In the Matter of Arbitration between	)	Arbitrator's Opinion and Award
ARCELORMITTAL USA	)	Grievance 306
and	)	Award Issued: September 19, 2014
	)	Case 69
UNITED STEELWORKERS LOCAL UNION 979	)	

Subject: Insurance Agreement Program of Insurance Benefits Summary Plan Description – Prescription Drug Benefits – Prior Authorization

Appearances of Counsel:

Thomas H. Barnard, Esquire
On behalf of the Company

Joseph P. Stuligross, Associate General Counsel
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On behalf of the Union

In this grievance filed and processed under the Basic Labor Agreement between ArcelorMittal and the United Steelworkers it is claimed, in essence, that the Insurance Agreement Program of Insurance Benefits Summary Plan Description for Eligible Retirees (former ISG) and Surviving Spouses for Life Insurance and Prescription Drug effective January 1, 2011 was violated beginning in 2012 when certain prescription medications were first subjected to prior authorization for medical necessity in order to be covered under the Prescription Drug Benefit plan.

The Program of Insurance Benefits Summary Plan Description provides, in part, as follows:

SECTION 4.
PRESCRIPTION DRUG BENEFITS

Introduction

Coverage for medically necessary and appropriate prescription drugs requiring a prescription written by a licensed physician and dispensed by a licensed pharmacist pursuant to Federal or State law is provided under the Prescription Drug Benefit plan. ...

Prescription drug benefit coverage will be administered by a prescription drug benefit manager who will be responsible for developing and maintaining a network of retail pharmacies, offering a mail service option for the purchase of maintenance medications for chronic or long-term conditions, managing drug utilization, and making payments for covered prescriptions.

The prescription drug plan is a 3-tier formulary plan. A formulary is a list of preferred drug products developed by a committee of physicians and pharmacists. Your coinsurance will be based on whether the drug your doctor prescribes is a generic, formulary brand, or non-formulary brand prescription drug. ...

Prescription Drug Costs and Benefit Payments

Your coinsurance for covered prescription drugs, by drug type and where purchased is:

In-Network Retail Prescriptions (up to a 30-day supply)	Coinsurance
Generic	$10
Formulary Brand	$20
Non-Formulary Brand	$30

* * *

Prescription Drug Coverage Limitations, and Exclusions

The following drugs are subject to limitations:

(a) Smoking cessation products that can be obtained only with a physician's prescription (non over-the-counter) are covered at the generic co-pay level;

(b) Drugs prescribed for erectile dysfunction are subject to prior authorization approval and limited to eight (8) pills maximum per month;

(c) Certain drugs may require step therapy;

(d) Certain drugs may be limited in quantities covered;

(e) Certain drugs may require prior authorization; and

(f) Anti-obesity or diet pills prescribed for obesity are subject to prior authorization approval.

Prescription drug benefits are not payable for:

(a) Drugs that can be purchased over-the-counter without a prescription (except for insulin);

(b) Experimental, investigational, or drugs not approved by the FDA;

(c) Anti-obesity or diet pills without a physician's diagnosis of obesity and prior authorization approval;

(d) Vitamins (obtained over-the-counter or by prescription), minerals, or supplements;

(e) Food and food or nutritional supplements;

(f) Refills of prescriptions older than one year;

(g) Drugs prescribed for treatment of infertility;

(h) Drugs prescribed for cosmetic purposes;

(i) Drugs prescribed in amounts greater than the manufacturer's recommended dosing or for diagnoses for which the drug is not FDA approved; or

(j) Replacement of lost or stolen prescription drugs.

Prior Authorization

Some prescription drugs require review by the prescription drug benefit manager before certain quantities or an extended duration of therapy will be covered under the Prescription Drug Benefit plan. Prescription drugs that are subject to review and prior authorization are those that cause potentially serious side effects, are costly, or have a high potential for inappropriate use.

* * *

SECTION 7.
OTHER INFORMATION

This Summary Plan Description (SPD) is the official Plan document that has been established pursuant to the Insurance Agreement dated September 1, 2008, between ArcelorMittal USA LLC (the "Company") and the United Steelworkers (the "Union").

