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Standing Committee on Government Operations and Estimates
Sixth Floor, 131 Queen Street
House of Commons
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Canada

Briefing Note to Government Operations and Estimates Committee, Standing Committee established to study the transition of the Public Service Health Care Plan from Sun Life Financial to the Canada Life Assurance Company.

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In 2013, after 30 years of federal government employment, I retired as Director, Health Data Analysis, Statistics Canada. As a retired federal employee, I pay 50% of the cost of PSHCP with the remaining 50% being a taxable benefit. Like nearly 70% of all Canadians, I hold an additional health benefit plan paid in-full or in-part by the subscriber and/or the employer.

On 1 July 2023 some 1.7 million current and former federal public servants and their dependents, of whom 48% are veterans, retired members of the Armed Forces, RCMP, and federal public service experienced their health benefits transition from being administered by Sun Life (SL) to Canada Life (CL). At the time we were told that the contract would deliver more health benefits to Members and their Dependents and that the transition would be seamless.[1]

From all accounts Canada Life (CL) was not up to the task. The CBC has run heart-breaking stories of benefits denied due to a faulty registration process, poorly designed IT system, inadequate online and telephone response capacity, and delays in repayments to PSHCP Members for costs incurred due to CL's failure to settle claims and approve Prior Authorisations in a timely manner. Members have received little to no communication from CL. When it does occur, it was and remains frequently incorrect, misleading, and designed to download work to pharmacists, medical practitioners, and PSHCP Members. Increasingly, Members, including myself, are appealing to their Member of Parliament for assistance and to the CL Ombudsman for adjudication of denials of claims to which Members are entitled.

The OGGO Parliamentary Standing Committee has been asked to examine what went wrong and why, and how to fix this situation. In my Brief, I am asking OGGO Standing Committee to address the following three questions:

1. Why was CL seemingly unprepared for the 1 July 2023 PSHCP transition?

2. Why did TBS negotiate a PSCHP contract that:

i) Was not intended to come into effect until January 1, 2024, some 6 months after the termination of the SL contract?

ii) Failed to accommodate the needs of senior Members thereby denying them access to and benefit of their PSHCP entitlements.

iii) Disclosed to CL,10 years of Member and Dependents' personal medical data without Member notification thereby denying us the option of erasure of data for Dependents, most of whom were children when they received benefit coverage and now are no longer covered by PSHCP.

[1] https://www.canada.ca/en/treasury-board-secretariat/services/benefit-plans/health-care-plan/information-notices/improvements-changes-public-service-health-care-plan.html

iv) Restructured the scope of Prior Authorisations for PSHCP benefits.

3. How should TBS and CL move forward to address existing contract delivery problems?

I am asking the Standing Committee to consider making the following recommendations:

1) Ask the Auditor General to audit the contract. It does not deliver value for money.

2) Ask the Human Rights Commission to consider as a form of discrimination, TBS failure to include in the PSHCP contract accommodation for Members unable to register online and conduct transactions online.

3) Ask the Office of the Federal Privacy Commission to investigate why 10-years of historical PSHCP health and dental data on 1.7 million Canadians was transferred to CL without Members' knowledge. Does this data transfer meet the test of data limitation required by PIPEDA? Does it exceed the boundaries of legitimate interest? What measures need to be in place to protect the privacy rights of children, dependents and former employees no longer in receipt of PSHCP benefits?

4) Ask the federal government in association with provincial ministries of health to work together to adopt consumer protection legislation to regulate Prior Authorisation timeliness and ensure transparency about denials of benefits to which the health insurance holder is entitled.

5) Ask for greater scrutiny and monitoring of MSH and to consider options for improved communications and greater transparency with Members and Dependents.

Please note that in preparing this brief, I will be referring to the redacted RFP dated 2021/11/30 that I obtained through TBS ATIP request, scholarly articles, and legislation. I am also a member of the Face Book (Unofficial) PSHCP Group. I have notified the FB group administrator of my intention to submit a Brief. Any reference, I make regarding this social media forum will not associate individuals to comments, which I have redacted and rendered anonymous.

