Chapter 3
3sHealth—Managing Disability Claims

1.0 Main Points

Health Shared Services Saskatchewan (3sHealth) is responsible for administering four disability income plans for certain healthcare employees (e.g., working in hospitals or long-term care facilities) in Saskatchewan. 3sHealth staff assess and adjudicate disability claims, and may obtain advice from medical advisors to help guide adjudication decisions or from physicians to help interpret medical information and the appropriateness of treatment.

At October 31, 2021, our audit found 3sHealth had generally effective processes to manage disability claims for certain healthcare employees, but needs to improve its processes to address delays experienced by members.

3sHealth does not always process incoming disability benefit applications in a timely manner, which delays claims adjudication and resulting benefit payments. For about one-third of the applications we tested, staff submitted completed applications to adjudicators between four to 11 business days after the application completion date. Such delays place more stress on members waiting for decisions on their disability claims and impacts subsequent payment of benefits.

In addition, 3sHealth does not always make appeal decisions in a timely manner. Collective bargaining agreements provide members with the ability to appeal disability claim decisions. As set out in collective bargaining agreements, 3sHealth expects staff to review and make a decision regarding an appeal within 30 business days of receipt. Our data analysis found, during 2020 and 2021, 3sHealth made over 80% of its appeal decisions later than the expected 30 days.

Furthermore, 3sHealth needs to:

- Enhance its reports to senior management and the Board of Trustees to include all key performance information, analysis of results, and action plans to address issues
- Centrally track and analyze plan member complaints regarding disability benefit claims

Effective processes to manage disability claims can contribute to timely recovery of injured or ill employees. It helps minimize delays in employees receiving the appropriate support and treatment needed to improve their mental and physical health, and return to work.

2.0 Introduction

This chapter outlines results from our audit of Health Shared Services Saskatchewan's (3sHealth) processes to manage disability claims for certain healthcare employees for the 12-month period ending October 31, 2021. This audit did not question medical decisions of healthcare providers for the disability claims.

2.1 Managing Disability Claims

Through its service agreement with the Employee Benefit Plans' Board of Trustees, 3sHealth is responsible for administering four disability benefit plans for certain healthcare employees (i.e., plan members) in Saskatchewan.[1,2] For example, plan members include healthcare workers in hospitals, emergency services, and long-term care facilities across the province. At October 2021, there were 40,144 healthcare employees from various healthcare organizations among the four disability income plans (**See Figure 1**).

Figure 1—Number of Healthcare Employees in Each Disability Plan (October 2021)

	CUPE	SEIU–West	SUN	General	Total
Employee Members	11,789	10,605	9,745	8,005	**40,144**

Source: Adapted from information provided by 3sHealth.

The disability plans provide protection for members against loss of income due to injury or illness. Each plan is self-insured. Both employers and employees contribute to the plan in accordance with the respective collective bargaining agreements. The contributions and resulting investments fund the plan (see **Figure 2** for 2020 contributions).[3] The Employee Benefit Plans' Board of Trustees set the contribution rate annually for each plan.

Figure 2—Contributions and Surplus Position (in millions) by Disability Plan for 2020

	CUPE	SEIU–West	SUN	General	Total
Employee Contributions	$5.3	$4.3	$4.1	$3.2	**$16.9**
Employer Contributions	$5.3	$4.3	$4.8	$3.2	**$17.6**
Total Contributions	**$10.6**	**$8.6**	**$8.9**	**$6.4**	**$34.5**
Surplus	$49.4	$29.3	$40.0	$25.0	**$143.7**

Source: Adapted from 3sHealth Disability Income Plan Audited Financial Statements.

As shown in **Figure 3**, the number of disability claims for each plan has increased over the last four years. Claims for the first 10 months of 2021 already exceeded the total number of claims in 2020 with 34 and 23 diagnosed COVID-19 claims in 2021 and 2020 respectively.

Figure 3—Number of Disability Claims by Plan

Year	CUPE	SEIU–West	SUN	General	Total
2018	1,204	986	312	252	**2,754**
2019	1,438	1,096	340	238	**3,112**
2020	1,447	1,168	373	275	**3,263**
2021 (January–October)	1,348	1,640	371	292	**3,651**

Source: Adapted from information provided by 3sHealth.

With increasing claims, 3sHealth has also seen an increase in payments made to members (see **Figure 4**).

[1] 3sHealth's Board of Directors signed a formal trust agreement with the Employee Benefit Plans' Board of Trustees in January 2015 effectively making it the governing authority for the four disability plans.
[2] Disability benefit plans include Canadian Union of Public Employees (CUPE), Service Employees International Union–West (SEIU–West), the General Plan, and the Saskatchewan Union of Nurses (SUN).
[3] *Long-term Disability Plan Commentary*, p. 4 (CUPE, SEIU–West, SUN, General).

Figure 4—Disability Claim Payments from 2018 to 2021

	2018	2019	2020	2021 (January–October)
	(in millions)			
Disability Claim Payments	$36.6	$40.9	$47.9	$42.0

Source: Adapted from information provided by 3sHealth.

Depending upon the nature of the plan members' health, they may be able to return to work with modifications (e.g., return to work part-time or return full-time with different duties). For members needing modifications, 3sHealth along with the employee, employer, and health professionals work together to customize a suitable return to work program based on members' abilities.

In spring 2019, 3sHealth began work on a disability claims management redesign project called "Path to Health." The focus of this three-year project was to improve members' experiences through the disability claim lifecycle, align disability management processes with good practice, select a rehabilitation service provider, and look for options to replace the current claims management IT systems.

