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JOINT COMMUNICATION

Multi-Employer/UNA Collective Agreement

Resolution of Employee Benefits Grievances and Drug Claim Denials

January, 2006

The Issues:

Over the past years, there have been two major issues in dispute regarding the benefits provided under Article 21.01(a) of the Multi-Employer/UNA Collective Agreement in the Supplementary Benefits Plan. These are::

- The requirement for Supplementary Benefit Plans to be equivalent to the Health Organizations Benefit Plan (HOBP) Supplementary Benefits Plan; and
- The substances covered as medications under the Supplementary Benefits Plan drug coverage.

The Multi-Employer/UNA Joint Committee has been in discussions to resolve these issues and has now reached a mutually agreed resolution.

The Resolution:

This settlement resolves all of the outstanding policy, group and individual grievances regarding equivalency. This settlement is also intended to resolve all grievances and issues related to drug claims that have been denied since July 1, 2001, subject to a review of documented previously denied drug claims.

Highlights of the resolution are provided below. The terms and conditions of the settlement are provided in the Appendix attached to this Joint Communication.

I. Article 21.01(a) and 21.02(b): Health Organization Benefit Plan Equivalency Requirement

Calgary Health Region

The Calgary Health Region will implement the following amendments to the Supplementary Benefit Plan effective April 1, 2006:

- Increase coverage and limits for paramedical practitioners to provide for a maximum of $35/visit, 20 visits/year for chiropractor, physiotherapist, speech therapist, osteopath, podiatrist, chiropodist and registered masseur treatments. In order to be covered, treatment by a registered masseur must be ordered by a physician.
- Amend coverage for diabetic supplies from 80% Direct Bill coverage to 100% Reimbursement coverage.
- Add coverage for Synvisc treatments.

Capital Health

Capital Health will implement the following amendments to the Supplementary Benefit Plan effective April 1, 2006:

- The Royal Alexandra Hospital Supplementary Benefit Plan, with the following changes, will form the basis for the region-wide Supplementary Benefit Plan applicable to all sites:

  - Increase coverage and limits for paramedical practitioners to provide for a maximum of $35/visit, 20 visits/year for chiropractor, physiotherapist, speech therapist, osteopath, podiatrist, chiropodist and registered masseur treatments. In order to be covered, treatment by a registered masseur must be ordered by a physician.
  - Amend coverage for Medical Equipment Rentals, Respiratory Services and Medical Aids (including diabetic supplies, blood test monitor, orthotic inserts, orthopaedic shoes and hearing aids) to provide 100% reimbursement coverage (was 80% Direct Bill). The current Royal Alexandra Hospital Supplementary Benefit Plan maximums to remain unchanged.
  - Add coverage for Synvisc treatments.

Open Enrollment Period

In consideration of the new benefits being provided, there will be a 60 day open enrollment period from March 1, 2006 to April 30, 2006 to allow Capital Health and Calgary Health Region employees who had previously opted out of the Supplementary Benefit Plan to now enroll in the Plan.

Detailed Benefit Plan Information and Enrollment Details

In February/March, 2006, Calgary Health Region and Capital Health Employees will be receiving detailed information regarding the new coverage to be provided

under the Supplementary Benefit Plan. The Calgary Health Region and Capital Health will also be providing information to Employees that previously opted out of the Supplementary Health Care Plan about how to sign up for the Supplementary Benefit Plan during the open period if they choose to enroll.

II. Article 21.01(a)(ii) – Coverage for physician or dentist prescribed medication

The parties have agreed to a process that will ensure coverage is provided for medications that meet the underlying intent for providing such coverage. In order to accomplish this, the parties have agreed upon a process and criteria to ensure appropriate coverage rather than relying on any specific benefit plan wording. Under the agreed upon process, claims will initially be covered in accordance with the current benefit plan language. In the event that a claim is denied, an appeal process has been established that would review the denied claim on the basis of the agreed upon set of criteria.

Appeal Criteria

The criteria against which a drug claim denied by the insurer would be reviewed throughout the appeal process is as follows:

> *"A substance, prescribed by a physician or dentist, and dispensed by a pharmacist, which is required to be consumed (orally, by injection, absorbed or inhaled) to correct or treat a medical condition based on a diagnosis made by a physician or dentist."*

Appeal Process

It is intended that the appeal process be significantly more expeditious that the grievance/arbitration process, give the Union an opportunity to be involved and still have the ability for a third party to make a final decision in the event that consensus is not reached by the parties during the process. Both parties are optimistic that this process will resolve issues in a timely fashion, and in a manner that protects confidentiality of personal medical information.