1. Why was CL seemingly unprepared for the 1 July 2023 PSHCP start-up?

Answer. CL was never asked to be ready to deliver the PSHCP to 100% of Members on 1 July 2023, the "Operations Ready Date (ORD)."[2] The contract clearly states*: "The Contractor must undertake a program to ensure that at least 85% of PSHCP Members complete the process to confirm their PE (Positive Enrollment) information and provide Consent prior to ORD"*.[3] TBS 'Service Level Performance monitoring' does not come into effect until 1 January 2024[4] some 6 months after the transition from SL to CL on July 1, 2023.

TBS by negotiating the Incentive Fee Calculation for Positive Enrollment of 85% of Members[5] never expected nor did it demand 100% Member enrolment by ORD. TBS never required that 100% of Pharmacy and Electronic Medical Supply Providers[6] be enrolled by ORD. The Member Contact Centre was to be in place 6 months prior to ORD, but the Emergency Travel Assistance

[2] s.1.6.1.2 at p7.
[3] S. 3.4 Positive Enrolment and Membership Management Services Set-up at p102.
[4] s.8.1.5.at p50
[5] s.5.2.1 at v, p48
[6] s.5.2.2 at iv, p49

and Comprehensive Coverage Contact Centre was to be established no later than ORD. Member facing communication services were not required to be Contractor or User Acceptance Tested by ORD.[7]

In effect, the contract did not require CL to fully deliver the PSHCP to 100% of the 1.7 million Members and Dependents on 1 July 2023. It appears that there was no expectation of full delivery of the service until 1 January 2024 when TBS monitoring would commence.

Consequences: legal, contractual, and ethical
The consequence of a six-month interval between the transfer of the SL administration of PSHCP to CL on 1 July 2023 and the contract requirement to be fully operational and prepared for monitoring on 1 January 2024 has caused at worse a full denial of benefits for some members and at best partial denial of benefits for others. Many members have experienced long delays in the delivery of benefits and settlement of unpaid claims. Co-ordination of benefits between Members has been cumbersome and error prone. Some Members incurred financial hardship because of CL's failure to pay drug and treatment claims in a timely manner.[8] Others experienced health condition deterioration.[9]

During the 6-month start-up period, the federal government and retirees paid for a health benefit plan that could not and would not be knowingly delivered in full until 1 January 2024. It is my view, that the inclusion of the 6-month transition clause in the CL PSHCP contract breaches terms and conditions of negotiated union/management agreements to provide health benefits to employees and the agreement that retirees signed when they elected to continue their health benefit plan on a 50:50 payment basis.

As we come closer to the actual contract implementation date of 1 January 2024, telephone and claim response times have improved. As a Member, I am being told to feel grateful for the efforts being made to get the contract back on track. This 'sympathy' narrative fails to address the key issue: TBS and CL never expected the contract to be 100% functional on 1 July 2023.

Recommendation
The CL contract should be referred to the Auditor General of Canada. I fail to see that inclusion of 6-month phase-in period produces value for money for the government or works to the benefit of Members especially when the contract was signed 20 months prior to ORD. Putting the health of 1.7 million Canadians at risk demonstrates a TBS failure of duty of care for current employees and retirees. It shows a contractual disregard for previous commitments made to unionised members and retirees.

2. Why did TBS negotiate a contract that failed to accommodate the needs of Members lacking internet connectivity?

Answer: The TBS contract at s.2.15 states: *"The Contractor [CL] must make electronic communications the default for all Members and Providers' products and services. Paper communication processes must also be available at Member's request."*[10]

[7] Appendix 7 to Annex A. Member Contact Centre # 72-73; Emergency Travel # 74-76 at p443-444.
[8] https://www.cbc.ca/news/canada/ottawa/canada-life-insurance-federal-employees-1.6981164
[9] https://www.cbc.ca/news/canada/ottawa/faces-canada-life-1.7000251
[10] RFP at p92 Annex A SOW General Requirements.