2.2 Importance of Effectively Managing Disability Claims

According to the Canadian Society of Professionals in Disability Management, at any given time, 8% to 12% of the workforce in Canada is off work due to injury, and receiving workers' compensation, long-term disability, or weekly compensation benefits. A serious injury or illness can mean loss of income and future security, which can create emotional, personal, and financial difficulties for the injured employee.[4]

The long-term effects of the COVID-19 pandemic on Canada's health workforce, including mental health, remain to be fully seen. Healthcare workers continue to provide care for patients despite exhaustion, personal risk of infection, fear of transmission to others, and the loss of patients and colleagues.[5]

Moreover, the longer individuals stay away from work with a disability, the less likely they are to return to employment. After one year of absence, only 20% of employees return to work.[6]

Effective processes to manage disability claims can contribute to timely recovery of injured or ill employees. It helps minimize delays in those employees receiving the appropriate support and treatment needed to improve their mental and physical health, and to return to work.

[4] The Canadian Society of Professionals in Disability Management is part of the International Association of Professionals in Disability Management, an organization overseeing the global certification process of two professional designations: Certified Return to Work Coordinators and Certified Disability Management Professionals. www.cspdm.ca/dm-in-context/impact-of-disability/ (21 September 2021).
[5] www.cihi.ca/en/health-workforce-in-canada-highlights-of-the-impact-of-covid-19/overview-impacts-of-covid-19-on (12 October 2021).
[6] The Canadian Society of Professionals in Disability Management, *Impact of Disability,* www.cspdm.ca/dm-in-context/impact-of-disability/ (21 September 2021).

3.0 AUDIT CONCLUSION

We concluded that, for the 12-month period ended October 31, 2021, Health Shared Services Saskatchewan (3sHealth) had, other than in the following areas, effective processes to manage disability claims for certain healthcare employees.

3sHealth needs to:

- **Provide complete disability benefit claim applications to adjudicators in a timely manner**
- **Follow its established timelines to complete disability claim appeal reviews and document reasons for significant delays**
- **Enhance its reports to senior management and the Board of Trustees to include all key performance information, analysis of results, and action plans to address issues**
- **Centrally track and analyze complaints regarding plan member disability benefit claims**

Figure 5—Audit Objective, Criteria, and Approach

Audit Objective:

The objective of this audit was to assess whether 3sHealth had effective processes to manage disability claims for certain healthcare employees for the 12-month period ending October 31, 2021.

Audit Criteria:

Processes to:

1. **Adjudicate disability claims and appeals**
   - Set policies and procedures for adjudicating disability claims and appeals, aligning with good practice
   - Communicate clear requirements for submitting disability claims and making appeals
   - Assess disability claims (e.g., use qualified, independent staff to assess eligibility)
   - Issue timely decisions (e.g., claims, benefits, with rationale)
   - Reassess disability claim decisions when requested by members (i.e., appeals)
2. **Administer disability claims**
   - Facilitate creation of members' recovery plans in collaboration with key partners (e.g., medical practitioners, employers)
   - Actively manage implementation of recovery plans (e.g., member check-ins, referrals to rehabilitative supports, gradual return to work)
   - Periodically reassess members' disability claims and benefits
3. **Monitor and report on claims managed**
   - Maintain quality assurance processes (e.g., claim file reviews, detecting fraudulent claims/inaccurate data, member surveys)
   - Analyze key information about disability claims management (e.g., timeliness of decisions, number of members returning to work, duration of claims, number of appeals)
   - Periodically report key information to senior management and Board of Trustees

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate 3sHealth's processes, we used the above criteria based on our related work, review of literature including reports of other auditors, and consultations with management. 3sHealth's management agreed with the above criteria.

We examined 3sHealth's policies and procedures relating to managing disability claims. We interviewed key staff responsible for adjudicating and managing disability claims. We tested a sample of declined and approved disability claims, including appeals, to assess whether staff followed 3sHealth's established processes for managing disability claims. We also conducted data analytics on the data in 3sHealth's IT system. In addition, we used an independent consultant with subject matter expertise in the area to help us identify good practice and assess 3sHealth's processes.

4.0 KEY FINDINGS AND RECOMMENDATIONS

4.1 Requirements for Disability Claims and Appeals Clearly Communicated

3sHealth makes plan members and employers aware of the requirements for submitting disability claims and making appeals through its website, booklets and welcome packages for members, and through newsletters.[7]

3sHealth uses its website to provide members with an overview of disability benefits (e.g., how to apply, what forms to complete), to answer frequently asked questions, and to direct members to booklets on each of the four disability income plans. We found the website easy to navigate in providing members with clear and sufficient information about applying for benefits and filing appeals if their application is denied or benefits are terminated (see more on appeals in **Section 4.7**).

The collective bargaining agreements between the unions and employers for each plan outline member eligibility for disability benefits. 3sHealth maintains members' booklets for each disability income plan and makes them publicly available on its website. We found the members' booklets provide clear and sufficient detail on each plan, for example:

- Plan details and eligibility for benefits (e.g., a member must be unable to perform their job duties due to illness or injury)
- How to apply for disability benefits, the forms to be submitted to 3sHealth (e.g., employee application, employer application, attending physician statement), and other supporting documents required (e.g., void cheque, medical test results)
- The adjudication process, noting that a 3sHealth adjudicator will review an application once the application is complete (i.e., all forms and supporting documentation have been received) and make a decision within eight business days
- Disability coverage and benefit information[8]
- How to request a review for a denied or terminated claim (i.e., the appeal process)

[7] www.3shealth.ca/employee-benefit-plans (7 February 2022).
[8] Members of CUPE and SEIU–West are eligible for short-term benefits that equals 66.66% of pre-disability regular weekly earnings to cover the first 119 days from the date of disability if members' sick leave does not cover that period. After the 119 days, CUPE and SEIU–West members receive long-term benefits equalling 60% of pre-disability regular monthly earnings. SUN and General members do not have short-term disability benefits. Members receive 75% of pre-disability regular monthly earnings after 119 days from the date of disability.

