IN THE MATTER OF AN ARBITRATION
Pursuant to the *Labour Relations Act,* R.S. 1995

BETWEEN:

UNITY HEALTH TORONTO

("Employer")

- and –

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 5441

("Union")

(Policy Grievances #2019-005, #1590-237, UHT-20-154, and UHT-20-04-155)

ARBITRATION BOARD:
Jasbir Parmar, Chair
Greg Shaw, Employer Nominee
Joe Herbert, Union Nominee

On Behalf of the Employer:
Carolyn Kay, Hicks Morley
Manson Locke, Senior Director, Human Resources
Monica Brown, Manager, Total Rewards Administration

On Behalf of the Union:
Kelly Doctor, Goldblatt Partners
Madeline Stewart, Goldblatt Partners
Daniel Callaghan, President, CUPE Local 5441
Marcel Comeau, Vice President, CUPE Local 5441
Jonah Ginden, CUPE
Louis Rodrigues, First Vice-President, OCHU

Hearing held October 25, 2021; January 4, 5, February 1, 2022 via videoconference, with an executive session on April 20, 2022.

THE PARTIES

[1] Unity Health (the "Employer) is a health care corporation created on August 1, 2017 through the integration of three institutions: Providence Healthcare, St. Joseph's Health Centre and St. Michael's Hospital.

[2] Prior to the integration, CUPE Local 1590 ("CUPE 1590") represented a combined full-time/part-time bargaining unit of service employees at Providence. Meanwhile, CUPE Local 1144 ("CUPE 1144") represented four bargaining units at St. Joseph's: a full-time clerical unit, a full-time service unit, a part-time clerical unit, and a part-time service unit. There were no CUPE represented employees at St. Michael's. Both CUPE 1590 and CUPE 1144 participated in central bargaining, and therefore each had collective agreements comprised of a central agreement (expiring September 28, 2021) with a local appendix (expiring September 28 and September 27, 2017 respectively).

[3] In 2019, as a result of the integration, by virtue of a number of decisions of the Ontario Labour Relations Board, CUPE became the bargaining agent for three bargaining units of the Employer: one for clerical employees, one for service employees, and one for spiritual care practitioners. CUPE Local 5441 (or the "Union") received its charter from CUPE National to become the bargaining agent for the Employer's clerical and service bargaining units effective November 5, 2019. In December 2019, the Union and the Employer reached an agreement on a composite collective agreement for the clerical unit and a composite collective agreement for the service unit. The parties started negotiations at the end of the November 2020 with respect to the new, consolidated collective agreement. At the time of the hearing, these negotiations were ongoing. The parties have not reached an agreement on the content of the benefits plan to apply to all members of the Union.

THE GRIEVANCES

[4] This decision addresses four policy grievances alleging a breach of the collective agreement on the basis of certain changes relating to extended healthcare benefits.

[5] The CUPE central collective agreement, in Article 18.01(b), obliges the Employer to pay the premium for coverage under the "existing Blue Cross Extended Health Care Benefits Plan in effect as of September 28, 1993… or comparable coverage with another carrier". The parties have been unable to find a copy of the Blue Cross Plan in effect in 1993 (the "1993 Blue Cross Plan") at either Providence or St. Joseph's.

[6] From at least 2004 to January 1, 2019, the extended healthcare benefit plan for eligible CUPE staff at Providence was managed by Medavie Blue Cross Plan ("Medavie") through an administrative services only ("ASO) agreement. From at least April 1, 2012 to January 1, 2019, the extended health care benefits plan for eligible CUPE staff at St. Joseph's was managed by Desjardins Group Insurance ("Desjardins") through an ASO agreement. Effective January 1, 2019, the Employer changed carriers at both Providence and St. Joseph's, and moved to an ASO agreement with Sun Life Financial ("Sun Life"). St. Michael's Hospital already had Sun Life as their benefit carrier.

[7] The first two grievances were filed respectively by CUPE 1590 (on December 12, 2018) and CUPE 1144 (on January 23, 2019). The parties are agreed that the Union has carriage over these grievances and that the outcome of this proceeding will apply to all CUPE employees in the clerical and service bargaining units who are eligible to receive extended healthcare benefits. The final two grievances were filed by the Union on behalf of all its bargaining unit members.

[8] The issues raised by the grievances are as follows:

i) Whether the Employer breached Article 18 of the collective agreement by moving to Sun Life on the basis it had substantially lower reasonable and customary limits on paramedical benefits;

ii) Whether the Employer breached Article 18 of the collective agreement by implementation of a $9 cap on dispensing fees;

iii) Whether the Employer is in breach of Article 18 and/or the management rights clause by implementing a requirement that certain medical supplies be obtained only through an Approved Provider Network ("APN");

iv) Whether the Employer violated Article 18.01(f) of the collective agreement with respect to the timing of when it provided the Union a copy of the Sun Life master policy; and

v) Whether the Employer breached Article 18.02 of the collective agreement with respect to the timing and/or content of information related to changes in the benefits provided to the Union and the employees.

[9] In a preliminary decision issued November 29, 2021, based on the fact that the Employer advised that it was reverting back to the reasonable and customary limits for services that existed at each hospital site prior to the change of carriers, the Board determined that the dispute about changes to reasonable and customary limits was moot, and therefore dismissed that aspect of

the grievance. Consistent with the agreement of the parties, even though we will not be determining this issue on its merits, we remain seized to deal with any remedial issues relating to the change for the time it was in place.

[10] Also, on January 4, 2022, the Employer acknowledged its actions in imposing a $9 dispensing fee cap constituted a breach of Article 18.01 and 18.02 the collective agreement, in terms of not providing the level of benefit coverage required, and that therefore it was removing the cap. Accordingly, we declare there was a breach of the collective agreement in that respect. We also remain seized to deal with any remedial issues relating to the period when the cap was in place.