For medication claims that are denied after February 1, 2006, Employees should commence the appeal process within 30 days of their original claim being denied.

Resolution of Individual Grievances and Previous Claim Denials

At the time that the Multi-Employer/UNA Joint Committee undertook discussions to resolve this issue, it was agreed by both parties that employees would not be required to file individual grievances in order to be affected by any potential resolution of the issue. Therefore a joint process will be established to review medication claims that have been denied during the period from June 1, 2001 to February 1, 2006. Employees have a limited period (February 1, 2006 to April 30, 2006) to notify UNA of a claim denial that they wish to submit for review. Employees will be required to submit a copy of the original claim denial

and a form (available from your UNA representative) indicating the medical diagnosis that the medication in question was prescribed and dispensed to treat. Following review by UNA, such appealed claim denials will be forwarded directly to the Joint Appeal Panel for review in accordance with the agreed upon criteria.

If the joint review determines that the denied claim meets the new, agreed-upon criteria, the joint review panel will recommend to the employer that the claim be paid. Upon receiving such a joint recommendation, the employer may choose to pay the claim directly, instruct the insurer to pay the claim or decline claim payment. In the event that the employer declines claim payment, the claim will be referred to the Umpire for final resolution.

This Settlement Agreement will be effective until the end of this collective agreement, or until the start of the next collective agreement, which will give both parties an opportunity to determine if the process is working effectively.

Next Steps

The Calgary Health Region and Capital Health will be providing further detailed information regarding the agreed upon coverage amendments and how previously opted-out employees can enroll in the Supplementary Benefit Plan.

All Employers will be advising Employees and the Union of the name of the Employer representative that will be designated to review the denied medication claims at the first step of the appeals process.

UNA will be advising members of the process for forwarding previously denied medication claims and related grievances, if applicable to the agreed upon joint review process for individual resolution.

Appendix A

Multi-Employer/UNA Joint Committee

Settlement of Employee Supplementary Benefit Plan Grievances and Drug Claim Denials

January, 2006

1. Article 21.01(a) and 21.02(b): Health Organizations Benefit Plan Equivalency

(a) The Supplementary Benefit Plans for David Thompson Health Region, Chinook Health Region, St. Mary's Hospital, Camrose and Mineral Springs Hospital, Banff are agreed to be equivalent as per the coverage being provided as at January 13, 2006.

(b) The Calgary Health Region and UNA have agreed to implement the following amendments to achieve an agreement regarding equivalency:

- Amend coverage and limits for paramedical practitioners to match the Health Organizations Benefit Plan (i.e. maximum $35/visit, 20 visits/year). Note: Massage coverage to require physician referral – regardless of outcome of UNA appeals on HOBP arbitration decision).
- Amend coverage for diabetic supplies from 80% Direct Bill coverage to 100% Reimbursement coverage.
- Add coverage for Synvisc treatments as per the Health Organizations Benefit Plan.

(c) Capital Health has agreed to the following amendments to achieve an agreement regarding consistency and to move all nurses to a single, region-wide Supplementary Benefit Plan Plan:

- The Royal Alexandra Hospital Supplementary Benefit Plan, with the following changes, will form the basis for the region-wide Supplementary Benefit Plan applicable to all sites:

  - Amend coverage and limits for paramedical practitioners to match the Health Organization Benefit Plan (i.e. maximum $35/visit, 20 visits/year). Note: Massage coverage to require physician referral – regardless of outcome of UNA appeals on HOBP arbitration decision).
  - Amend coverage for Medical Equipment Rentals, Respiratory Services and Medical Aids (including diabetic supplies, blood test monitor, orthotic inserts, orthopaedic shoes and hearing aids) to provide 100% reimbursement coverage (was 80% Direct Bill). Note: Current maximums to remain unchanged.
  - Add coverage for Synvisc treatments.

(d) This would resolve all of the outstanding policy, group and individual grievances regarding equivalency and the grievances regarding the provision of benefits at no less than those in place as at February 25, 2001 for the Chinook Health Region that were filed at the time that the Chinook Health Region moved the Supplementary Benefit Plan from Maritime Life to Blue Cross. The recent grievances in the Chinook Health Region related to placing new employees on the regional plan after July 1, 2004 remain in dispute.

