OPINION OF TRUSTEES

In Re

Complainant: Pensioner
Respondent: Employer
ROD Case No: CA-0097 – October 7, 2011

Trustees: Michael H. Holland, Daniel L. Fassio, Morris D. Feibusch, and Carlo Tarley

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of benefits under the terms of the Coal Industry Retiree Benefit Act of 1992 (Coal Act) Employer Benefit Plan maintained pursuant to section 9711 of the Internal Revenue Code.

Background Facts

Complainant is receiving health benefits from Respondent under the terms of the Coal Industry Retiree Benefit Act of 1992 Employer Benefit Plan (the "Plan"). Complainant attempted to refill a prescription for Viagra, but Respondent's pharmacy benefit manager (the "PBM") denied payment. The PBM then faxed a pre-authorization form consisting of 13 questions to Complainant's physician. Complainant's physician filled out the pre-authorization form and faxed it to the PBM the following day. However, the PBM denied payment again because Complainant's physician failed to answer all of the questions on the pre-authorization form. Another physician subsequently filled out the pre-authorization form on Complainant's behalf and returned it to the PBM. The prescription was ultimately filled, and Complainant was approved to receive benefits for Viagra for one year.

Complainant asserts that Respondent may not include questions in a pre-authorization form for Viagra prescriptions beyond the six guidelines set forth in ROD 98-024.

Dispute

May Respondent require Complainant's physician to complete a pre-authorization form containing questions other than the six guidelines set forth in ROD 98-024 for Complainant to receive benefits for Viagra?

Positions of the Parties

Position of the Complainant: Respondent may only require Complainant's physician to address the six guidelines set forth in ROD 98-024, and other similar RODs pertaining to Viagra, for Complainant to receive benefits for Viagra.

Position of the Respondent: The Plan Administrator may require a pre-authorization form as a health care cost containment measure pursuant to Article IV of the Plan.

Pertinent Provisions

The preamble to Article III of the Plan states:

ARTICLE III BENEFITS

> Subject to Article IV, the benefits provided under this Plan are set forth in this Article III. Benefit payments shall not exceed reasonable and customary charges for covered services and supplies. 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. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided. Services which are not reasonable and necessary shall include, but are not limited to the following: procedures which are of unproven value or of questionable current usefulness; procedures which tend to be redundant when performed in combination with other procedures; diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly; procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care. The benefits described in this Article are subject to any requirements implemented pursuant to Article IV. Covered services that are medically necessary will continue to be provided, and accordingly, while benefit payments may be subject to managed care and cost containment rules, this paragraph shall not be construed to detract from plan coverage or eligibility as described in this Article III.

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

(4) Prescription Drugs

(a)Benefits Provided

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a nonoccupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in (3)(e). The initial amount dispensed shall not exceed a 30 day supply. Any original prescription may be refilled for up to six months as directed by the attending physician. The first such refill may be for an amount up to, but no more than, a 60 day supply. The second such refill may be for an amount up to, but not more than, a 90 day supply. Benefits for refills beyond the initial six months require a new prescription by the attending physician.

Article III.A(10)(b) of the Plan states:

(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. The Trustees of the UMWA 1992 Benefit Plan will resolve any disputes, including excessive fee disputes, to assure consistent application of the Plan provisions which are identical to the benefit provisions of the 1992 Benefit Plan.

Article IV.A of the Plan states in pertinent part:

The Employer may also implement a formulary for prescription drugs; implement a mail-order procedure for prescription drugs, including appropriate limits on quantity and periodic physician review; and subject the prescription drug program to a rigorous review of appropriate use.

Article IV.B of the Plan states:

> 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 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.

Discussion

Article III of the Plan provides coverage for prescription drugs dispensed by a licensed pharmacist, provided that they are medically necessary. Article IV.B of the Plan permits Employers to implement cost containment rules that do not result in a reduction of benefits or additional costs for covered services under the Plan.

Respondent adopted the pre-authorization form in the instant case as a cost containment measure to ensure the medical necessity of Viagra prescriptions. The Funds' Pharmacy Program Manager and Medical Director have determined that Respondent's pre-authorization form provides a reasonable basis for determining the medical necessity of Viagra prescriptions. Inasmuch as the terms of the Plan subject prescription drug benefits to cost containment rules implemented by the Employer, Respondent's pre-authorization form does not result in a reduction of benefits. Furthermore, Respondent's pre-authorization form imposes no additional costs on Complainant and is, therefore, a permissible cost containment rule under the terms of the Plan.

Opinion of the Trustees

Respondent may require the completion of its pre-authorization form before providing benefits for a Viagra prescription.