[11] The last three issues identified above remain to be determined.

COLLECTIVE AGREEMENT PROVISIONS

[12] The following are the relevant portions of the central collective agreement:

> 18.01 – INSURED BENEFITS
>
> The following provision will appear in all collective agreements replacing any provision related to insured benefits that existed in the hospital's expiring Collective Agreement, (subject to inserting in the following language any percentage contribution by the Hospital which is greater than that contained in the following provision):
>
> The Hospital agreed, during the term of the Collective Agreement, to contribute towards the premium coverage of participating eligible employees in the active employ of the Hospital under the insurance plans set out below subject to their respective terms and conditions including any enrolment requirements:
>
> (a) The Hospital agrees to pay 100% of the billed premium towards coverage of eligible employees in the active employ of the Hospital under the Blue Cross Semi-Private Plan in effect as of September 28, 1993 or comparable coverage with another carrier.
> (b) The Hospital agrees to contribute 75% of the billed premium towards coverage of eligible employees in the active employ of the Hospital under the existing Blue Cross Extended Health Care Benefits Plan in effect as of September 28, 1993 (as amended below) or comparable coverage with another carrier providing for $22.50 (single) and $35 (family) deductible, providing the balance of monthly premium is paid by the employee through payroll deductions….
>
> ….
>
> (f) A copy of all current master policies of the benefits referred to in this Article shall be provided to the Union.
>
> 18.02 – CHANGE OF CARRIER
>
> It is understood that the Hospital may at any time substitute another carrier for any plan (other than OHIP) provided the benefits conferred thereby are not in total

> decreased. The Hospital shall notify the Union sixty (60) days in advance of making such a substitution to explain the proposed change and to ascertain the views of the employees. Upon a request by the Union, the Hospital shall provide to the Union, full specifications of the benefit programs contracted for and in effect for employees covered herein. The Hospital will provide the Union with the full details of any changes made by an existing carrier to current plan provisions.

WITNESSES

[13] The parties proceeded by way of an Agreed Statement of Facts, supplemented with evidence from four witnesses. Dan Callaghan is the president of CUPE 5441, and has been since 2020. Prior to that, since 2018, he was the president of CUPE 1590. Marcel Comeau was the first vice-president of CUPE 5441 from January 2020 to December 1, 2021. From October 2018 to January 2020, Mr. Comeau was the first vice-president of CUPE 1144, although he spent almost the entirety of that time as acting president. Andrea Volpe is the director of risk management at Orion Audit Ltd., a third-party company that performs benefits audits retained by the Employer to perform certain services. Monica Brown was the Manager of Total Rewards Administration from April 2018 until January 2022, when she became the Director.

[14] The evidence relevant to each of the issues will be discussed below. However, it is useful to note that there is no material dispute on the facts.

IS IMPLEMENTATION OF THE APN A VIOLATION OF THE COLLECTIVE AGREEMENT

[15] The APN went into effect on November 1, 2019. As a result, employees are required to purchase certain medical supplies, specifically compression hose, orthopedic shoes, orthotics, TENS machines, and braces, through providers listed in the APN in order to have their claims approved.

[16] The decision to require that employees make purchases from APN providers in order to have their claim approved was a decision of the senior leadership of the Employer. At the direction of the Employer Sun Life does not approve claims when the employee has not made the purchase through an APN provider. This decision followed a discovery of the existence of a significant number of fraudulent insurance claims. Specifically, in 2017/18 St. Joseph's and St. Michael's requested Orion to conduct an audit of insurance claims. The audits resulted in a finding that there were certain providers and certain employees engaged in insurance claim fraud, leading to the terminations of about 69 employees at St. Michael's and 3 employees at St. Joseph's (only one of which involved a CUPE member). Ms. Volpe testified that it is difficult for

claims adjudicators to detect claim fraud in the same manner as the auditors did because they simply do not have all the relevant information available at the time they are processing an individual claim (e.g., patterns of certain providers or patterns of claims by an employee).

[17] A group of hospitals in the Greater Toronto Area (GTA), including the Employer, then formed a committee to discuss the issue of fraud and came up with the idea of an APN. The APN was developed by Orion. A process was developed whereby a provider had to apply in order to be listed in the APN. Approval of the application is dependent on a number of criteria, including the hours of operation, location, accessibility of the location, the types and cost of supplies sold, the qualifications/credentials/training of staff, and any history of fraud or claim-related concerns with any insurers. Initially the APN included only 149 locations. However, the APN now includes 350 locations, mostly in the GTA, but also with some locations elsewhere in Ontario and a few locations in others parts of Canada. At the time of the hearing, the Employer was the only employer-member of the APN. There is a website employees can use to search for APN providers. The website does not list the particular supplies available at any particular provider.

[18] It is not disputed that the APN is a new initiative and did not previously exist in this workplace. Neither Medavie or Desjardins ever required employees to purchase or obtain services or supplies from a specified group of providers, but they both did keep a list of delisted providers – providers in respect of which claims would not be accepted.

[19] Ms. Brown testified that when the transition to the APN occurred, a number of employees complained they wanted to continue to obtain supplies from their previous providers. Ms. Brown advised them to have their provider apply to join the APN. It is, of course, the provider that must apply, and so employees are limited to simply recommending to their provider that they apply. The Union noted that employees may prefer to purchase their medical supplies at their previous provider for a number of reasons, including a trust relationship with their specific provider.