In addition, 3sHealth clearly requires members to apply to other disability programs, such as Workers' Compensation Board (for a workplace injury) and Saskatchewan Government Insurance (for a motor vehicle accident injury) prior to applying for benefits through 3sHealth.

3sHealth also provides (via mail) a welcome package to all new members. It includes such information as disability income plan eligibility, reference to 3sHealth's website for members' booklets, how to contact 3sHealth (e.g., email, phone numbers), and a brief overview of the various disability income benefits. We found the welcome package provides members with the necessary information to apply for disability benefits.

In addition, 3sHealth sends out an *Employee Benefit Plans* newsletter to its members twice a year. We found some newsletter topics related to processing disability claims (e.g., the goal to make a claim decision within eight business days of receiving a complete application) or success stories of members on disability benefits.

We also found that if changes to disability benefits terms (e.g., changes to the contribution rates for disability plans) or to 3sHealth's processes occur, 3sHealth provides an update to employers through ad hoc bulletins. In addition, it meets with employers monthly to discuss any questions or issues regarding disability benefits.

Providing all parties with clear, accessible, and understandable information about disability benefits, including how to apply, helps them know what to expect during the disability claim process.

4.2 Well-Defined Procedures to Adjudicate and Manage Claims

3sHealth maintains up-to-date, clear, and understandable standard procedures about adjudicating and managing disability claims.

3sHealth provides its staff with standard procedures for processing incoming applications, setting up members' information in the claims management IT systems, adjudicating claims, establishing a plan to manage a claim (e.g., routinely contact members, refer members to rehabilitation services such as psychology, physiotherapy), and handling appeals.

We found all procedures current (i.e., updated within the last two years), easy to understand, and accessible to staff (i.e., located on an the intranet). All work standards clearly outline staff roles and responsibilities, and provide clear decision-making structures.

We also found that procedures not only align with good practice, but also with terms set out in the collective bargaining agreements (e.g., necessary claim information, timelines for appeal decisions).

Having clearly written and up-to-date procedures helps 3sHealth communicate expected processes to staff responsible for adjudicating and managing disability claims.

4.3 Delays in Processing Incoming Applications

3sHealth does not always process incoming disability benefit applications on time, which delays the adjudication of claims.

A claim application for disability benefits is complete when 3sHealth receives both employee and employer applications, and an attending physician statement. See **Figure 6** for the information 3sHealth requires from each party to complete these forms.[9] 3sHealth makes these forms available on its website.[10]

Figure 6—Information Required to Complete a Disability Claim Application

Employee Initial Application	Employer Initial Application	Attending Physician Statement
• Plan member information (e.g., name, address) • Claim information (e.g., medical condition preventing member from working, nature of medical condition, expected date of return to work) • Other income received (including other benefits from SGI or WCB) during absence from work • Direct deposit information	• Plan member information • Payroll information (e.g., member's position, date member last worked, number of hours in a regular work week) • Additional information (e.g., return to work plan) • Employer information (e.g., payroll, attendance, and accommodations contacts) • Job description	• Plan member information • Diagnosis (e.g., primary diagnosis and its date, whether work-related) • Treatment/care plan (e.g., medication taken, hospitalization date(s), future plans) • Functional abilities (e.g., member's restrictions and limitations, expected return to work date or timeframe)

Source: Based on information provided by 3sHealth.

When 3sHealth receives a completed application, its benefit service officers set up a member profile in the claims management IT systems. The benefit service officers are required to contact members (via phone, letter, and/or email) the same day advising their application is complete and then submit it to an adjudicator to assess members' eligibility and coverage.

3sHealth receives about 250 disability benefit applications monthly. At October 2021, 3sHealth had 15 benefit service officer positions (including five temporary officers, one vacant position, and one officer on leave) to process applications, as well as other duties such as processing member enrolment forms and retirement requests.

For the 30 applications tested, we found the benefit service officers called and sent emails to members advising their application was complete. However, officers did not always make timely application submissions to the adjudicator, which caused delays in decision-making. For example, for 12 out of 30 applications tested, we found the delays in submitting completed applications to adjudicators ranged from four to 11 business days after application completion date (i.e., the day the last piece of the application was submitted). As a result, some members did not receive a claim decision up to 30 days later.

3sHealth management noted that such delays are due to the increased number of claims 3sHealth received in the last two years. As described in **Figure 3**, 3sHealth already received more disability claims in the first 10 months of 2021 (3,651 claims) compared to all claims in 2020 (3,263 claims) and 2019 (3,112 claims). Management indicated this is due to the ongoing impact of the COVID-19 pandemic on front-line healthcare workers (e.g., work-related demands on their physical and mental health).

[9] Forms can be submitted by email, mail, fax, or in person.
[10] Forms available at www.3shealth.ca/applying-for-disability-benefits (7 January 2022).

Delays in processing incoming applications cause further delays in adjudicating, which places more stress on members waiting for decisions on their disability claims and subsequent payment of benefits.

1. **We recommend Health Shared Services Saskatchewan send completed disability benefit claim applications to adjudicators on time.**

4.4 Qualified and Objective Personnel Adjudicate Disability Claims

3sHealth hires qualified personnel to assess and adjudicate disability claims, and it requires its staff to declare conflicts of interest.

The Employee Benefits Division at 3sHealth is responsible for managing disability claims and appeals. At October 2021, Claims Services had 19 positions: one claims manager, two claims services specialists, 12 adjudicators (two positions vacant and one adjudicator on leave), two rehabilitation advisors, and two mental health advisors (one position vacant).

Adjudicators use medical advisors (i.e., mental health advisors, rehabilitation advisors) as a source of advice for understanding medical conditions (e.g., multiple sclerosis' impact on a member's ability to perform their job) and helping to guide adjudication decisions. 3sHealth also uses physicians to help understand and interpret medical information, as well as to advise whether a plan member's treatment is appropriate.