If there is a conflict between this document and any other description of the Plan, the text of this Plan and/or Agreement controls. ...

ERISA Information (Employee Retirement Income Security Act of 1974, as Amended)

* * *

The Plan Administrator for life insurance and prescription drug benefits is the ArcelorMittal USA LLC Manager, Employee Benefits. ...

* * *

Coverage for New Drugs

* * *

All determinations as to whether or not a new or existing drug, medical test, device, or procedure is covered or not covered under the Plan are made by the Plan Administrator, at his or her sole discretion.

* * *

According to the evidence offered at the arbitration hearing the Company advised the Union in late 2011 that due to high cost/utilization concerns with the Prescription Drug Benefit plan consideration was being given to changing the prescription drug benefit manager's treatment of thirty-four brand name drugs then covered under the plan without restriction to either exclude them from coverage, cover them at the non-preferred (non-formulary brand) level of the 3-tier formulary plan subject to prior authorization for medical necessity, or cover them at the non-preferred (non-formulary brand) tier. The Union objected to any unilateral exclusion of these thirty-four drugs from coverage or to covering them at the non-preferred tier subject to prior authorization. The Union insisted that, in the absence of negotiation and mutual agreement on plan changes, the status quo should be maintained with these drugs continuing to be covered at the non-preferred (non-formulary brand) tier without prior authorization. Beginning in 2012, though, CVS Caremark (the prescription drug benefit manager) implemented a change and began to treat these thirty-four drugs as non-formulary brand drugs subject to prior authorization for medical necessity for coverage under the Prescription Drug Benefit plan. Other prescription

medications were added to this list of non-formulary brand drugs subject to prior authorization in 2013 and again in 2014 (raising the total number of higher-cost drugs so affected to approximately seventy). Lower-cost generic and/or brand alternatives continued to be available. Savings were recognized.

The Union contends that classifying so many commonly prescribed brand medications (e.g., Lipitor, Plavix, Actos) as non-formulary brand drugs subject to prior authorization is contrary to the intent of the negotiating parties and the past practice of administering the Prescription Drug Benefit plan. The Union asserts that, before 2012, the prior authorization requirement was applied to a limited number of drug classes (i.e., Anabolic Meds, Androgen Meds, Retinoids [over age 30], Anti-Obesity Diet Meds, and Growth Hormone) rather than to individual drugs within a class, and that the prior authorization requirement generally impacted only relatively inexpensive and minimally used drugs with unique medical characteristics and risk factors. The Union insists that, with the changes in 2012 and 2013 and 2014, participants' access to many commonly prescribed non-formulary drugs is now delayed and/or restricted by the prior authorization process unless the participants choose to pay full price for these drugs. The Union characterizes the prior authorization process as burdensome and cumbersome since it requires participants' physicians to interact with the prescription drug benefit manager to secure approval for coverage under the Prescription Drug Benefit plan for prescribed drugs which are not generic or formulary brand drugs even when the available alternative medications may be different chemically or in dosage or delivery method from the originally prescribed drugs. The Union observes that 601 participants were affected in 2012 by this application of the prior authorization requirement to their non-formulary brand prescription drugs, and that only 41.5% of the 106 requests made for prior authorization during the period between April 2012 and May 2013 were approved.

The Union contends this grievance is arbitrable and should be sustained.

The Union stresses that Article Five Section I of the Basic Labor Agreement contains a broad arbitration provision and no language excluding a grievance of this type from arbitration. In fact, the arbitration provision expressly provides that the arbitrator "shall have the authority to hear and decide any grievance appealed in accordance with the provisions of the grievance procedure as well as disputes concerning the Insurance Agreement." The Union insists the presumption of arbitrability is therefore applicable here, and that the Company failed to offer forceful evidence to overcome this presumption. The Union disputes that the existence of Claim Procedures in the Program of Insurance Benefits Summary Plan Description or the allegation that this grievance seeks to represent retirees rather than active employees or the fact this grievance does not identify any individual grievant undermines its position on the arbitrability issue. The Union urges that the Claim Procedures in the Plan provide no recourse to address violations of the Insurance Agreement as such, as opposed to individual participants' claims for benefits, and that the focus of this grievance is the Company's failure to have fulfilled its negotiated obligation to the Union to provide the level of benefits conforming to the mutually negotiated and agreed

Program of Insurance Benefits Summary Plan Description when the Company authorized the prescription drug benefit manager to change the manner in which it administered the Prescription Drug Benefit plan for these drugs.