(e) Agreed upon amendments to the plan, including the movement of all of the UNA certified employees in Capital Health to the region-wide Supplementary Benefit Plan, would become effective April 1, 2006. There would be no retroactive claim payments required, unless an individual grievance regarding equivalency is identified as having already been filed (neither party was aware of any). There will be a 60 day open enrollment period from March 1, 2006 to April 30, 2006 to allow Capital Health and Calgary Health Region employees who had previously opted out of the Supplementary Benefit Plan to now enroll in consideration of the new benefits being provided.

2. Article 21.01(a)(ii) – Coverage for physician or dentist prescribed medication

(a) ***Appeal Criteria*** - The criteria against which a drug claim denied by the insurer would be reviewed throughout the appeal process is as follows:

> *"A substance, prescribed by a physician or dentist, and dispensed by a pharmacist, which is required to be consumed (orally, by injection, absorbed or inhaled) to correct or treat a medical condition based on a diagnosis made by a physician or dentist."*

(b) ***No Change to Current Insurer Contracts*** - For administrative efficiency, employers will continue to provide drug coverage in accordance with the current benefit plan description of covered drugs implemented by all employers. If, as a result of the insurers' contract language, coverage for a medication is denied, the agreed upon appeal process may be implemented.

(c) ***Appeal Process*** - The appeal process would be clearly communicated to all employees, employers and Union representatives. It is intended that the appeal process be significantly more expeditious that the grievance/arbitration process, give the Union an opportunity to be involved and still have the ability for a third party to make a final decision in the event that consensus is not reached by the parties during the process. The appeal process would involve the following steps:

(i) <u>*Employee Submission of Appeal*</u> – Employees would be advised that they should commence the appeal process within 30 days of their original claim being denied.

(ii) <u>*Employer Designated Individual(s)*</u> – An employee with a denied claim for a prescribed medication would first take the issue to an

identified representative of the employer for review. At this point the employer representative would review the claim and determine if it was eligible for payment under the agreed upon criteria. If it meets the criteria, the employer would instruct the insurer to pay the claim under the special authorization processes. If not, the employer would advise the employee. The employee would then have an opportunity to have the claim reviewed by a Joint Appeal Panel. It is anticipated that this phase of the appeal process would be completed within two weeks from the time that the employee brings the denied claim forward for appeal.

(iii) *Joint Review Process* – A joint group with representatives of UNA and participating employers would be established for the purposes of reviewing employee appeals on denied medication claims. Again, the review would be conducted on the basis of the agreed upon criteria. In the event that the joint review panel determines the claim meets the criteria, they would recommend to the employer that the employer instruct the insurer to pay the claim. If the joint panel cannot reach consensus on a recommendation, or if the employer chooses not to implement a jointly issued recommendation, the issue would be referred to a single umpire. It is intended that the joint review panel will meet with sufficient regularity to be able to deal with claim denial appeals within approximately one month of the original claim denial.

(iv) *Umpire* – The parties have agreed to have Jay Spark serve as a single Umpire. The Umpire will review the claim and his/her decision regarding payment or denial of the claim will be final.

(d) ***Individual Grievance/Claim Denial Resolutions*** – At the time that the Multi-Employer/UNA Joint Committee undertook discussions to resolve this issue, it was agreed by both parties that employees would not be required to file individual grievances in order to be affected by any potential resolution of the issue. The parties agree that a joint process will be established to review medication claims that have been denied during the period from June 1, 2001 to February 1, 2006. Employees will be provided with a limited period (February 1, 2006 to April 30, 2006) to notify UNA of a claim denial that they wish to submit for review. Employees will be required to submit a copy of the original claim denial and a form indicating the medical diagnosis that the medication in question was prescribed and dispensed to treat. Following review by UNA, such appealed claim denials will be forwarded directly to the Joint Appeal Panel for review in accordance with the agreed upon criteria.

If the joint review determines that the denied claim meets the new, agreed-upon criteria, the joint review panel will recommend to the employer that the claim be paid. Upon receiving such a joint recommendation, the employer may choose to pay the claim directly, instruct the insurer to pay the claim or decline claim payment. In the event that the employer declines claim payment, the claim will be referred to the Umpire for final resolution.

This Settlement Agreement will be effective until the end of this collective agreement.