3sHealth appropriately uses job descriptions to set out expected educational and experience requirements for its staff involved in adjudicating claims. It expects adjudicators to have at least five years of experience in disability claims adjudication. In addition, it expects the claims services specialists and manager to have three to six years of experience in benefit plan administration, insurance, or claims management.

We found the two adjudicators, two specialists, and the manager we tested had significantly more applicable experience than required. Further, we found all three medical advisors 3sHealth used for consultation had appropriate education and certification for their positions (e.g., mental health advisor is a psychiatric nurse), along with experience in rehabilitation.

3sHealth also contracts two physicians to provide consultations for adjudication and appeals. Both contracted physicians were licensed by the College of Physicians and Surgeons of Saskatchewan and in good standing as of November 2021.

Upon hiring, 3sHealth provides adjudicators with on-the-job training specific to their responsibilities (e.g., how to use 3sHealth's claims management IT systems). Medical advisors provide ad hoc training to adjudicators on topics of interest (e.g., rehabilitation after stroke) to deepen adjudicators' knowledge about different medical conditions and recovery expectations.

Between June 2020 and April 2021, 3sHealth offered its adjudicators in-house courses on nine different areas as set out in **Figure 7**. It expected adjudicators to take at least two courses. We found all adjudicators employed with 3sHealth at April 2021 took two or more of the offered courses. Throughout the remainder of the year, adjudicators received ad hoc training (e.g., stroke rehabilitation, functional capacity evaluations) from medical advisors.

Figure 7—3sHealth's In-House Courses Offered to Adjudicators

• Documentation • Communication skills for client-centred service • Time management and prioritization • Cultural sensitivity • Addictions	• Business writing skills • Supporting grief and loss • Different types of grief and loss • Self-care, wellness, and resilience

Source: Adapted from information provided by 3sHealth.

In addition, 3sHealth has a process for its staff to declare any conflicts of interest to ensure they remain objective when adjudicating claims. Each year, it requires staff to sign an annual code of conduct with a conflict of interest declaration. For two adjudicators and two medical advisors tested, we found each signed the code of conduct declaration, noting no conflicts of interest.

For claims where the assigned adjudicator or advisors know the plan member, they are to inform the claims specialists and remove themselves from the claim. In our testing of 30 disability claims, we found one instance where the medical advisor declared a conflict of interest and appropriately removed themselves from providing consultation on the claim.

Having qualified and trained staff to adjudicate claims helps ensure plan members receive a fair assessment of their eligibility and coverage for disability benefits. Moreover, objective staff reviewing and making decisions on claims reduces the risk of bias, either real or perceived, in making claim decisions.

4.5 Advice Sought and Rationale Documented for Disability Claim Decisions

3sHealth adjudicators seek input from medical advisors when needed and document claim decisions in members' files.

Using the forms submitted by both employees and employers, adjudicators make decisions about whether members are eligible and have coverage (e.g., a casual employee must have worked at least 390 hours in the first 26 weeks of employment).

Adjudicators primarily make a claim decision—whether to approve or deny an application—based on provided medical information (e.g., initial physician statement along with test results, reports) about the member's medical condition and its impact on the member's ability to perform their job duties. To be eligible for disability benefits, provided medical information must show that a member is unable to perform their job duties due to illness or injury (e.g., a care aide cannot perform their duties due to knee replacement surgery).

3sHealth received about 250 claims each month from November 2020 to October 2021. This means each adjudicator has to make a decision on about 28 new claims a month, as well as manage existing claims and appeals. As noted in **Section 4.4**, 3sHealth has three adjudicator vacancies as of October 2021.

Adjudicators may seek advice from claim specialists (e.g., if an adjudicator is unsure about a member's eligibility for disability benefits) or medical advisors, including contracted physicians. Such advice is necessary when adjudicators need more clarification

concerning a member's medical condition and/or recovery (e.g., plan member has a diagnosis like a rare blood disorder).

In our testing of 30 claims, we found adjudicators appropriately sought medical advice for eight applications; a rehabilitation advisor was consulted for two applications, a mental health advisor was consulted for four applications, but could not consult on one application because of a conflict of interest, and a contracted physician was consulted for one application. Medical consultations include discussions about prolonged recovery, treatment plans and specific medical conditions.[11]

3sHealth reported that the top four medical diagnosis for disability benefits claims in the last 2.5 years were:

- Musculoskeletal injuries (e.g., carpal tunnel syndrome)
- Mental or nervous disorders
- Neurological conditions
- Cancer

In addition, we noted the number of diagnosed COVID-19 claims in 2020 and 2021 was 23 and 34 claims respectively (about 1% of all claims in those years).

During our testing of 30 claims, we found adjudicators appropriately documented each decision—to approve or deny a claim—in members' files with rationale (e.g., evidence of adjudicator review of medical information and input from medical advisors). For the 30 claims tested, we found adjudicators approved 28 claims and denied two.

For both denied claims, adjudicators provided rationale for their decision in the file, sent a denial letter to each member outlining reasons for denial, as well as phoned each member to explain details of the claim denial (e.g., one claim denied due to the medical condition not being work-related).

For the 28 approved claims, we found:

- Adjudicators called members the same day they made their decision.
- All members received appropriate information (e.g., letter, paystub) outlining the decision, along with the duration and benefit amount the member will receive.
- All members had their benefits correctly calculated. For three members receiving benefits from another disability program (e.g., CPP, SGI), 3sHealth appropriately adjusted their benefits.

Seeking advice and documenting rationale for claim decisions helps ensure members' claims are consistently assessed and properly supported.

[11] We found on average, for the period November 2020 to October 2021, 3sHealth engaged two rehabilitation advisors in a review of medical information for about 35 claims each month. These advisors also provided consultation (e.g., answered adjudicators' questions) for about 20 claims each month. For the same period, 3sHealth used a mental health advisor for a review and consultation of about 15 claims each month. Adjudicators sought contracted physicians' advice for 47 claims in total for the same period.