[20] The Union also suggested that its possible employees may not be able to find their preferred brand or style of medical supply, or even the one recommended by their own physician, at any of the APN providers. Ms. Volpe acknowledged that while efforts were made to ensure a selection of brands and products were available, no effort was made to ensure every existing brand or product would be available through the APN providers. The Union noted that the employee or his/her dependent may be travelling or not reside in Ontario or Canada at the time the particular supply is required to be purchased, whereas previously claims could be made involving providers throughout Canada and even from outside of Canada. When these concerns were put to Ms. Brown, she stated that after the APN was implemented she did not receive many

complaints of that nature. However, she acknowledged that certain issues of this nature were brought to her attention, and that after investigating the matter and noting that the pandemic lockdowns had impacted accessibility, she directed Sun Life to approve 15-20 specific claims which would otherwise have been denied in accordance with the APN requirement. As Sun Life is only the administrator for the benefit plan, Ms. Brown is able to direct them to approve a specific claim. While Ms. Brown indicated she would be willing to consider a specific case, there was no evidence that employees are advised that exceptions can and will be granted. Rather, employees are told that only claims involving the APN providers will be approved.

[21] The Union objects to the implementation of the APN. The Union submits that the requirement that employees purchase their supplies through the APN in order to obtain reimbursement is a violation of Article 18.01, which requires that the Employer provide benefit coverage that is comparable to coverage under the 1993 Blue Cross plan, and a violation of Article 18.02, which requires that any change in carrier not result in benefits being "in total decreased".

[22] Unfortunately, as noted above, the 1993 Blue Cross plan for Providence or St. Joseph's cannot be located by the parties. The Board has been provided with a generic 1993 Blue Cross brochure held by CUPE, and a copy of a generic 1990 Blue Cross Plan held by the Ontario Hospital Association. The Board has also been provided with the Medavie and Desjardins plans that were in effect in 2018, immediately prior to the Employer's change to Sun Life. These plans have been in place, respectively, at least since 2004 and 2012.

[23] With respect to the significance of the Medavie and Desjardin plans that have been in place most recently at Providence and St. Joseph's, the Union relies on *Scarborough Hospital and CUPE, Local 1486* (unreported, November 6, 2014) (Goodfellow) and submits that the content of benefit plans implemented subsequent to the 1993 Blue Cross plan are not an appropriate evidentiary basis to conclude they reflect the content of the 1993 Blue Cross plan.

[24] The Union submits that the fact that the 1993 Blue Cross plan is unavailable is not actually material in the present case. The reason, it argues, is because the evidence is clear that the APN is a new initiative and one that has never previously existed in this workplace. The Union submits that maintaining a list of delisted providers is a distinctly different concept, since it is directed specifically at addressing issues about fraud. The APN, on the other hand, limits the ability of employees to access their benefits unless they are purchased from a provider unilaterally chosen by the Employer. The Union submits this is a fundamental change in benefit coverage and is not permitted by the collective agreement. The Union submits that a "basket approach" should be followed to determine whether the Employer is providing comparable coverage to the 1993 Blue

Cross plan. It submits the APN is a reduction in benefits and that in the absence of evidence to suggest there has been any other change to counterbalance this reduction, its implementation has resulted in less than comparable coverage and a total decrease in benefits.

[25] The Union also submits that the requirement to use APN providers in order to have a claim approved is not reasonable because it is interference with personal choice with respect to health care. This, it submits, is particularly objectionable since it is without reasonable foundation, as employees are prevented from using legitimate providers simply because they have not been selected by the Employer to be included in the APN.

[26] The Union relied on the following authorities: *Scarborough Hospital, supra*; *Metropolitan Authority and ATU, Local 508*, 1989 CarswellNS 701; *Hamilton Health Sciences Corp. and CUPE, Local 7800*, 2019 CarswellOnt 4036; *Air Canada and CUPE, Air Canada Component*, 2012 CarswellOnt 12649; *Labatt Brewing Co. and SEIU, Local 2*, 2016CarswellOnt 17207; *Labatt Breweries of Canada and I.B.W.U, Local 308*, 2017 CarswellBC 1968, upheld on appeal 2018 BCCA 108.

[27] For its part, the Employer disagrees the implementation of the APN is a violation of the collective agreement. The Employer notes that the manner in which a benefit plan is referenced in a collective agreement determines the extent of an employer's obligations and, by extension, the scope of arbitral authority to review an employer's conduct for compliance with the collective agreement obligations. In the present case, the Employer submits that the collective agreement only obliges the Employer to pay premiums with respect to benefit coverage of a certain level. The Employer submits that the APN is not a benefit under Article 18.01, and therefore the introduction of the APN is not a change in benefit coverage. The Employer submits the APN is just an administrative process, comparing the APN to reasonable and customary limits, which are recognized to be a standard part of the administrative process by which insurance carriers administer claims. The Employer submits that an administrative process is typically beyond arbitral review unless it is somehow inconsistent with the collective agreement. The Employer notes that the implementation of the APN in the present case has been directed by the Employer and does not actually flow from the insurance carrier. It submits, therefore, that there is no basis to review the APN's implementation under Article 18.01, and that the only issue is whether the Employer's decision to implement the APN is a reasonable exercise of its management rights.

[28] In the event the Board determines that the implementation of the APN can properly be reviewed under Article 18.01, the Employer submits that the APN is consistent with the benefit plans provided by Medavie and Desjardins before the Employer moved to Sunlife in 2019. The

Employer notes these plans have been in place for years without objection from the Union. The Employer refers to the fact the Medavie and Desjardins plans permitted those insurance carriers to exclude supplies not provided by an "approved provider" or select suppliers for a "preferred provider network". The Employer submits these provisions gave the carriers the right to create a list of approved providers. The Employer submits that even though neither carrier exercised that right, both instead creating a list of delisted providers, the exercise of a pre-existing right is not a change in coverage.

[29] The Employer submits that given the implementation of the APN is an employer-initiated action, the issue really is whether the Employer has reasonably exercised its management rights under the management rights clause. The Employer notes that the problem of fraudulent claims was significant and well-documented, and submits this is a legitimate basis for the Employer to take action to address this serious issue. The Employer submits that the APN is just the flip-side of the delisting process, in that the insurance carriers always had the right to deny a claim based on the provider involved in the claim. The APN, the Employer submits, simply avoids any surprises for the employees by identifying the approved providers in advance. The level of benefit, the Employer submits, remains the same.