On the merits, the Union insists it was clearly the intent of the negotiating parties that the Company was to provide -- except in limited circumstances -- coverage for prescribed medications at the generic or formulary brand or non-formulary brand levels under the 3-tier formulary scheme set forth in the Prescription Drug Benefit plan. The Union asserts it agreed to the Prescription Drug Benefit plan being so structured with a financial incentive for participants to select less expensive generic and formulary brand drug options in return for the Company agreeing not to exclude any prescription medications and to cover non-formulary brand drugs at the higher copayment associated with drugs in that tier. The Union urges that the Company's decision to have the prescription drug benefit manager change the manner of administering the Prescription Drug Benefit plan, and to subject the individual drugs involved here to the prior authorization requirement, violated this bargain and exceeded the Company's authority under the Insurance Agreement to alter plan benefits without negotiation and Union agreement. The Union recalls that the Insurance Agreement specifically provides: "Any contracts entered into by the Company with respect to the benefits of the Program shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklets." The Union adamantly rejects the notion that the Company possesses the right to unilaterally change benefits or their delivery method during the term of the parties' agreement.

The Union asserts that the negotiating parties agreed on an open formulary scheme, not a closed formulary scheme, and that participants were intended to have free access to prescribed medications in exchange for the graduated copayment structure for generic, formulary brand, and non-formulary brand drugs as provided in the Program of Insurance Benefits Summary Plan Description. Non-generic drugs not included on the list of preferred drug products developed by the committee of physicians and pharmacists are not to be restricted, in the Union's view, and are to be available as non-formulary brand drugs at the applicable copayment. The Union considers the Company's unilateral denial of coverage for many widely prescribed and effective non-preferred brand medications, in the absence of prior authorization, to constitute a violation of the parties' agreement. It notes that the Summary Plan Description contains no mandatory generic provision, and it urges that when the Company does not cover any brand alternative to certain therapeutic drug classes where the available generic alternative differs in terms of dosage or delivery mechanism or chemistry from the originally prescribed brand drug medication the intended and negotiated benefit of the 3-tier formulary structure is violated and participants are improperly deprived their choices of medications.

The Union urges that, in proper context, the Prior Authorization provision should be interpreted in this case as applying to classes of drugs rather than to individual drugs and to those drugs which are not widely prescribed where such review and authorization is needed to protect against risk factors or abuse. The Union insists this interpretation is consistent with the past

practice of the parties and with the language of the provision specifying that the prescription drugs subject to prior authorization "are those that cause potentially serious side effects, are costly, or have a high potential for inappropriate use." It states that, previously, no drugs have been subjected to prior authorization on the basis of their cost. And it denies that the Prior Authorization provision was intended to confer upon the Company the unilateral right to alter the parties' practices as to which drugs are subject to prior authorization and undermine the intent of the negotiated formulary structure to allow participants to make choices among available medications and copayments. Moreover, it denies that the Prescription Drug Coverage Limitations, and Exclusions provision reference to the fact certain drugs may require prior authorization confers upon the Company the unilateral right to implement such a limitation on all the drugs involved in this case.

The Union cites two arbitration awards from other relationships (i.e., an ALCOA/USW arbitration award issued in February 2006 and a USS/USW arbitration award issued in March 2007) in further support of its position that prescription drug insurance is a bargained benefit which cannot be unilaterally altered.

The Company maintains this grievance is not arbitrable and, alternatively, that it should be denied.