4.6 Claims Decisions Monitored for Timeliness

3sHealth makes disability claim decisions within eight business days of receiving a completed application and monitors claim decisions taking longer than four business days (i.e., 3sHealth's internal target).

3sHealth, through various means (e.g., website, members' booklets, emails), makes members aware that adjudicators will make a decision on their claim within eight business days of receiving a complete application. Management indicated they communicate an eight-day timeframe to members, and adjudicators strive to make a decision within four business days of receiving a complete application. This is consistent with good practice.

As shown in **Figure 8**, for the 30 claims we tested, we found 3sHealth made a decision on 26 applications (87%) within eight business days.

Figure 8—Timelines for 30 Claim Decisions Tested

Number of Business Days to Decision From Complete Application	Number of Applications	Percentage of Claim Decisions Made on Complete Applications
Within 4 days	5	17%
Within 8 days[A]	26	87%
> 8 days	4	13%

Source: Based on our testing of plan member files.
[A] Applications decided within eight days also encompasses those applications decided within four days.

When adjudicators do not make a decision within eight business days, the delay is typically a result of waiting for additional medical information or needing to consult with a medical advisor. However, in one case, management indicated a misplaced manual application resulted in 3sHealth having no contact with the member for 52 days nor did the member contact 3sHealth about the delay. Once the file was found, the adjudicator requested additional medical information (which took 69 days to receive). The adjudicator did not make a decision until 144 days after receiving the complete application.

3sHealth is not meeting its internal target of providing a claim decision within four business days as it only made a claim decision on five applications tested (17%) within that timeframe. Management indicated delays are due to having three vacant adjudicator positions, along with 3sHealth receiving more disability claim applications than in past years (see **Figure 3**).

In addition, adjudicators are not always receiving completed applications in a timely manner, which caused delays in decision making (see **Section 4.3**).

At October 2021, our data analysis showed the caseload per adjudicator averaging, at that point in time, between 135 and 160 claims (i.e., processing new claims and managing existing claims). Management stated its goal is 120 claims per adjudicator which is marginally above good practice of 100 claims.

Each day, claims services specialists monitor the number of overdue claim decisions (i.e., exceeding four days). For example, on November 2, 2021, there were 10 overdue claim decisions. The claims services specialists noted they are responsible for managing adjudicator caseloads and discussing overdue claim decisions as needed.

We encourage 3sHealth to continue toward meeting its four-day target for making claim decisions once adjudicators receive completed applications. This will help ensure members do not wait extended periods of time, which causes undue stress while waiting for decisions and benefits.

4.7 Appropriate Appeal Process in Place

3sHealth has an adequate appeal process available to members who are dissatisfied with their disability claim decision.

3sHealth may deny a disability claim or terminate benefits for two main reasons:

- **Medical**: the disability plan does not support the member's disability as outlined in their medical information
- **Administrative**: pre-existing condition (i.e., health condition that a member had or received treatment for six months prior to joining the plan), late application, or no coverage (e.g., temporary employee who does not qualify for disability coverage)

A member dissatisfied with the adjudicator's decision has a right to request a review if they believe information is missing from the application, or if they believe the adjudicator incorrectly applied the plan's terms to their claim. As set out in the collective bargaining agreements, members can appeal 3sHealth's disability claim decisions.[12] Members have 60 days after the initial decision or termination of benefits to make an appeal. They can email or mail their request for appeal and provide additional information to 3sHealth (e.g., additional medical information such as exams and lab results).

There are three levels of appeal reviews available to members (see **Figure 9**).

Figure 9—Levels of Review for Appeals

Review Level	Performed By	Review Considers
First Level	3sHealth adjudicator and one claims specialist with a medical consultant available	Medical information and administrative terms such as late application or eligibility for plan membership
Second Level	3sHealth claims services manager with a medical consultant available	Medical information and administrative terms such as late application or eligibility for plan membership
Third Level (Final Adjudication)	External adjudicator (i.e., physician)	Medical information only

Source: Adapted from information provided by 3sHealth.

To complete its first and second appeal reviews, 3sHealth uses standard forms (i.e., one for medical appeals and another for administrative appeals) that document information such as claim details, appeal information, and recommendation (i.e., agree or disagree with the initial or termination decision). Claims specialists, medical advisors, and the claims service manager (if required) will review the forms and sign off on the decision. Once the decision is made, 3sHealth provides the member, as well as the employer, with the written appeal decision.

[12] 3sHealth does not receive appeals from employers as the main basis for appeals is medical information, and employers do not, and should not, have access to such information.

Once the two-stage, internal appeal process is complete, and 3sHealth denied or terminated the claim on medical grounds, a member can chose to proceed to an external, independent adjudication. The external adjudicator is a physician chosen by an External Appeal Committee, comprised of employers' and unions' representatives. External adjudicators sign a contract with 3sHealth outlining roles and responsibilities for completing appeals. For the period of November 2020 to October 2021, 3sHealth used three physicians to complete external adjudications.[13] We found all three external adjudicators were licensed physicians in good standing.

We found 3sHealth's appeal process and forms used for appeals align with good practice.

We tested six appeals and found:

- Members submitted five appeals within 60 days, as required. For one third-level appeal, the member did not submit the appeal until 282 days after the decision was made. However, 3sHealth granted multiple extensions on the appeal due to COVID-19 restrictions and the member's inability to see a medical specialist.
- Staff used the appropriate appeal form to document the member's medical information, appeal summary and recommendation, and the medical advisor's agreement with the decision for all first and second level appeals.
- 3sHealth staff engaged medical advisors when needed and appropriately forwarded the third-level appeal to an external adjudicator (i.e., physician).

As shown in **Figure 10**, our data analysis found a small number of claims are denied, and the number of first-level appeals (on denied claims) has been declining (22.7% appealed in 2021 compared to 49.3% appealed in 2019).