[30] The Employer submits that while the Union suggested there could be circumstances where employees may not be able to access a medically-necessary product from a provider in the APN, there is no evidence there is any real problem in that respect. The Employer also notes that exceptions have been made where an issue of that nature has been brought to its attention, although it acknowledges that it has not told employees that exceptions can be made. This, the Employer states, is to encourage them to only use APN providers. The Employer submits that the APN does not limit where the employee receives health care, since it does not place a limit on where the employee obtains the prescription for the medical supply – only where the employee purchases it.

[31] The Board relied on the following authorities: Brown & Beatty, *Canadian Labour Arbitration*, 5th Edition, 4:1400; *Redpath Sugars and C.U.O.E.*, 2002 CarswellOnt 3812; *London Life Insurance Co. v. Dubreuil Brothers Employees Assn.,* 2000 CarswellOnt 2419; *Teamsters, Local 879 and Lafarge Canada Inc.*, 2002 CarswellOnt 927; *Cambridge Memorial Hospital and ONA*, 2011 CarswellOnt 11834; *Health Sciences North and ONA*, 2021 CarswellOnt 10697; *Windsor Regional Hospital and ONA (Reimbursement)*, 2008 CarswellOnt 10021; *Windsor Regional Hospital and ONA, 2008 CarswellOnt 7505; Hamilton Health Sciences Corp. and ONA*

(2012), 222 L.A.C. (4th) 96; and *Trillium Health Partners and CUPE, Local 5180*, 2017 CarswellOnt 14413.

[32] The fundamental issue in dispute is whether the implementation of the APN is a breach of the collective agreement. More precisely, the issue is whether the collective agreement is violated by the implementation of a rule that requires employees to purchase the medical supplies at issue from the specific providers included in the APN in order to obtain benefit coverage. For the following reasons, we find there is a violation of the collective agreement.

[33] There is no dispute that Article 18.01 and 18.02 obliges the Employer to provide employees extended health benefit coverage at a particular level. While the collective agreement itself does not make reference to the particular medical supplies at issue, and while the 1993 Blue Cross plan cannot be located, there is no dispute between the parties that the required level of benefit coverage includes the particular medical supplies to which the APN applies.

[34] We find that a rule which results in employees being denied coverage for these supplies, despite the fact that their claim is a legitimate and valid one, is a failure to provide the required level of coverage. That is the effect of the implementation of the APN, unless the employees follow the requirement to purchase the supplies from specific providers unilaterally chosen by the employer. As such, the requirement to use APN providers in order to receive reimbursement for the expense of medical supplies which are required to be covered is a violation of both Article 18.01 and 18.02.

[35] This conclusion is supported by the analysis in all the arbitration decisions brought to this Board's attention which involved an employer limiting benefit coverage to circumstances where the employee used providers chosen by the employer.

[36] In *Labatt Brewing Co. and SEIU, supra,* the employer identified a particular organization as its "preferred pharmacy", a misnomer since this was in fact a mandatory program that required employees to obtain maintenance medications from that pharmacy in order to obtain reimbursement for the expense of these medications. The employer argued that there was nothing in the collective agreement about the method by which medical benefits were delivered and so it was open to it to take such action. Arbitrator Surdykowski noted that the collective agreement entitled employees to prescription medication at no cost to them, subject only to dispensing fee limits. He stated that while the employer had the right to adopt a medication program or delivery vehicle, this right did not permit it to adopt a program which denies an employee compensation for the cost of prescription medications required to be covered under the

collective agreement, and that was the effect of the pharmacy program as implemented by the employer. He concluded this was a failure to provide the negotiated benefit and therefore a violation of the collective agreement.

[37] A similar conclusion was reached in *Air Canada*, *supra*. In that case, as a result of numerous fraudulent claims the employer introduced two new requirements: that employees obtain predetermination of eligibility for purchase of orthotics, orthopedic shoes, compression stockings and physiotherapy, and that certain medical supplies be purchased from a list of approved vendors in order to qualify for reimbursement. Arbitrator Kaplan rejected the union's argument that the employer had no right to restrict providers, finding that such a position in the face of documented fraud was untenable and that there was an implied duty of reasonableness that applies to collective agreement interpretation. However, in making this statement Arbitrator Kaplan was not suggesting that the employer could impose a list of providers from which medical supplies had to be obtained in order to receive benefit coverage. This is clear from the fact that while he concluded that the employer had the right to decline further claims from providers where fraud has been established (i.e., delist a provider), he then went on to state that if a claim was from a legitimate provider, it had to be paid, stating that "other than in limited circumstances, it is not within the employer's right to direct where medical care is obtained". He also went on to state that the employer could encourage employees to obtain pre-approval but could not compel employees to do so by denying claims where such pre-approval was not obtained. This decision supports the conclusion that where there are valid reasons to question the legitimacy of a provider, an insurer/employer may well be in a position to reject a claim on the basis of the involvement of that particular provider. However, in the absence of such, an employer cannot institute requirements which result in denial of coverage for legitimate claims.

[38] The concern referenced by Arbitrator Kaplan about interference with employees' health care choices by an employer limiting which benefit claims will be covered based on their own preferred provider was underscored in *Labatt Breweries and I.B.W.U., supra,* which involved the same "preferred pharmacy" program as in the other *Labatt* decision discussed earlier. The arbitrator noted the collective agreement required reimbursement of generic drugs without limitation. The arbitrator concluded the effect of the pharmacy program was to require employees to enter a relationship of trust with a particular health care provider in order to receive reimbursement for the drug expense. He held that an individual's choice of health care provider engages privacy interests of the highest order, and an intrusion on that right could not be justified

in the absence of an extraordinary countervailing justification or clear and express collective agreement language.