The Contract further requires: *"The Contractor [CL] must conduct the biennial confirmation and obtain Consent of Positive Enrollment using the process established during the Start-up Phase (SOW Article 3.4.7).*[11]

A careful reading of the 480-page contract shows that while online and paper processes were to be in place for Members, there exist no accommodation clauses that expressly establish the obligations of CL to address the needs of those lacking internet connectivity or the ability to access online services. Notification of registration and completion of registration was to be undertaken online. The online registration process was complex, error prone, and impossible for persons without a computer and access to the Internet to undertake. On 1 July 2023, Members could contact CL directly. But phoneline capacity was insufficient and CL operators were unable to deal with call volumes and Members' questions.

The mandated biennial confirmation of consent and PE information risks a repeat of the 1 July 2023 situation unless attention is paid to the needs of those lacking access to the Internet.

Consequences: legal, contractual, and ethical

TBS negotiated a contract knowing that over 590,000 Members were seniors. It now appears that some 100,000 Members were disenfranchised and denied benefits because they did not have access to the internet or to a computer. These 100,000 Members most of whom are quite elderly have been blamed for their lack of IT access, skills, and knowledge.[12]

TBS put Members into a Catch-22 situation. If they had no online access, they could not be contacted. Once they were made aware, they could not enrol because they did not have internet. In fact, most of these Members discovered their lack of coverage when they tried after 1 July 2023 to obtain PSHCP benefits, such as prescription renewals. Since 1 July 2023 elderly Members and Dependents have struggled to get registered, to file claims, and to have their claims paid in a timely manner.

The failure of the TBS contract to recognise special needs is an example of how easily we allow social media and modern technology to disenfranchise, stigmatise, and exclude groups. We expect everyone to have internet connectivity. I live some 65 KM from Ottawa. I have little to no cell phone access. Like many Canadians, I am underserved by IT networks.

Dr Sophia Moreau, Canadian moral philosopher and lawyer, argues that discrimination ought to be seen as negligence, the failure to do something that a person could reasonably expect.[13] As a retired Member, I expected TBS to have negotiated a duty of accommodation for Members disenfranchised by technology. It was not too burdensome for TBS to have considered how seniors caught in the digital divide that continues to exist in Canada would experience the 'seamless transition' that TBS and CL claimed would occur. Decision makers cannot close their eyes to the needs of this group of Canadians.

Nor can CL plead ignorance to the hardship caused by their failure to establish from the outset suitable pathways for non-IT savvy seniors. CL was given 10 years of SL data.[14] CL knew full well the volume of paper transactions. Yet in the months leading up to 1 July 2023, CL relied on online communications with Members. It failed during the initial registration phase to establish a dedicated communications program for persons without internet and computer access.

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[11] RFP at p159.

[12] https://www.federalretirees.ca/en/news-views/news-listing/november/november-update-on-the-pshcp-from-the-pensioners-representative

[13] Sophia Moreau, 'Discrimination as negligence' **Canadian Journal of Philosophy** 2010 (40) 123 at 124.

[14] Annex A SOW s.3.16.5 Historical and Current Data at ii a), b) and c) at p 138.

By late July 2023, CL was scrambling to put in place remedial measures. It sent letters to the wrong addresses. Without enough dedicated and fully staffed phonelines, CL required seniors and family members helping their elderly parents enrol to try for days to reach CL by phone only to wait on the phonelines for 2-3 hours and then be cut off. The impacts have been considerable for family members, seniors, and health care professionals. A local pharmacist told me: "It is unethical how seniors have been treated in this transition to CL."

Recommendation
We must face the reality of disadvantage due to lack of internet connectivity and IT ability. The narrative that 'blames the victim' for being old and unable to negotiate complex IT systems stigmatizes, discriminates, and disenfranchises Canadians.

I am asking the Standing Committee to recommend that the Human Rights Commission consider as a form of discrimination the failure of the TBS to build into a $514 Million contract consideration for seniors who were unable to receive information and register online and CL's omission to accommodate from the outset the needs of those without IT skills, internet connectivity, and the up-to-date IT and software needed to access the CL site and submit claims.