The Company asserts the Union has no right under the Basic Labor Agreement to grieve on behalf of retirees. The Company insists the Adjustment of Grievances provisions in Article Five Section I and the Recognition and Coverage provisions in Article Two Section A make it clear that grievances may be filed by employees and that retirees are not employees in the recognized bargaining unit. The Company also asserts that the issue of whether Management may unilaterally authorize or accept the prescription drug benefit manager's changes in administering the Prescription Drug Benefit plan is not a matter ripe for resolution on behalf of active employees who will eventually retire, or on behalf of retirees, since it was not shown that any individual has been or assuredly will be affected to their detriment by such changes. And it notes that the Step Two Grievance Form does not identify any individual grievant. Finally, in further support of its contention that this grievance is not arbitrable, the Company asserts that whether or not a drug is covered under the Plan is a matter within the sole discretion of the Plan Administrator as reflected in Section 7 of the Program of Insurance Benefits Summary Plan Description (i.e., "All determinations as to whether or not a new or existing drug ... is covered or not covered under the Plan are made by the Plan Administrator, at his or her sole discretion").

In the event this grievance is determined to be arbitrable, the Company maintains this grievance must be denied because Management was not obligated to negotiate with the Union over the prescription drug benefit manager's creation of a list of high-cost prescription medications requiring prior authorization for medical necessity in order to be covered under the non-formulary brand tier of the Prescription Drug Benefit plan. The Company urges that the prescription drug benefit manager's action in this regard is unambiguously authorized in the

Program of Insurance Benefits Summary Plan Description. The Company notes that Section 4 of the Summary Plan Description expressly provides that the prescription drug manager is responsible for "managing drug utilization", that certain drugs "may require prior authorization", and that the prescription drugs subject to review and prior authorization include those that "are costly" in addition to those that "cause potentially serious side effects" and those that "have a high potential for inappropriate use." The Company further notes the absence of any specific language in the Summary Plan Description requiring Management or the prescription drug benefit manager to negotiate with the Union over which drugs may be classified as non-preferred and subject to prior authorization. The Company disputes that past practice or the two arbitration cases cited by the Union compel the conclusion that the changes in the administration of the formulary which subjected these drugs to prior authorization violated the Insurance Agreement Program of Insurance Benefits Summary Plan Description because they were not jointly negotiated.

FINDINGS

At issue, initially, is whether this grievance is arbitrable under the Basic Labor Agreement between ArcelorMittal and the United Steelworkers.

Article Five of the Basic Labor Agreement provides in part as follows:

ARTICLE FIVE – WORKPLACE PROCEDURES

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Section I. Adjustment of Grievances

1. Purpose

> Should any differences arise between the Company and the Union as to the interpretation or application of, or compliance with, the provisions of this or any other Agreement between the Company and the Union, prompt and earnest efforts shall be made to settle them under the following provisions.

2. Definitions

   a. Grievance shall mean a complaint by the Union which involves the interpretation or application of, or compliance

with, the provisions of this or any other Agreement between the Company and the Union.

* * *

4. General Provisions

* * *

m. Notwithstanding anything to the contrary, the grievance procedure may be utilized by the Union with or without an individual grievant. Such grievances shall be filed in Step 2.

* * *

6. Board of Arbitration

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b. The member of the Board (arbitrator) chosen in accordance with Paragraph 7(a) below shall have the authority to hear and decide any grievance appealed in accordance with the provisions of the grievance procedure as well as disputes concerning the Insurance Agreement. The arbitrator shall not have jurisdiction or authority to add to, detract from or alter in any way the provisions of this Agreement or the Insurance Agreement.

* * *

The Insurance Agreement, signed by Company and Union representatives, expressly provides that the Program of insurance benefits established by the Agreement and described in the Summary Plan Descriptions adopted by the parties incorporates those Summary Plan Descriptions. To the extent the Company and the Union have negotiated prescription drug benefits in these documents, the prescription drug benefit provisions constitute agreements between the parties. The present grievance, viewed as a claim by the Union that the Company violated the Insurance Agreement Program of Insurance Benefits Summary Plan Description, beginning in 2012, by having the Prescription Drug Benefit plan administered so as to classify the affected medications as non-formulary brand drugs subject to prior approval for medical necessity, is found to involve the interpretation or application of, or compliance with, an