[39] The Board finds the concerns referenced by these arbitrators about interference with personal decisions around health care valid. Contrary to the Employer's submissions, we are of the view that there is no practical distinction in the personal choice involved in choosing a provider that prescribes a medical supply and one that sells the medical supply. We note no such distinction was made in *Air Canada.* The best example, highlighted in the evidence, is that a podiatrist may prescribe orthotics and also sell the orthotics, providing advice and guidance about the need for the item as well as the purchase and use of the product. Under the APN, an employee would be prevented from purchasing the item from the podiatrist unless the Employer decided it would include the podiatrist in the APN. The Board is of the view that clear language would be required to conclude that the collective agreement permitted such intrusion on the privacy attached to health care choice in the course of providing health benefits. That said, it is the Board's opinion that the conclusion that implementing the APN is a failure to provide the requisite benefit coverage can be reached without referencing those concerns, because the impact of the APN is that it inevitably leads to the outright denial of benefit coverage for legitimate claims.

[40] We do not accept the Employer's submission that the APN does not impact benefit coverage, but rather is as just an administrative process. We do not agree that the APN is analogous to reasonable and customary limits, which are recognized to be acceptable administrative practices with respect to benefit plans: see for example *Windsor Regional Hospital, supra,* and *Trillium Health Partners, supra*. In fact, the contrast between the APN and reasonable and customary limits highlights how it does not make sense to characterize the APN as an administrative process. The application of a reasonable and customary limit is not intended to and does not result in the denial of a claim; it only impacts the maximum amount of the reimbursement that will be provided in the course of providing coverage. However, the application of the APN determines whether or not the claim will be approved and whether coverage for the medical supply will be provided. This is not an incidental outcome. The APN is designed to impact benefit coverage, by controlling where employees obtain the products at issue and denying all claims where employees do not comply with the exercise of that control.

[41] Furthermore, the APN is not simply "the flip side" of maintaining a list of delisted providers or the denial of a claim because it is from a delisted provider, both of which the Union takes no issue with. In both those cases, the denial of a claim would be on the basis of a specific concern

with the legitimacy of the claim. Such a denial is consistent with the notion that collective agreement rights must be interpreted and implemented reasonably. As noted by Arbitrator Kaplan in *Air Canada,* it is, of course, reasonable to restrict further claims involving providers in respect of which there is a documented history of concerns of fraudulent behaviour.

[42] However, inclusion in, or conversely exclusion from, the APN is based on the basis of a number of factors, many of which quite simply have nothing to do with the legitimacy of the purchase of the medically-necessary supplies by the employee from that provider. As a result, when a claim is denied because the provider is not part of the APN, it is not because of any specific concern about the validity or legitimacy of the claim. Rather the claim is denied because the Employer decided they simply will not provide coverage for claims involving providers other than those which they unilaterally choose. The obvious result is that legitimate claims are denied.

[43] We also do not agree with the Employer's submission that the right to require employees to use only specific providers in order to have a claim approved already existed under the Medavie and Desjardin plans, and that therefore the implementation of the APN is simply an exercise of that pre-existing right rather than a change to the benefit plan. Since we reject this submission, we need not decide whether it is even appropriate to consider plans in place years after 1993 in determining whether the coverage provided at the present time is comparable to the 1993 Blue Cross plan.

[44] We accept that the Medavie and Desjardin policies reserved the carriers' right to approve a provider or restrict claims from certain providers. Specifically, the Medavie plan made reference to exclusions for any health care service or supply "not provided by a Medavie Blue Cross approved provider". The Medavie policy defined a "Medavie Blue Cross Approved Provider" as a provider of health care services and supplies "recognized and approved by Medavie Blue Cross". Meanwhile the Desjardin policy in place before the Sun Life plan stated:

> Preferred providers network
>
> The Insurer may select suppliers for the distribution of drugs and supplies and may restrict payment for Eligible Expenses incurred at another supplier.

[45] In our view, this language is insufficient to establish an absolute right to deny legitimate claims simply because the provider is not one chosen unilaterally by the carrier. Having the right to approve a provider or restrict payments related to certain suppliers is not the same as having a right to deny claims unless they come from a specified subset of providers or the right to choose the providers from which an employee must obtain the medical supply. As noted above, the former is part of the reasonable interpretation and administration of collective agreement rights.

The latter involves a level of control that interferes with the collective agreement obligation to provide benefit coverage for the purchase of these supplies. Clear and express language would be required to conclude the parties intended benefit coverage required by the collective agreement to be subject to that level of control by the carrier or the Employer.

[46] Our conclusion about the proper interpretation of the Medavie and Desjardin policies is consistent with and supported by the evidence of Ms. Volpe and Ms. Brown, both of whom have many years of experience with insurance carriers and their practices. In response to a question about whether she was aware of insurers maintaining lists of approved providers, whereby they were the only ones employees could utilize in order to have a claim approved, Ms. Volpe testified that she was aware that many insurers have lists of delisted providers. The only reasonable assumption from this response is that Ms. Volpe, despite her extensive insurance industry background, is not aware of any insurers maintaining such lists of approved providers. Notably, Ms. Volpe then went on to explain that the term "preferred" or "approved provider", as used by insurers, actually is a broad category, with the goal of an insurance company being to keep the number of providers "wide and open". She stated that the APN has a more narrow and specific focus because they are choosing to include only a small subset of providers. Meanwhile, Ms. Brown stated that she was aware that insurers would "delist" a provider based on concerns around fraud or other legitimacy-related issues. While she speculated there may be other reasons "delisting" may occur she had no actual knowledge of any other reason that a provider had actually been delisted. This evidence suggests that the right to "approve" a provider or restrict payment to a certain provider is not understood in the insurance industry as a right that is about limiting the number of providers in respect of which a claim could be made. Furthermore, there is no evidence of any general practice amongst insurers about administrative processes intended to limit the ability to have legitimate claims approved such that the APN could be viewed as just a standard industry practice.