I am asking the Standing Committee to make recommendations to CL and TBS regarding the need to accommodate those without internet access so that the biennial confirmation of consent and PE information can be undertaken with due regard to all Members. CL should be asked to demonstrate how it will accommodate those without internet access prior to obtaining Project Authority Approval for this undertaking scheduled for 1 July 2025.[15]

3. Why was 10 years of personal medical data transferred from SL to CL without Members' knowledge? Why was it necessary to transfer the historical data of persons no longer PSHCP Members and Dependents?

Answer: The RFP does not provide a clear rationale and evidence of the need by CL for 10 years of historical data for all Members and Dependents. For example, the contract cites only one benefit for which coverage will be provided on a 10-year basis.[16] The majority of benefit coverage periods are for 5-years or less.[17] A careful reading of the RPF suggests that investigations for fraud or misuse do not require a 10-year data timeline though on this matter I defer to criminal law best practices. As for using historical data to grant Prior Authorisations, the experience of the last 5+ months bears out CL's failure to use the data it received from SL.

Consequences: legal, contractual, and ethical
The RFP clearly sets out the steps to be taken at the end of the contract regarding the removal from the CL data systems all acquired data[18]. The Contract demonstrates requirements for careful adherence to data security procedures. These are warranted and precisely drafted elements of the contract. In my view, the contract needs to show a similarly careful regard for the justification of the transfer of 10 years of historical data especially for Dependents many of whom were children when they received benefits and are no longer covered by the PSHCP.

Personal information and especially medical data are our economy's 'new oil.' It could be argued that 10 years of prescription and treatment data on 1.7 million+ Canadians is as

[15] Annex A SOW s.3.4.7. i) and ii) requirements at p104.
[16] TENS repairs incurred in the previous 10 years. RFP at p245.
[17] Appendix 1 to Annex A, p239-254.
[18] Annex A SOW 4.0 Operations Phase Security p224-225.

valuable to CL as a contract award of $514 Million. For CL, this run of historical data plus the ongoing information they collect over the lifetime of the contract will power AI, support algorithms, shape marketing, and influence medical decision-making. Members and Dependents have the right to know that data use is limited to that which is legally necessary. We need to be better informed about the historical and current retention, use, and sharing of our data.

Members are expressing concerns about over-collection of medical data by CL for Prior Authorisations.[19] Members have questioned CL's need for and safekeeping of notarised Powers of Attorney when a CL designed consent form would suffice in most instances.[20] Some Members have observed what they consider to be lapses in data protection.[21] We need greater assurance that stated data protection measures are being undertaken.

Recommendation
I am asking that the Standing Committee recommend that the Office of the Federal Privacy Commissioner review the transfer of 10 years of SL data and the retention of this information by CL until the end of the contract. The Committee should ask the Commissioner if this transfer meets the test of data limitation set out in law. CL should be required to demonstrate the need to retain this data on identifiable persons no longer covered by the PSHCP due to their age (e.g. no longer child dependents who never consented in the first place to the processing of their data), death, and change of employment and circumstances.

The Federal Privacy Commissioner should be asked review and comment on the CL Privacy Policy buried at the bottom of the website, and to advise CL and TBS on how to report to Members about data misuse and breach incidents.

The Federal Privacy Commissioner should be asked to review and comment on the biennial re-consenting and positive enrollment process scheduled for 1 July 2025 and in every 2nd year thereafter. Members will need to be fully informed and given assurances about how their data will be used.

4. **Why does the TBS contract never mention Prior Authorisations (PA) or set specific time limits for their determination?**

Answer. 'Prior Authorization' (PA) is a management process used by insurance companies to determine if a prescribed product or service will be covered. The PA approval decision is based on a written justification of a prescribing decision and obtained from the patient's physician/healthcare provider(s). PSHCP Member/Dependent's drug, treatment, or device will not be funded until the PA is approved by CL. The Member can self-fund the prescribed medical care at which point they assume the risk of CL PA denial. The wait for PA approval can be extensive. PAs can be denied and be subsequently challenged. During this period, the health of the patient can be put at risk.

