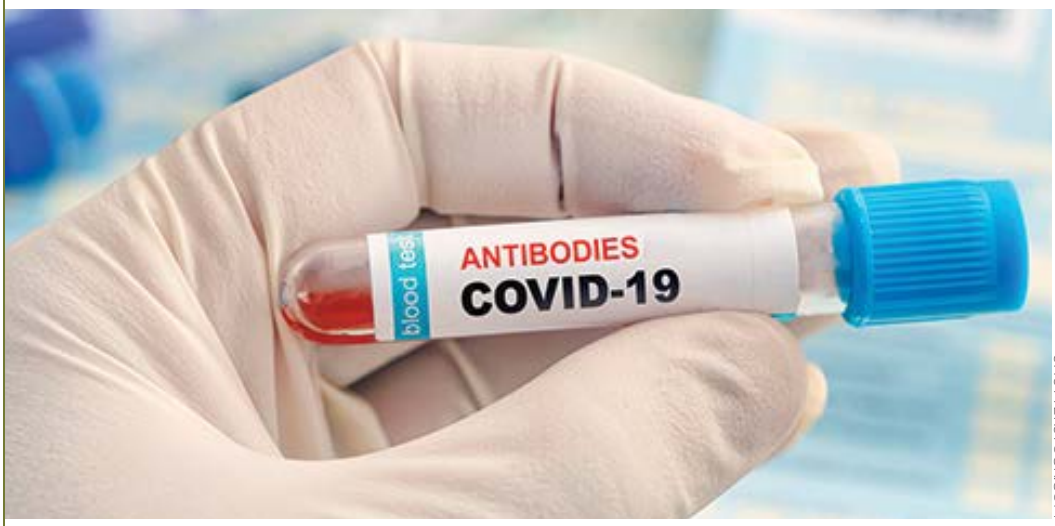
For everyone who works with benefit plans, it's been a challenge to keep up with the laws and regulations surrounding COVID-19.

In normal times, legislation and regulations are finalized following debate, comment periods and hearings. Those impacted by the new statutes typically have several or more months to prepare before the laws and regulations take effect. This can be an opportunity for industry stakeholders to educate themselves on the new requirements and seek clarification as needed.

COVID-19 has upended the normal order of business.

The Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act enacted in March 2020 included a number of provisions that directly and almost immediately affected health plans. In the weeks following, the federal agencies governing benefit plans released a deluge of regulations and FAQs interpreting the provisions.

So where do things stand? Let's take a look at the issues and the most recent guidance (as of this writing, in July).



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The federal agencies governing benefit plans have released a deluge of regulations and FAQs interpreting the COVID-19 provisions.

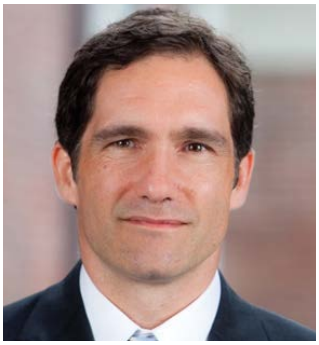
What coverage is required?

FFCRA, as amended by the CARES Act only nine days later, requires health plans (other than retiree-only) to cover the following, without any cost-sharing, prior authorization or other medical management requirements:

- **In vitro tests** for the virus that causes COVID-19 that are approved by the Food and Drug Administration, in development, or approved by the Department of Health and Human Services.
- **Serological tests** to detect antibodies to the virus that causes COVID-19, which can reveal a past infection.
- **Other related tests** ordered during a visit to a provider's office (including telehealth), urgent care clinic or emergency room, or drive-up testing site.
- **Other items and services** furnished during the provider visit that relate either to the evaluation of the patient to determine the need for a diagnostic test, or to the administration of the test.

A set of FAQs released in April by the departments of Labor, Health and Human Services, and the Treasury stated that the above tests, items and services must be covered at no cost to the

The bottom line is that the newest FAQs permit the attending provider, who need not be a physician, to decide whether diagnostic testing is medically appropriate.



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

Participant "when medically appropriate for the individual, as determined by the individual's attending healthcare provider in accordance with accepted standards of current medical practice." At first glance, this seemed straightforward enough, but not all insurers and plans agreed on what it meant.

A number of insurers interpreted it to mean that only "medically necessary" COVID-19 testing ordered by a physician would be covered at no cost to the Participant. Others took a more expansive view and waived cost-sharing for all diagnostic tests. Fortunately, a new set of FAQs issued in June brought some clarification.