[47] We note the Union's submissions about the basket-approach to determining comparable coverage (an approach with which the Employer agrees), and the fact that there is no evidence that there has been any corresponding increase in other benefits to balance the implementation of the APN. We do not think this analytical approach is necessary where employees are being outright denied coverage for medical supplies which the parties agree is required by the collective agreement. We are unaware of any decision, and none has been brought to our attention, which suggests that the obligation to maintain "comparable coverage" means the outright elimination of required coverage for certain items can be justified by improvements in respect of other items.

That said, if we were to follow that approach, the analysis in *Hamilton Health Sciences, supra* would be directly applicable to the facts of the present case and lead to the same conclusion – that there was a reduction in benefits and a failure to provide comparable coverage, resulting in a violation of the collective agreement.

[48] Lastly, we have considered the Employer's submission that the APN does not involve Article 18, but rather is the exercise of a management right and should simply be reviewed against the standard of reasonableness. This is a meaningless distinction in the present case. The managements right clause in the collective agreement requires that these rights be exercised in a manner consistent with all the provisions of the collective agreement. We find that the implementation of the APN and the rule that only claims involving APN providers will be approved is inconsistent with and a violation of Article 18, which obliges the Employer to ensure benefit coverage for the purchase of these supplies is provided to employees. The fact that this rule was implemented by the Employer and not the insurance carrier does not change the fact that it violates Article 18, and accordingly the Employer's actions in implementing the APN are also a violation of the management rights clause.

[49] We wish to emphasize that there is no evidence to suggest that the Employer's actions in implementing the APN were motivated by anything other than valid concerns about fraudulent claims and a good faith attempt to address this issue. We appreciate insurance fraud is a serious problem for all parties impacted by insurance costs, which includes employees. However, given the terms of the collective agreement, the actions the Employer took are simply not permitted.

WAS THERE A BREACH OF ARTICLES 18.01(f) and 18.02?

[50] The Union submits the Employer breached Article 18.01(f) and Article 18.02 with respect to the contents and timing of the information provided to the Unions about the benefit plan.

[51] Article 18.01(f) requires the Employer to provide a copy of all current master policies to the Union, and Article 18.02 requires the Employer to provide the Union, upon request, "full specifications of the benefit programs contracted for and in effect for employees". Also, Article 18.02, while confirming the right of the Employer to substitute a new carrier, requires the Employer to provide the Union notice sixty days in advance of doing so "to explain the proposed change and to ascertain the views of the employees".

[52] The Employer advised CUPE 1590 on November 1, 2018 that it was changing to Sun Life. At the time of the notice, the Employer asserted that "current coverage levels would remain the

same". The Employer advised CUPE 1144 on November 14, 2018 that it was changing to Sun Life, indicating there were "no changes to benefits for CUPE employees". Sun Life became the insurance carrier effective January 1, 2019. The Union learned about the dispensing fee cap in mid to late November 2018, the reasonable and customary limits in March 2019, and the APN in May and October 2019 (there are two dates because the two locals learned of it at different times).

[53] On November 7, 2018, Mr. Callaghan requested the Employer provide it with the Sun Life master policy and brochure (also known as the membership guide). In response, the Employer advised that the contracts and policies for Sun Life had not been finalized and would be provided to the Union once that occurred. The brochure was not made available until October 2, 2019. The master policy was not provided until April 2020. Ms. Brown stated that in her experience it was normal practice that the process to draft a master policy did not begin until after the new carrier was already in place. She stated that typically the focus prior to the date a new carrier takes effect is on ensuring the systems are in place for the transition to the new carrier. She stated that in her experience the process of preparing such a policy, which is done by the insurer in conjunction with the Employer, typically takes about six months. She stated that the instant case was not a typical one, as it involved consolidating three different plans for a number of different employee groups. It was provided to the Union once it was completed.

[54] While the Employer gave notice to CUPE 1590 of the switch to Sun Life sixty days before it took effect, it gave less than sixty days' notice to CUPE 1144. In addition, there are three other elements of the notice with which the Union takes issue. They are the $9 dispensing fee cap; the APN; and reasonable and customary charges. The Union submits that these are all changes the Employer was required to explain as part of the notice under Article 18.02, because these are all changes to benefits, effecting how much employees will have to pay and how much reimbursement for expenses they will receive. Anticipating the argument that reasonable and customary limits are just an administrative part of the plan, the Union submits that is not how employees understand it. The Union submits that employees only see the fact that they will not be reimbursed for their expenses as they used to be.

[55] The Union also submits that the Employer breached Article 18.02 by not setting up any process to "ascertain the views of employees". While the Employer did conduct information sessions for employees in December 2018 and January 2019, the Union notes Ms. Brown acknowledged that these were sessions to answer employee questions about the Sun Life, not ascertain the views of employees. The Union submits the purpose of ascertaining the views of employees is for the employer to consider them in the course of making its decision. The Union

noted Ms. Brown's evidence that once the Employer decided it was going to change to Sun Life it was not going to change that decision just because the Union objected. The Union submits the Employer has to adopt a more flexible, proactive approach to hearing the Union's concerns given the obligation to ascertain the views of employees.