A word search of the RFP reveals no match for the words "Prior Authorisation'. Yet the information distributed to employees and retirees and the forms listed on the CL website refer to PA.[22] The RFP uses the phrase "in the opinion of the Contractor [CL]" as a proxy for PA.

[19] Observations made by Members in social media.
[20] Comments made by Members in social media.
[21] Advice provided by social media administrators to members observing possible data breaches has been to report such incidents to CL and Office of the Federal Privacy Commissioner. Some members may be reporting incidents to their MP and to Provincial Privacy Commissioners.
[22] **Sage** Winter 2022. https://www.federalretirees.ca/en/publications/sage-magazine at p.30;

In the contract, the 'opinion of the contractors' aka Prior Authorisation (PA) is required for all treatments, drugs, and medical aids except for: generic drug benefit, vision care benefit, medical practitioners benefit involving the following services — physiotherapist; massage therapist; speech language pathologist; psychologist; social worker (isolated posts only); chiropractor; osteopath; naturopath; electrologist; and Miscellaneous Expense Benefits excluding where a PA is required for braces, rental or purchase of cost effective durable equipment, and a set of listed devices for specific treatments; and Hospital Provision (dependent on Level).[23]

CL response times are specified in the RFP as 5 days for an electronic claim and 10 days for a paper-based claim.[24] The contract does not specify the time permitted for CL to 'provide their opinion' on for example non-generic drugs, compound drugs, biologics, insulin pumps, lifts and hoists, or for any of the other specified benefits requiring approval 'in the opinion of the Contractor' [CL].

Consequences: legal, contractual, and ethical

Prior Authorisation (PA) is a double-edged sword. Insurers and plan funders justify the application of PA as a tool to safeguard the healthcare system, achieve insurance cost reductions, and effect physician oversight. US research provides evidence that PAs curbed physician over-prescribing of anti-psychotics and opioids during the 2010s.[25]

Yet there is another side to this story. For PAs to improve the efficiency for the health system overall, any cost savings for insurers would need to be larger than the cost incurred by physicians completing PA requests and the cost of any decreased health or well-being that patients may experience. Research shows that PA use in the US has resulted in a substantial administrative burden, unnecessary delays in patient care, and care-delivery inequities with rejections being more common for women, racial minorities, those with low education, and for low-income groups.[26]

Organisations such as the American Medical Association (AMA) have repeatedly expressed the view that the healthcare costs of PAs outweigh financial gains for insurers and plan funders, and that the added administrative work drives increased overhead and physician burnout.[27] The 2022 AMA survey found that 82% of physicians considered PAs to contribute to higher health costs including more office visits, use of ineffective therapies that needed to be undertaken to substantiate the need for the prescribed treatment or drug, and more emergency care incidents. As well, 35% of physicians reported hiring staff to work exclusively on PAs.[28]

PSHCP Members' comments made on social media about CL PAs reflect encounters with physicians about the imposed paperwork, inability to obtain specialist's appointments for PA form-filling, delays in treatment, and worsening of health due to an inability to self-fund the

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[23] Appendix 1 to Annex A Overview of the PSHCP Directive p239-254. Additional conditions for Comprehensive Coverage provisions which do not apply to Retirees. Dental benefits are not discussed as to date SL delivers this service to Retirees. I have no experience with CL administration of this element of the contract except that social media reports indicate that it is inept, clumsy, and that dentists have seen a large workload increase.

[24] RFP Annex A SOW 4.3 Claims processing and Claims Payment Service at p.151-156.

[25] Timothy E. Wilens, et al., 'Prior Authorizations: A Necessary Evil?' **Journal of the American Academy of Child & Adolescent Psychiatry** 2020: 59(9) at 1005.