Who determines what's medically appropriate?

The new FAQs clarified that the attending health care provider who orders the test need not be directly responsible for providing care to the patient as long as the provider makes an individualized clinical assessment to determine that the test is medically appropriate. An attending provider can be a physician or, as authorized by state law, a pharmacist, nurse or other practitioner who provides care to the Participant while acting within the scope of his or her license. A footnote buried in the FAQs explains that a medical necessity review (including a concurrent review) is considered medical management and cannot be used to restrict coverage of diagnostic testing. The bottom line is that the newest FAQs permit the attending provider, who need not be a physician, to decide whether diagnostic testing is medically appropriate.

So when would diagnostic testing not be medically appropriate? One example in the FAQs is testing for employment purposes: Screening tests for employees as mandated to reopen a business don't need to be covered because they are not for a medical purpose. It's less clear whether a test requested by an asymptomatic individual following a possible exposure to the virus is a screening test, or medically appropriate. That may be up to the attending provider to determine.

Congressional Democrats have pushed for legislation that would eliminate the distinction between screening and medically appropriate tests so that individuals would not be charged in either case. As the COVID-19 situation continues to evolve, our clients can count on BeneSys to stay on top of all legislation and regulations pertaining to benefit plans. •

Look out for out-of-network price gouging

Within the latest COVID-19 health plan rules lies at least one potential land mine: out-of-network pricing for diagnostic tests.

While in-network costs for the tests are generally reasonable, there have been reports of non-network providers billing over $2,000 for a test. How is this possible? Under the rules, plans must either pay the cash price that non-network providers are required to post on a public website, or try to negotiate a lower price with the provider. Even if the non-network provider agrees to accept a reduction in its public cash price, the final bill to the plan could still be multiples more than the network rate. Participants cannot be balance-billed for diagnostic testing, but this restriction does not apply to testing-related services. When it comes to COVID-19 testing, plan sponsors may want to encourage their Participants to use network providers or help them find no-cost clinics.

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.

BeneSys brings its A game to pandemic response

When the COVID-19 crisis hit, BeneSys responded with technology infrastructure solutions designed to serve our clients and their Participants during a critical time — and beyond.

- **A secure work-from-home infrastructure:**

Within six weeks we enabled over 90% of the BeneSys workforce to work securely from home. We installed a larger internet circuit and a new VPN (virtual private network) appliance to handle the additional load of employees serving our clients from home. BeneSys uses a secure VPN with multifactor authentication to allow employees to connect to their work computers; all data, voice and phone traffic transmit through this encrypted connection. The BeneSys IT team continues to monitor the performance of our work-from-home infrastructure to ensure high quality standards.

- **Robust phone service:** The phone system we implemented in 2019 gave us more scalability, increased functionality and enhanced metrics, providing our agents with the tools required to ensure an effortless customer experience.

- **A powerful, secure cloud platform:** By year-end we plan to finish moving our internal benefits administration applications, including BenefitDriven, to Microsoft Azure cloud, providing scalability, enhanced disaster recovery and advanced data security. •

Self-registration is a hit with Participants

BeneSys recently rolled out a new online self-registration process that lets plan Participants quickly and securely register for our Participant website. All that is needed is the Participant name, date of birth, SSN or Alternate ID, and ZIP code as they are recorded at the Benefit Office. Once the system verifies that the key fields match what is on file, the Participant's website account is created and ready for use.

Participant response has been positive: Since we enabled self-registration earlier this year, we've seen a significant increase in new registrations and account usage.

BeneSys Now mobile app makes its debut

BeneSys clients can now offer plan Participants the option of accessing their benefit information from their mobile device 24/7 thanks to the new BeneSys Now app.

The mobile app debuted this summer, making BeneSys the first TPA in the industry to launch an app of this kind.

Using facial recognition or fingerprint authentication, BeneSys Now allows Participants to check a host of information that's updated daily, including:

- Hours reported on their behalf.
- Current and historical eligibility.
- Claims history and payment status.
- Current accrued pension benefits.

BeneSys Now eliminates the need to carry a plastic ID card — it's viewable in the app, which also lets Participants email their card to their provider's office right from their phone.

The app is available for both Android and iOS devices. If you think BeneSys Now would be of value to your Participants, talk to your plan manager about implementation costs and scheduling.