Figure 10—Number of Appeals Compared to Total Number of Claims

Year	Number of Claims	Denied Claims	First-Level Appeals	Percentage of First-Level Appeals on Denied Claims	Second-Level Appeals	Third-Level Appeals
2019	3,112	150	74	49.3%	24	9
2020	3,263	146	50	34.2%	8	10
2021 (January–October)	3,651	128	29	22.7%	0	2

Source: Adapted from information provided by 3sHealth.

We also found 3sHealth overturned (i.e., approved claim) about half of the first-level appeals in 2019 and 2020 (see **Figure 11**). In addition, we found 3sHealth overturned the majority of decisions during appeal review, mainly due to members providing new medical information (more than 98% for both first and second appeal levels).

[13] One contract expired in July 2021 and was not renewed.

Figure 11—Number of Overturned Claims Decisions

Year	First-Level Appeals Overturned	Percentage of First-Level Appeals Overturned	Second-Level Appeals Overturned	Percentage of Second-Level Appeals Overturned	Third-Level Appeals Overturned	Percentage of Third-Level Appeals Overturned
2019	36	49%	10	42%	4	44%
2020	29	58%	3	38%	3	30%
2021 (January–October)	5	17%	0	0%	1	50%

Source: Adapted from information provided by 3sHealth.

Having an appropriate appeal process increases members' confidence they will be treated fairly and that any errors in decisions will be rectified.

4.8 Appeals Not Always Decided in a Timely Manner

3sHealth does not always make appeal decisions in a timely manner; nor does it document rationale for not meeting expected timelines.

As set out in the collective bargaining agreements, 3sHealth expects staff to review and make a decision on all appeals within 30 business days of their receipt. It tracks all appeals in a spreadsheet, noting receipt dates, review completion dates, number of business days to assess appeals, and the appeal outcome.

As shown in **Figure 12**, our data analysis found 3sHealth does not make timely appeal decisions. For example, we found the average time to complete first and second level appeal reviews (i.e., to make a decision) in 2020 was 59 days and 49 days in 2021 (up to October) with over 80% of all appeal decisions made later than the expected 30 days.

Figure 12—Timeliness of First and Second Level Appeals

Year	First-Level Appeals	Second-Level Appeals	Number of Appeals Reviewed Longer Than 30 Days	Percentage of Appeals Reviewed Longer Than 30 Days	Average Time to Review Appeals (Days)	Maximum Number of Days to Review Appeals
2019	74	24	49	50%	31	86
2020	50	8	47	81%	59	164
2021[A]	29	0	25	86%	49	93
2021[B]	10	1	9	82%	60	121

Source: The Office of the Provincial Auditor based on 3sHealth records.
[A] Appeals completed between April and October 2021.
[B] Appeals not completed as of October 2021.

For third-level appeals completed by external adjudicators, it took 48 days on average to make appeal decisions in 2020 (for 10 appeals), while it took 23 days on average (for two appeals) in 2021.

Our testing of six appeals showed similar results. We found three appeals tested took longer than 30 days:

- 3sHealth completed two first-level appeals 51 and 56 business days after receipt of the appeal. 3sHealth did not document reasons for delays.

- An external adjudicator completed one third-level appeal 35 business days after receipt of the appeal and included rationale for the delay (i.e., waiting on specific information from the member).

Management indicated increased workload in processing more claims in 2020 and 2021, as well as adjudicator vacancies, as reasons for delays in reviewing first and second level appeals.

Without timely appeal review and decisions, members may not be receiving benefits on time, which may place undue stress on plan members. Without knowing why appeal decisions take longer than expected, management cannot address root causes of delays.

2. We recommend Health Shared Services Saskatchewan follow its established timelines to complete appeal reviews on disability claims and document reasons for significant delays.

In addition, we found 3sHealth reports the number of appeals received to senior management and the Board of Trustees, but it does not report on meeting its target to review appeals within 30 business days of receipt. Without reporting on the status of appeal decisions, senior management and the Board of Trustees may be unaware of potential issues with the appeal process and therefore may not take timely action to address issues. See **Recommendation 4** about enhancing reporting to senior management and the Board of Trustees.

4.9 Complaints Not Centrally Tracked or Analyzed

3sHealth does not centrally track the number, or specific nature, of complaints related to plan member disability benefit claims and subsequent resolution. This limits 3sHealth's ability to analyze complaints and adjust processes as necessary.

3sHealth does not have documented procedures on how to handle complaints (e.g., how quickly to respond). However, if a member has a complaint or inquiry, the member can contact 3sHealth (via phone or email). 3sHealth expects adjudicators to escalate complaints or inquiries through the IT systems to management (e.g., a claims specialist) who will contact the member to resolve the issue. Escalations can also include other internal matters (e.g., determining whether an application was late) where an adjudicator may need advice from the claims specialist.

3sHealth tracks all escalations to claims specialists in its IT system. However, it does not specify whether the escalation was a complaint, inquiry, or other internal matter. Between November 2020 and October 2021, 3sHealth escalated 49 items to claims specialists.

3sHealth does not centrally track the number, or specific nature, of complaints received. Rather, 3sHealth records the complaint, and the resolution, in members' files. As a result, 3sHealth could not provide us with the total number of complaints received in our audit period. We tested three complaints (identified by management in its IT system) and found that all three were appropriately resolved within three to eight business days. For example, a member complained about their adjudicator and requested a new one because of issues in reaching the assigned adjudicator. The claims specialist contacted the member to provide an update on the claim and determined the best way for the adjudicator to contact

the member (i.e., via email rather than phone). The complaint was resolved within three business days.

Without centrally tracking complaints, 3sHealth does not know the number and nature of complaints it receives. As such, it is unable to analyze complaint information to improve its disability claims management processes.