[56] The Union also submits the Employer breached Article 18.01 and 18.02 because of the timing of when it provided the Union with a copy of the Sun Life contract (April 2020) and the brochure (October 2019). The Union had requested the Master Policy and Membership Guide in November 2018. The Union submits that Ms. Brown's evidence that about her experience of the usual process is insufficient evidence to provide a valid explanation for the Employer's failure to meet a clear collective agreement obligation. The Union submits that the Employer's obligation to provide the "full specifications of the benefit programs", which are contained in the master policy and, to a certain extent, the brochure, are reiterated in Article 18.02 with a timeliness reference, "upon a request". The Union submits this underscores the parties' acknowledgement of the importance of ensuring this information is provided to the Union in a timely fashion, and that therefore Ms. Brown's evidence about her experience about it "just being the process" to not prepare these documents earlier is insufficient to mitigate against a conclusion that the collective agreement was breached by the failure to provide these documents until several months after the Union requested them. The Union submits the Employer should have waited to have the Sun Life plan take effect until it was able to comply with the collective agreement obligation to produce this information. The Union submits that having access to the contract has a purpose, namely permitting the Union to do its job in representing employees and ensuring the Employer is meeting its collective agreement obligations. The Union submits it does not have to simply rely on the Employer's assertion that "nothing has changed with the benefit levels"; it has a right to review the contract in order to be satisfied that is the case. The Union submits that telling employees to refer to the previous carrier's brochure is simply insufficient, since the obligation is about providing this information for the plan that is "in effect" – not some previous one. The Union submits that because it did not have this information, it was unable to properly assess and answer employee questions about how claims were being processed and whether the collective agreement was being breached. The Union submits that as a new bargaining agent that impaired its reputation with the its members.

[57] The Employer submits that Article 18.02 confirms, rather than limits, the Employer's right to decide it will change to another carrier to provide the benefits required under the collective agreement. The Employer submits that Article 18.02, contrary to other collective agreement

provisions such as Articles 9.08A, 9.13, 10.03 and 21, is not a clause that requires the Employer to engage in a consultative process before it can make the decision to change carriers. The Employer submits that a proper reading of the second sentence of Article 18.02 is that it imposes upon the Employer a singular obligation - to give the Union sixty days' notice in advance of making a carrier change, which it asserts it did. The Employer submits the latter part of the second sentence only describes the purpose of the notice and does not set out separate and discreet obligations on the part of the Employer. The Employer also notes that any interpretation that the Employer has an obligation to ascertain the views of employees would be inconsistent with Ontario *Labour Relations Act,* which requires the Employer to deal with the bargaining agent about collective agreement issues and not deal with employees directly.

[58] The Employer submits that since in its view there was no proposed change to the level of benefit coverage, there was nothing further to be explained. The Employer acknowledges that during the hearing process it changed its view on the significance of dispensing fee caps, but submits its actions should be judged on its understanding at the time, which is supported by Ms. Brown's evidence that she did not understand the fee cap to be a change in benefit coverage. As for the APN and the reasonable and customary limits, the Employer submits these are not changes to the benefits being provided. The APN, the Employer submits, is not part of Article 18.01 or 18.02 because it did not flow from the insurance carrier. Because, it asserts, it was an exercise of management rights, there was no obligation to notify the Union of that under Article 18.02. As for the reasonable and customary limits of Sun Life, the Employer notes Ms. Brown's evidence that these are part of the administrative process of benefit administration and are not part of the benefit plan itself. Ms. Brown testified that these are elements of the administrative process which every carrier has and are not within the control of the Employer. She testified that carriers revisit these limits every year or two, and so they may change at any time. In fact, she noted, the carrier does not always communicate to the Employer when changes are made. The Employer submits it was transparent with the Union about the impact of the carrier change and made all reasonable efforts to share the information it had with employees and the Union, including holding information sessions for everyone.

[59] The Employer submits that it met its obligations to share information as required by Article 18.01 and 18.02. The Employer submits that it could not provide the Union the master policy until it had one, and did provide it to the Union as soon as it actually received it. The Employer notes there is no specific time limit referenced in Article 18.01. As for the requirement to provide the "full specifications" in Article 18.02, the Employer submits the parties did not mean the master

policy, since they would have said that if that were the case, just as they did in Article 18.01. The Employer also submits there is no specific time limit in Article 18.02 for the provision of this information. That said, the Employer also submits that it did provide extensive information to the Union, pointing specifically to two documents titled “Change in Benefits Carrier – Overview” and “Benefits Carrier Change – Frequently Asked Questions”. These documents, provided to the Union in November 2018, made reference to a number of matters related to the benefits (including the dispensing fee cap) and issues related to transferring the processing of claims to Sun Life. The Employer submits that it provided the Union the information it had when it was available. The Employer submits that the Union’s suggestion that Article 18 should be read as preventing the Employer from changing carriers until the policy is fully prepared simply is not supported by the collective agreement language.

[60] Having considered the parties’ submissions, the Board finds that the Employer breached Article 18.02. First of all, we observe that CUPE 1144 did not receive notice of the change to Sun Life sixty days before it took effect. However, we are also of the view the nature of the notice provided to both CUPE locals was not sufficient to meet the collective agreement obligations.

[61] We agree with the Employer that the second sentence does not set out three distinct obligations on the part of the Employer. This is made clear when the sentence is read without reference to the timing of the notice - “the Hospital shall notify the Union…*to* explain the proposed change *and to* ascertain the views of the employees”. If in fact there were three distinct obligations, it would read “the Hospital shall notify the Union…*and* explain the proposed change *and* ascertain the views of the employees”. We find that a proper reading of this sentence is that the latter portion of that sentence indicates the purpose of the required notice - “to explain the proposed change and to ascertain the views of the employees”. That means in order for the notice provided to be sufficient, it should have enough information to both explain the proposed change and to ascertain the views of the employees.

[62] In the present case, the notice failed to meet this threshold with respect to the addition of the dispensing fee cap. That is clearly a change to the benefit plan, one which the Employer now acknowledges. It failed to advise the Union of this change. We reject the Employer’s submission that compliance should be measured based on the Employer’s subjective opinion about whether something constitutes a change. This sort of subjective approach is not supported by the language of the provision.

[63] We do not, however, find that the notice was insufficient because it did not include reference to the APN. This is because the obligation in the second sentence of Article 18.02 is

to notify the Union of a change flowing from the substitution of the carrier. We have found that the introduction of the APN was a failure to meet the obligation to provide benefits at the specified level. However, it was not a change flowing from the Employer's change of carriers, which is most evident from the fact that it was a decision of the Employer that was not implemented when Sun Life took over but months later, when the Employer determined it should take effect. As such, there was no obligation to give notice of the APN at the time notice of the change of carrier was given.