agreement between the parties. Even without an individual grievant being identified on the Step Two Grievance Form it is determined that the Union was eligible and entitled under Article Five Section I of the Basic Labor Agreement to file this grievance in order to resolve its differences with the Company over whether these changes in the administration of the Prescription Drug Benefit plan could be made without negotiation and agreement by the parties. And this determination is not considered to be inconsistent with the fact the Plan Administrator has discretion to decide whether or not a new or existing drug prescribed by an individual participant's doctor is covered or not covered under the plan, since this grievance is viewed as focusing not on an individual participant's claim for a drug to be covered but rather on the Union's claim that the Company has improperly interpreted or applied and has failed to comply with the Insurance Agreement Program of Insurance Benefits Summary Plan Description. In this context it is concluded the grievance is arbitrable and that the arbitrator has the authority to hear and decide this dispute concerning the Insurance Agreement.

In assessing this grievance on its merits the following Program of Insurance Benefits Summary Plan Description provisions are deemed to be particularly relevant:

SECTION 4.
PRESCRIPTION DRUG BENEFITS

Introduction

* * *

Prescription drug benefit coverage will be administered by a prescription drug benefit manager who will be responsible for … managing drug utilization, and making payments for covered prescriptions.

The prescription drug plan is a 3-tier formulary plan. A formulary is a list of preferred drug products developed by a committee of physicians and pharmacists. Your coinsurance will be based on whether the drug your doctor prescribes is a generic, formulary brand, or non-formulary brand prescription drug. ...

* * *

Prescription Drug Coverage Limitations, and Exclusions

The following drugs are subject to limitations:

* * *

(e) Certain drugs may require prior authorization;

* * *

Prior Authorization

Some prescription drugs require review by the prescription drug benefit manager before certain quantities or an extended duration of therapy will be covered under the Prescription Drug Benefit plan. Prescription drugs that are subject to review and prior authorization are those that cause potentially serious side effects, are costly, or have a high potential for inappropriate use.

* * *

SECTION 7.
OTHER INFORMATION

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The Plan Administrator for ... prescription drug benefits is the ArcelorMittal USA LLC Manager, Employee Benefits. ...

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Coverage for New Drugs

* * *

All determinations as to whether or not a new or existing drug … is covered or not covered under the Plan are made by the Plan Administrator, at his or her sole discretion.

* * *

This grievance was filed to protest that, beginning in 2012, a number of prescription medications previously available without prior authorization under the Prescription Drug Benefit plan in the Insurance Agreement Program of Insurance Benefits Summary Plan Description were classified as non-formulary brand drugs subject to prior authorization and thus were no longer available to participants under the 3-tier formulary prescription drug plan without restriction as before. In 2012, in the absence of satisfying the prior authorization for medical necessity requirement, participants were no longer able to secure coverage for thirty-four drugs under the

Prescription Drug Benefit plan and would have to either pay full price for them or use a covered alternative medication. Some other drugs were added to this list of non-preferred drugs subject to prior authorization in 2013 and 2014 and were similarly treated. The Union strongly objects to the exclusion of these drugs from coverage under the Prescription Drug Benefit plan, without restriction, and it insists these changes violated the Insurance Agreement Program of Insurance Benefits Summary Plan Description and could not properly be made unilaterally and without negotiation and its agreement.

The Section 4 Prescription Drug Benefits provision in the Insurance Agreement Program of Insurance Benefits Summary Plan Description clearly provides for a 3-tier formulary prescription drug plan with participants' coinsurance being based on whether the drug their doctors prescribe is a generic, formulary brand, or non-formulary brand drug. The Prescription Drug Benefit plan is not found to contemplate the limitation or exclusion of any brand prescription medication other than under the Prescription Drug Coverage Limitations, and Exclusions provision in Section 4 of the Program of Insurance Benefits Summary Plan Description. If it was determined here that the thirty-four medications which were classified as non-formulary brand drugs subject to prior authorization beginning in 2012, and/or that the medications added to the list of non-formulary brand drugs subject to prior authorization in 2013 and 2014, had been so classified in order to actually exclude them and render them unavailable under the Prescription Drug Benefit plan in all circumstances then such changes would be found to have been inconsistent with and in violation of the Insurance Agreement Program of Insurance Benefits Summary Plan Description. Likewise, if it was determined the Company or the prescription drug benefit manager had improperly applied and utilized the prior authorization process in this case a violation of the Insurance Agreement Program of Insurance Benefits Summary Plan Description would be found to have occurred. The Section 4 Prescription Drug Benefits provision is a bargained benefit which cannot be unilaterally changed.