3. **We recommend Health Shared Services Saskatchewan centrally track and analyze complaints from plan members regarding disability benefit claims.**

4.10 Quality Assurance Processes in Place

3sHealth maintains quality assurance processes for administering and managing disability claims.

3sHealth has a quality assurance process to ensure all required information for a disability claim is maintained in a member's file. 3sHealth claims services specialists complete a claims management checklist on each claim file. Each area (i.e., administrative, benefit service officer, adjudicators, claims payment officer) is required to complete and sign off on the checklist when each step of managing a claim is complete. For example, the benefit service officer verifies all required documents (i.e., employee application, employer application, attending physician statement) are complete and recorded in the file. For the 30 claim files we tested, we found each file had a completed checklist signed by appropriate individuals.

In addition, 3sHealth's claims services specialists conduct monthly quality audits of claims (one claim per adjudicator per month—about 100 audits each year) based on pre-determined criteria (e.g., claims opened for more than 12 months). These audits help 3sHealth assess whether staff properly administer and manage claims. The claims services specialists discuss the audit results with adjudicators. The audits examine three areas:

- Technical: completion of adjudication procedure (e.g., decision call to member completed, member check-ins scheduled)
- Initial claim decision: accuracy of the initial adjudicatory decision (e.g., enough information in member file to approve a claim, potential barriers such as workplace issues, transportation, childcare identified and considered in the decision)
- Ongoing management: effective use of advisors or consultants, and appropriate review and update of ongoing claims (e.g., advisors engaged appropriately, external rehabilitation referrals process followed—see **Section 4.11**)

We tested four quality audits and found the claims services specialist appropriately completed the audit form and provided comments to adjudicators about areas for improvement.

3sHealth also tracks defects (e.g., an error impacting a plan member—such as an overpayment or privacy breach) found through quality assurance checklists and audits.

Staff will follow up on defects until resolved. 3sHealth tracks various information about defects such as member name, specific issue, impact (e.g., late payment), action taken to mitigate the defect, and the date resolved. Between January and October 2021, we determined 3sHealth had approximately 2.7 defects per month, with the majority being either a late payment under $1,000 or an overpayment. We found 3sHealth appropriately resolved the defects (e.g., EFT for late payment).

Effective processes to assess the quality of administering and managing claims brings confidence to 3sHealth management that its processes to properly manage claims in a timely manner are working as intended.

4.11 3sHealth Supports Development of Return to Work Plans

3sHealth has a supporting role in members' return to work plans. It maintains regular communication with plan members and their employers regarding return to work, refers members to its external rehabilitation partner if recovery is not progressing as planned, and adjusts members' disability benefits when a member is on a gradual return to work plan.

Typically, the employer (e.g., Saskatchewan Health Authority) works with a plan member to develop a return to work plan considering the member's limitations and restrictions, if any. Return to work plans are based on members' abilities to perform their job duties. Employers provide return to work plans to 3sHealth for inclusion in members' files. In cases when other agencies are involved (e.g., Workers' Compensation Board), 3sHealth only receives updates on return to work plans and progress.

Regular Communication with Plan Members

3sHealth has regular check-ins with a member based on their expected recovery plan. For example, 3sHealth will schedule a call with a member a few weeks after surgery to enquire whether recovery is as expected. If recovery takes longer than expected, 3sHealth requests medical information (e.g., doctor's note) indicating current treatment (e.g., physiotherapy) and expected length of recovery. Based on medical information provided, 3sHealth may extend benefits until the date noted in the medical support documents.

For the 28 approved claims we tested, we found 15 claims where 3sHealth extended the benefits beyond the initially approved timeframe. We found each of these 15 claims had appropriate and sufficient medical support for extending benefits. We also found documented support in members' files of 3sHealth staff regularly communicating (e.g., phone calls, emails) with members and their employers on their recovery and return to work progress.

For the other 13 out of 28 claims, we found limited communication with employers and members, as those claims were issued short-term and members were either already back to work or were participating in a return to work program (e.g., a member was off work for four weeks post-surgery and returned to full duties). We assessed this limited communication as reasonable in those instances.

In addition to regular contact with members, 3sHealth schedules 12- and 18-month check-ins with members on long-term disability to evaluate whether they continue to be eligible

for benefits (i.e., whether a member's medical condition continues to limit their job duties).[14] Of 28 approved claims we tested, 10 claims were long-term disability claims. We found 3sHealth followed its processes to have 12- and 18-month check-ins with its members for these 10 claims and modify return to work plans, if necessary.

As shown in **Figure 13**, the number of long-term claims paid each year is increasing.

Figure 13—Average Number of Long-Term Claims Paid Per Month by Disability Plan

Year	CUPE	SEIU–West	SUN	General	Total
2018	424	116	214	181	**935**
2019	484	132	232	185	**1,033**
2020	580	143	272	212	**1,207**
2021 (January–September)	655	257	281	222	**1,415**

Source: Adapted from information provided by 3sHealth.

3sHealth also tracks the duration of long-term disability claims. Claims with long-term disability duration impose a considerable burden on injured or ill workers and are costly to disability insurance coverage plans and employers. As shown in **Figure 14**, the average duration of long-term disability claims decreased from 2019 to 2020.

Figure 14—Average Duration of Long-Term Disability Claims (in months)

Year	CUPE	SEIU–West	SUN	General
2019	56.3	56.7	65.1	81.1
2020	53.1	53.9	64.3	75.6

Source: Adapted from information provided by 3sHealth.

External Rehabilitation Referrals

When a plan member's recovery is not progressing as expected, 3sHealth may refer the member to its external rehabilitation partner for functional assessment.[15] The external rehabilitation partner will provide a recommended treatment plan for 3sHealth's consideration, including specific assessments, treatment and/or therapies recommended, cost, and expected impact to the member.

If 3sHealth agrees with the recommended treatment plan, it contacts the member to discuss the plan. It will also notify the employer of the treatment plan and expected return to work.