[26] Brian S. Marcus et al., 'Burden with No Benefit: Prior Authorization in Congenital Cardiology.' ***Pediatric Cardiology****, September 2023. https://doi.org/10.1007/s00246-023-03255-1*

[27] https://www.chiefhealthcareexecutive.com/view/ama-survey-finds-prior-authorization-hurts-patients-and-productivity# Accessed 3.12.2023.

[28] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf Accessed 3.12.2023.

treatment while waiting for PA approval. Members have also experienced PA denials that were subsequently approved when appeals were made to the CL Ombudsman's Office. In the US, a 2021 KFF report found that 82% of denials resulted in fully or partially overturning the initial PA decision.[29] This finding requires that we ask difficult questions about the administration of PA decision-making.

The US legislative response to PAs is instructive. Coming on the heels of over 30 US states[30] proposing to or already legislating insurers' PA applications, the Biden administration in December 2022 submitted for public review regulatory changes requiring health plans to speed up PA decisions (48 hours for expedited and 5 days for standard PAs) and to provide reasons for denials.[31] The AMA brief to this proposal recommends the adoption of a 24-hour turnaround for urgent requests and 48 hours for standard decisions.[32] My examination of the record of response to the US government proposal reveals that that AMA position is not unique.[33] For example, New Jersey is seeking a mandate for 24 hours for urgent PA decisions.[34] Michigan requires annual insurer reporting of PA decision and appeal times.[35]

The US is looking at taking strong measures to regulate insurer timeliness and responsiveness. Canada's health care system due to our provision of publicly funded hospital care is not as exposed to insurer coverage PA issues resembling those experienced in the US. Yet as our public health system weakens, and we come to rely more heavily on privatized services and supplementary insurance we need to look carefully at the implications for Canadians of delays and denials of physician prescribed healthcare treatments. We should take notice of the US response to legislate timely PA response periods, reporting, and denial transparency.

It is therefore not surprising that the Canadian health insurance industry has voiced concerns about recent US legislative initiatives. One of their key issues focusses on IT solutions for PAs. While a coordinated electronic PA approach is certainly needed, their interventions do not address patient and healthcare professionals' issues regarding imposed delays to patient care, PA denials that overwhelmingly will be overturned, and the time required by medical professionals to provide to insurers what amounts to a considerable amount of patient-specific medical information.[36]

The TBS contract with CL widened the scope of PAs to include non-generic drugs as well as other treatments and devices. A major problem with the contract is the lack of a specified time limit for PA approvals. The contract fails to indicate if PA approval times fall within the 5-day limit for electronic claims and 10-days for paper-based ones. Moreover, the CL narrative describing PAs as exceptional requests is not helpful. The Member is requesting access to a PSHCP

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[29] https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/ See also Report by the US Department of Health and Human Services, Office of the Inspector General, https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp Accessed 3/12/2023.

[30] https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization\ Accessed 3.12.2023.

[31] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability Accessed 3.12.2023.

[32] AMA submission https://www.regulations.gov/comment/CMS-2022-0190-0563 at p.2 Accessed 3.12.2023.

[33] https://www.regulations.gov/docket/CMS-2022-0190/comments. Accessed 3.12.2023.

[34] https://www.axios.com/2023/01/27/states-target-doctor-authorization Accessed 3.12.2023.

[35] Lauren Sausser. KFF News *'Feds Move to Rein In Prior Authorization, a System That Harms and Frustrates Patients' March 13, 2023. https://health.wusf.usf.edu/health-news-florida/2023-03-13/feds-move-to-rein-in-prior-authorization-a-system-that-harms-and-frustrates-patients* Accessed 3/12/2023.

[36] https://www.simplifypriorauth.ca Accessed 3/12/2023.

benefit. It has been prescribed by a licenced medical professional, be it a wheelchair, a chemotherapy drug developed to target their specific cancerous tumour, or compression socks.

