OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 93-098 – May 23, 2007

Trustees: Micheal W. Buckner, A. Frank Dunham, Michael H. Holland, and Elliot A. Segal.

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of benefits for name brand prescription drugs under the terms of the Employer Benefit Plan.

Background Facts

In March 1994, the Respondent implemented a prescription drug program that requires the use of generic drugs in lieu of brand name drugs. In order to receive a brand name drug, the prescribing physician must submit written justification of the medical necessity for the brand name drug(s) to the Employer's Plan Administrator for approval. In lieu of a letter from the physician, a 1-800-telephone number is available for physicians to contact the Plan Administrator directly. The Respondent requires that the Employee pay the difference between the cost of the generic and the brand name drug if the Employee does not receive approval from the Plan Administrator. The Respondent states that Employees were informed in writing and that Employee meetings were held to explain the procedures to obtain brand name drugs under the Respondent's drug program.

The Complainant's physician prescribed the brand name drug Tenormin for the Complainant's hypertension. The Complainant's spouse had the prescription filled and was required to pay the difference between the cost of Tenormin and its generic equivalent. Upset that she had to pay more than the co-payment for the Tenormin, the Complainant's spouse contacted the Respondent who advised her to obtain a statement of medical necessity for the brand name drug from the Complainant's physician.

In a letter to the Respondent dated June 23, 1994, the Complainant's physician indicated that the letter that he was providing addresses all of the physician's patients who receive prescription drugs through the Respondent's insurance carrier. The physician indicated that when he writes a prescription that states "Brand Medically Necessary," he does not want the prescription filled with a substitute drug. The letter also explained why the physician has an overall distrust of generic medications. However, the letter did not include any reference to the Complainant, or reasons for the use of Tenormin versus a generic equivalent. The Complainant states that this letter was the only response his physician would supply to the Respondent.

The Respondent's Plan Administrator informed the Complainant by letter dated July 6, 1994, that the Complainant's request for full benefits coverage for Tenormin was denied because the Complainant's physician was unable to provide a specific medical reason as to why Tenormin was medically necessary.

Dispute

Is the Respondent required to provide full benefits for the brand name drug Tenormin?

Positions of the Parties

Position of the Complainant: The Respondent is required to provide benefits for the brand name drug Tenormin because the Complainant's physician wrote "brand medically necessary" on his prescription. The physician also provided general arguments as to why generic drugs should not be substituted without his approval.

Position of the Respondent: The Respondent is not required to provide benefits for the brand name drug Tenormin because the Complainant was informed of the procedures to receive brand name drugs under the Employer Benefit Plan and the Complainant's physician did not provide a specific medical rationale that explains why the generic equivalent of the brand name drug Tenormin should not be utilized.

Pertinent Provisions

Article XX (10) b. of the 1993 Coal Wage Agreement states:

> Article XX-HEALTH AND RETIREMENT BENEFITS
>
> (10) HEALTH CARE:
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> * * * * * * * * *
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> Enhanced Cost Containment Program
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> * * * * * * * * *
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> b. Generic Drug Substitution
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> If a Beneficiary uses a brand name drug when a generic equivalent is available, the Beneficiary is responsible for the difference in cost between the generic drug and the brand name drug, in addition to the normal copayment. A

> generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered "available," and there will be no additional payment by the Beneficiary for the use of the brand name drug.

The Introduction to Article III of the 1993 Employer Benefit Plan states, in pertinent part:

> Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under this Plan. . . .

Article III. A. (4) (a) of the 1993 Employer Benefit Plan states, in pertinent part:

ARTICLE III BENEFITS

(4) Prescription Drugs

(a) Benefits Provided

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Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lessor of:

(1) The amount actually billed per prescription or refill,

(2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that the use of a brand name drug is medically necessary, the price of such brand name drug; or

(3) The current price paid to participating pharmacies in any prescription drug program established by the Employer.

However, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

Article III A. (10) (b) and (h) 2. of the 1993 Employer Benefit Plan state, in pertinent part:

(10) General Provisions

(b) Administration

The Plan Administrator is authorized to promulgate rules and regulations to implement and administer the Plan, and such rules and regulations shall be binding upon all persons dealing with the Beneficiaries claiming benefits under this Plan. . . .

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(h) Explanation of Benefits (EOB) and Hold Harmless

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2. The Employer and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Plan Administrator or his agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. . . .

Article IV. A. (2) of the 1993 Employer Benefit Plan state, in pertinent part:

Article IV. Managed Care, Cost Containment

A. (2) In addition, the Employer may implement certain other managed care and cost containment rules, which may apply to benefits provided both by PPL providers and by non-PPL sources, but which (except for the deductibles and co-payments specifically provided for in the Plan) will not result in a reduction of benefits or additional costs for covered services provided under the Plan.

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Discussion

Article XX (10) b. of the 1993 Coal Wage Agreement requires that a Beneficiary pay the difference in cost for the use of a brand name drug when the generic equivalent is available. If, however, the prescribing physician determines that the brand name drug is medically necessary, the generic equivalent will not be considered "available," and there will be no additional payment by the beneficiary. Article III A. (4) (a) 2. of the 1993 Employer Benefit Plan provides for the applicable generic substitution of brand name drugs if they are rated AB or better and have federal Food and Drug Administration approval. It also allows benefits for brand name drugs in those cases where the prescribing physician determines that the brand name drug is medically necessary.

Article III A. (10) (b) authorizes the Plan Administrator to promulgate rules and regulations to implement and administer the Plan. The Trustees have determined in prior RODs (see RODs 81-697 and 84-042) that such rules and regulations are binding if they are reasonable and have been effectively communicated to the Beneficiaries. Additionally, Article IV A. (2) states that an Employer may implement other managed care and cost containment rules but, except for the deductibles and co-payments provided for in the Plan, such rules cannot result in a reduction of benefits or additional costs for covered services provided under the Plan.

The Respondent in this case has established a generic drug substitution program to assist in containing drug costs. Under the program, if a prescription is filled with a brand name drug when a generic is available, the plan will pay only the generic price less the applicable co-pays and deductibles and the Beneficiary will be charged the difference. The Respondent states that it informed Beneficiaries by mail of the requirements to receive brand name drugs and also held Employee meetings. Information sent to Beneficiaries by the Respondent informed them that they "[m]ust submit a letter from the physician indicating the reason why taking a Brand Name drug is a medical necessity."

In ROD 93-079, the Trustees addressed the issue of whether an Employer can require a Beneficiary to provide medical documentation to support the use of brand name drugs. The Trustees determined that an "Employer's requirement that physicians provide a statement to the Plan Administrator justifying the use of a brand name over a generic drug is reasonable and consistent with the provisions of the 1993 Coal Wage Agreement and the 1993 Employer Benefit Plan; provided, however, the Employer does not impose rules that arbitrarily hinder or deny a Beneficiary reasonable and timely access to required medications. In the point-of-sale environment where drugs are secured by the Beneficiary, the rules should not be unnecessarily cumbersome or restrictive." Therefore, the Respondent may request that the Complainant provide medical documentation to justify the use of a brand name drug over a generic drug.

In reply to the Respondent's request for justification of prescribing the brand name drug Tenormin, the Complainant's physician submitted a letter stating that the letter addresses all of

his patients who receive prescription drugs from the Respondent's insurance carrier. The Complainant's physician indicated that when he writes "Brand Medically Necessary" on his prescriptions, he does not want the prescription filled with a substitute drug. The physician's letter, however, does not address why the physician prescribed the brand name drug Tenormin over a generic drug for the Complainant. Absent sufficient documentation from the Complainant's physician to justify prescribing Tenormin over a generic drug, the Respondent is not required to provide full benefits for the brand name drug Tenormin.

Opinion of the Trustees

In the absence of documentation to show medical necessity, the Respondent is not required to provide benefits to the Complainant beyond those for a generic substitute drug for the brand name drug Tenormin, consistent with the provisions of the 1993 Employer Benefit Plan.