In our testing of 28 approved claims, we found 3sHealth referred one claim to its external rehabilitation partner for further member assessment and treatment. We found evidence of 3sHealth discussing the treatment plan with the member. We also found evidence of 3sHealth contacting the employer to update them on the member's recovery and to enquire about whether they could provide any accommodations for the member (e.g., reduced or part-time duties to facilitate a gradual return to work).

[14] A member receives long-term disability benefits after 119 days of total disability.
[15] 3sHealth's contract with its external rehabilitation partner expires June 30, 2022.

Disability Benefits Adjusted Based on Earnings

A member may return to full or modified duties based on their abilities (e.g., part-time or gradual basis, modified duties). When a member is on a gradual return to work plan, the member may receive earnings from the employer for the hours worked. 3sHealth receives statements noting the hours worked and their pay. 3sHealth adjusts the member's disability benefits by the amount of earnings received from the employer.

Out of the 28 approved claims we tested, eight members participated in a gradual return to work program. We found 3sHealth correctly calculated and adjusted the disability benefits based on the additional earnings.

By providing a supportive role in return to work plans, 3sHealth helps support members recover from injury or illness and minimize delays in returning to work.

4.12 Most Key Performance Information Monitored, But More Analysis Needed

3Health reports most of its key performance information to senior management and the Board of Trustees, but could include more. The reports do not include written analysis.

3sHealth has two key performance measures related to disability claims that it reports monthly to senior management and quarterly to the Board of Trustees:

- Delivery: total number of disability claim applications processed within eight days with a 90% target. For the period of April 2020 to August 2021, 3sHealth reported it met its goal for 11 out of 17 months, results ranging from 84% to 95%.

- Quality: rate of disability claims' quality based on audits performed with a 97% target.[16] For the period of April 2020 to August 2021, 3sHealth reported that it met its target for 16 out of 17 months, results ranging from 95% to 100%.

In addition to key performance information reported, the Board also receives the following information at its quarterly meetings:

- Results of member surveys relating to the disability claims process (e.g., members' satisfaction regarding contact with 3sHealth, information received, overall satisfaction with process). From June 2019 to October 2021, there were 372 responses (out of approximately 40,000 members). Since starting the surveys in 2019, client satisfaction has remained consistent, with about 92% of clients satisfied with the disability claims process.

- Reports outlining emerging issues, service metrics (e.g., initial disability claims processed), and updates on the claims management redesign project (see **Section 4.13**).

- A claims activity report including information such as the total claim dollars paid quarterly and annually (per plan), total overpayments on a monthly basis for all

[16] Quality audits assess whether adjudicators assess and manage disability claims as expected (e.g., required information, file checklists).

disability plans combined, and overpayments by type (e.g., CPP, WCB). This report also provides details about the percentage of new claims denied on an annual basis along with the reasons for denial (e.g., ineligible medical condition, late application), and appeals in progress on a monthly basis.

- Reports of any suspicious activity by a member (e.g., earning additional income and not reporting to 3sHealth) as reported to 3sHealth by other members, employers, or other parties. We found there were no suspicious activities reported to the Board during the audit period.

However, as noted in **Section 4.8**, neither senior management nor the Board receive information on 3sHealth's performance target for appeals (i.e., making a decision within 30 business days of receiving the appeal). Good practice recommends reporting and analyzing such information.

3sHealth could further improve its reports to senior management and the Board by including written analysis of the results. For example, if 3sHealth is not meeting its delivery or quality targets, reports could explain why and any action required to address issues.

Having more information and analysis on its disability claims management process would allow senior management and the Board of Trustees to know whether the claims management process is working as intended, and adjust as needed.

4. **We recommend Health Shared Services Saskatchewan enhance its written reports to senior management and the Board of Trustees about its disability claims management processes.**

4.13 Disability Claims Management Redesign Project Underway

Following a review of its processes in 2018, 3sHealth began work in spring 2019 on a disability claims management redesign project called "Path to Health." The focus of this three-year project is to improve members' experience through the disability claim lifecycle, align disability management processes with good practice, select a rehabilitation service provider, and look for options to replace the current claims management IT systems.

As a result of this redesign project, 3sHealth hired medical advisors and increased communication with members (e.g., phone calls to discuss claim applications once applications are complete and outline expectations of the claims process). It also worked on developing standard procedures (e.g., claims case management checklist). 3sHealth is currently in the process of updating its IT systems, with implementation expected by March 31, 2022.

3sHealth reports to senior management and the Board of Trustees every two months and annually about its progress on the Path to Health project. This report includes performance metrics such as plan member satisfaction measured through member surveys, adjudicator quality scores measured through quality case audits, and time to decision. It also includes other statistical information such as adjudicator caseload, long-term disability recovery by diagnosis, and budget.

Having a plan to redesign its disability claims management processes helps 3sHealth ensure its processes reflect good practice to support members submitting disability claims.

5.0 SELECTED REFERENCES

Association of Insurance and Risk Managers in Industry and Commerce. (2015). *Achieving Best Practice in Claims—A Guide for Risk Managers*. www.airmic.com/sites/default/files/technical-documents/Claims-best-practice-guide.pdf (22 September 2021).

Auditor General of Nova Scotia. (2019). Report of the Auditor General to the Nova Scotia House of Assembly, Chapter 3, *Workers' Compensation Board: Claims Management*, Halifax: Author.

Office of the Auditor General of Canada. (2015). *Report 6—Canada Pension Plan Disability Program.* Ottawa: Author.

Provincial Auditor of Saskatchewan. (2021*). 2021 Report – Volume 1*, Chapter 9*, Office of Residential Tenancies—Adjudicating Tenancy Disputes*. Regina: Author.

Provincial Auditor of Saskatchewan. (2016*). 2016 Report – Volume 2*, Chapter 31, *Workers' Compensation Board—Co-ordinating Injured Workers' Return to Work*. Regina: Author.