The Prescription Drug Coverage Limitations, and Exclusions provision in Section 4 of the Summary Plan Description sets forth the parties' agreements on those matters. While the Plan Administrator has discretion pursuant to Section 7 of the Summary Plan Description to determine whether a new or existing drug is covered under the Plan, that discretion was not shown and is not interpreted as envisioning that it could properly be exercised in a manner inconsistent with the terms of the Plan -- including the Prescription Drug Coverage Limitations, and Exclusions provision in Section 4 -- or that it constituted a license to make material changes to the negotiating parties' express agreements on drug benefits. At bottom, therefore, the question is whether the protested changes (i.e., thirty-four medications being classified as non-formulary brand drugs subject to prior authorization in 2012, and other medications being added to the list of non-formulary brand drugs subject to prior authorization in 2013 and 2014) were inconsistent with and in violation of the Insurance Agreement Program of Insurance Benefits Summary Plan Description.

Although these changes in the administration of the Prescription Drug Benefit plan were not negotiated between the parties and to one degree or another were unwelcome and may be characterized as having negatively impacted participants who used the prescription drugs newly subjected to the prior authorization requirement, it was not proven that these changes violated the Insurance Agreement Program of Insurance Benefits Summary Plan Description. It was not established that the list of formulary brand or preferred drugs at this time had not been developed by the committee of independent physicians and pharmacists (i.e., the so-called P&T Committee, which according to the evidence also reviews and approves all utilization management tools such as prior authorization). Nor was it established that these changes actually excluded any of the medications involved from the 3-tier formulary plan or imposed a mandatory generic scheme in place of an open formulary or subjected these non-preferred prescription drugs to other limitations or exclusions beyond the contemplation of the Prescription Drug Coverage Limitations, and Exclusions provision in the Plan. Prior authorization is among the limitations identified in that provision, and the Plan specifies prescription drugs "subject to review and prior authorization are those that cause potentially serious side effects, are costly, or have high potential for inappropriate use." The fact these drugs were not previously subject to prior authorization for medical necessity is not considered to bar them from the prior authorization requirement if the drugs cause potentially serious side effects, are costly, or have high potential for inappropriate use. The medications newly subjected to prior authorization in this case were characterized as costly and were not shown to have been improperly approved for the prior authorization requirement. These changes are viewed as having been consistent with the responsibility of the prescription drug benefit manager for managing drug utilization and not as having constituted unilateral alterations of the parties' negotiated agreements which would clearly be impermissible.[1]

On the total record, the classification of these prescription medications as non-formulary brand drugs subject to prior authorization is not found to have violated the Insurance Agreement Program of Insurance Benefits Summary Plan Description. Accordingly, the grievance must be denied.

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[1] The 2006 ALCOA/USW arbitration award and the 2007 USS/USW arbitration award cited by the Union are found to be distinguishable from and not controlling in the present grievance. In contrast to the ALCOA/USW case, the credited record evidence did not establish that there had been a diminishment of the benefits negotiated in violation of the Summary Plan Description. And, in contrast to the USS/USW case, the Program of Insurance Benefits in this grievance did not include a provision reading "your doctor will always make the final decision on your medication" and the credited evidence did not establish that the Company or its selected pharmacy benefit manager had made a unilateral change resulting in participants no longer being provided benefits and conditions conforming to those agreed by the parties and set forth in the Program of Insurance Benefits .

AWARD

The grievance is denied.

David A. Petersen, Arbitrator