[64] As for notice about the reasonable and customary limits, we have already determined that the issue of whether the change to Sun Life's reasonable and customary limits was a breach of Article 18 is moot. In order to conclude the Employer was required to give notice under Article 18.02 about the change we would have to determine whether it was a "change" that was required to be explained. In our view the issues are inextricably linked, and therefore captured in our determination that we would not exercise our discretion to allow the dispute about the change to reasonable and customary limits to proceed.

[65] We have not considered whether the required notice about the dispensing fees the Employer provided was sufficient in light of the second purpose of the notice - "to ascertain the views of employees". This is because it is not necessary to do so. We have already found the notice was insufficient on the basis it failed to explain the change. Whether or not the notice was sufficient to ascertain the views of employees would not alter our conclusion that there was a breach of the collective agreement with respect to the notice provided.

[66] The final issue is the Employer's provision of the master policy and "full specifications" to the Union. Article 18.01(f) does not specify when the master policy is to be provided. As noted by Ms. Brown, the standard in the industry is that the policy is not prepared until after the contract goes into effect. In light of this uncontested evidence about the industry standard, we do not agree with the Union's suggestion that the obligation in Article 18.01(f) should be interpreted as meaning the Employer cannot change carriers until it is able to provide the master policy to the Union. The collective agreement must be interpreted reasonably, and if the parties wanted to place an obligation on the Employer about the timing of the provision of the policy which did not accord with the general practice in the industry, they should have done so with clear language. That said, the provision must have some meaning, and the most reasonable interpretation is that this obligation must be met within a reasonable period of time. Ms. Brown indicated that a policy typically takes about six months to prepare, but that this was not a typical situation because of the complexity of harmonizing a number of different plans applying to a number of different

employee groups. However, six months is notably different from the sixteen months it took to finalize the policy. In our view, the obligation lays with the Employer to explain why the additional ten months was necessary and required. The simple assertion that the matter was complicated is insufficient to draw that conclusion. We note there was no evidence indicating any efforts on the part of the Employer to ensure the master policy was obtained as soon as possible, nor any evidence that it could not have been obtained any earlier than the sixteen months. We find that there was a breach of Article 18.01(f).

[67] The Union also asserts the Employer violated Article 18.02 by not providing the "full specifications of the benefit programs contracted for and in effect for employees" to the Union. In our view, the "full specifications" are not the master policy. If that is what the parties had intended, they would have used that language, as they did in Article 18.01. We also find that while the collective agreement states this information is to be provided "upon a request by the Union", it must be considered within the context of the standard practice. The Board finds that providing the Union in November 2018 with the two documents related to the benefit changes, followed by the brochure in October 2019, was reasonable when considered in the context of the evidence about standard industry practice and the complexity of the issues involved. In other words, we do not find a breach of Article 18.02 with respect to the timing of the information provided.

DISPOSITION

[68] The grievances are upheld in part, as follows:

a) The Employer breached Article 18.01 and 18.02 by failing to provide benefit coverage at the required level, and in particular with respect to dispensing fees and the APN.

b) The Employer breached Article 18.01 by failing to provide the Union with a copy of the master policy in a reasonable time.

c) The Employer breached Article 18.02 by failing to give the Union the required notice with respect to the move to Sun Life, and in particular with respect to dispensing fees.

d) The Employer did not breach Article 18.02 in terms of the notice provided to the Union about the implementation of the APN.

e) The Employer did not breach Article 18.02 with respect to timing of the provision of the "full specifications of the benefit programs" to the Union.

[69] Employees impacted by the implementation of the APN are to be made whole. As noted earlier, by agreement of the parties, we remain seized with respect to employee reimbursement issues relating to dispensing fees and the reasonable and customary limits.

[70] We remain seized with respect to issues related to implementation of our decision.

DATED THIS 12th DAY OF AUGUST, 2022.

"Jasbir Parmar"
_____
JASBIR PARMAR, Chair

"Joe Herbert"
_____
JOE HERBERT, Union Nominee

Dissent in part - attached
_____
GREG SHAW, Employer Nominee

Dissent of the Employer Nominee

On the issue of the Dispensing Fee Cap, it is unnecessary to find a breach of the Collective Agreement. The Employer acknowledged an error in implementing said cap and undertook to make Employees whole. Like the R&C issue this matter should have been rendered moot. I fail to understand what Labour Relations value there is in this Board stating there was a violation of the Collective Agreement, when the Employer has acknowledged their error and offered to compensate employees who may have been disadvantaged.

On the APN issue, I believe that the implementation of the APN was well within the scope of Management Rights. In addition, the contract with the Carrier provides a right to *" …**restrict claims from certain providers and to exclude any health care services and supplies.**"*(paragraph 44 of the Award) . Therefore, the Carrier, has the ability to restrict certain providers. The creation of the APN is simply the other side of that coin and should be considered nothing more than an Administrative process that does not deny benefits to Employees. There was no loss of benefits coverage. The APN has more than 350 approved providers with the ability to add other providers who may apply to become part of the APN. This should be more than sufficient to meet the needs of Employees and their dependents.

A well publicized fraud was uncovered concerning the improper use of coverage for medical devices. This fraud was perpetrated on several Employers in the GTA. The overall cost of this fraud was reported to be several million dollars. Seventy-two employees of Unity Health were terminated for fraudulent use of this benefit. The creation the APN was a reasonable, and in my view, necessary exercise of Management Rights to protect from future fraud. This award makes that very difficult for not just this Employer but for other Employers seeking to protect themselves from fraud.

The creation of the APN should have been allowed as a proper exercise of Management Rights.

Respectfully submitted,

Greg Shaw