Since CL took over the contract, there have been real-life consequences for patients when PAs are not addressed in a timely manner or when drugs, treatments, and devices are denied, which appears to be happening with considerable frequency. The CBC profiled a recent case of PA delay resulting in emergency treatment of a patient whose chronic condition worsened.[37]

In the Canadian context, it is the federal and provincial taxpayer who bears the brunt of added costs, time burdens imposed on physicians, and decreased health of patients caused by PAs. At a time where Canada is experiencing a serious lack physicians, we are asking them to decide between filling out lengthy forms justifying why a brand name drug or a diabetic insulin pump is required, or whether they will see a few more patients that day. While doctors can charge Members for the completion of PAs, there are not enough hours in the day for doctors to complete PA forms and to also attend to the needs of patients needing care. For some Members, it can take 6-8 months to obtain an appointment with a specialist to request to have a PA completed.

I am concerned when I look at some of the detailed 7+ page CL forms to be completed by a doctor who has prescribed a drug, treatment or device based on their learned assessment of the patient's medical condition. The completed PA forms will be reviewed for approval by a CL doctor who is not specialist[38] and who does not know the patient. The detailed medical test and diagnostic information demanded on the PA form will then be recorded on the Member's/Dependent's file and presumably updated each calendar year as PAs appear to need to be renewed annually even in cases like Type 1 Diabetes which is a lifelong, chronic condition.

I fully understand the need of TBS to restrain costs. I do see the attention being given in the contract to auditing for fraud and benefit misuse by physicians, pharmacists, and Members/Dependents. However, TBS in widening the scope of PAs, failed to specify PA response timelines. Apart from the CL Ombudsman Office, the body being asked to deal with all manner of Member concerns about CL inadequacies in the delivery of the contract, there exists no streamlined and dedicated group adjudicating PA refusals. The contract provides little transparency about reasons for PA refusals. Nor does it mandate public reporting of PA denial and overturn rates.

Recommendation
I am asking the Standing Committee to question TBS and CL about their understanding of the timelines specified in the contract regarding PAs.

I am asking the Standing Committee to request that TBS and CL monitor timeliness and accuracy of PA decision-making and appeals separately from claims made for drugs, treatments, and devices not requiring PAs. This information should be made available to Members.

I am asking the Standing Committee to request that the federal government in association with provincial ministries of health work together to adopt consumer protection legislation mandating PA response times and transparency. Such legislation should take notice of the regulations in place in several Canadian provinces (Ontario, Saskatchewan for disability benefits) and

[37] https://www.cbc.ca/news/canada/ottawa/canada-life-series-feeding-tube-formula-1.7005507 Accessed 3.12.2023
[38] See the qualifications stated in the RFP Appendix 2 to Annex A, Part III at p290-311.

legislation already in place or proposed in over 30 US states and which following review by the Biden administration is expected to be passed in 2024.

3. How to go forward, improve, and address gaps in TBS/CL delivery of the contract?

The Standing Committee is a positive step forward. I hope it will encourage dialogue, sober second thought, and a commitment on the part of TBS and CL to achieve improvements.

Recommendations

MHS. CL subcontracted the Emergency Travel Assistance and Comprehensive Coverage Contact to MSH. The MSH IT system is deficient, phones are not answered promptly, claims are delayed, and MSH management of PSHCP benefits appears chaotic. I ask that the Standing Committee recommend that TBS take immediate steps to audit MHS and demand changes as needed.

Communication --- Member Sounding Board. I ask the Standing Committee to recommend that CL establish an English and a French Member Sounding Board that would meet on a regular basis to discuss ongoing problems, comment on solutions, and look at progress being made with the implementation of the PSHCP contract.

Transparency --- Reports. I ask the Standing Committee to recommend that summaries of audit reports, data breach reports, and use of and results from the Benefit Misuse and Abuse Data Mining Tool[39] be made available to Members on a regular basis and without need for ATIP. Such reporting should also include the annual listing of Reasonable and Customary eligible expenses used to ensure that the level of charges is within reason in the geographic area where the expense is occurred and on which the 80% reimbursement is calculated.[40]

[39] RFP Annex A SOW S.4.7.9 at p183.
[40] RFP Annex 1 to Annex A, at p239.