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The Financial Risks and Subsidized Rewards for Providing Retiree Rx Coverage: A Plan Sponsor's Guide to Plan Design Issues in Light of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*

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I. Executive Summary[1]

If your company sponsors retiree medical benefits for post-65 retirees, there are a couple of basic rules introduced as part of the underlying framework for new Part D of Medicare that you need to understand.

- If you so choose, you can provide a post-65 retiree Rx drug benefit that is "actuarially equivalent" to new Part D of Medicare and, if a participant elects your coverage instead of Part D coverage, you may receive a Federal subsidy for providing such benefits for that participant, which will help offset the cost of providing retiree Rx drug coverage.
- As an employer, you are *not* prevented by new Part D of Medicare from terminating your existing retiree Rx drug benefits. If you choose to terminate or significantly reduce your coverage (*i.e.*, to a level that isn't actuarially equivalent to new Part D benefits), participants can seek retiree Rx drug coverage under new Part D, but you obviously won't receive the Federal subsidy. You may also adopt a new program that is designed to supplement new Part D Rx drug coverage, but, again, you won't receive the Federal subsidy.

With those rules in mind, you should:

- begin assessing the effects of the Act upon your current retiree medical benefit plan(s), including, most importantly, retiree Rx coverage;
- monitor legislative proposals to amend new Part D of Medicare;
- monitor regulatory pronouncements from the Department of Health and Human Service's Center for Medicare & Medicaid Services, the Department of Labor and the Treasury Department;

[1] Certain terms and acronyms used in this Part I will be defined throughout Parts II through IV below.

- consider potential changes to your pre-65 retiree Rx benefit structure (perhaps using the newly-minted "Health Savings Accounts" or the recently created "Health Reimbursement Arrangements" to transition current and future retirees into a consumer driven model that is built around new Part D) and the impact of means testing for Part B, but don't plan to rely on the new Medicare Rx drug discount card, because, generally, it will not be available to participants unless they are eligible to be or are enrolled in Part A of Medicare or are enrolled in Part B Medicare coverage;
- if your pre-65 retiree medical benefits (*i.e.*, retiree Rx coverage and Part B-type benefits) are left in place, consider ways to minimize costs;
- if you are interested in reducing and/or eliminating your post-65 retiree Rx drug benefits (and possibly other retiree medical coverage), assess the likelihood that you will be able to successfully reduce and/or eliminate such coverage and whether you must bargain over such changes;
- assuming you can terminate your retiree Rx drug coverage, determine whether you want to continue providing post-65 retiree Rx drug benefits beginning in 2006, which will leave current and future retirees with only new Part D retiree Rx drug coverage;
- if you plan to continue providing retiree Rx drug coverage, assess your ongoing costs (including potential risks) of continuing retiree Rx drug benefits for post-65 retiree medical plans beginning in 2006 and whether the Federal subsidization of such benefits outweighs the costs;
- if you decide to continue providing post-65 retiree Rx drug coverage, but you aren't interested in the Federal subsidy, begin exploring whether to and the ways in which you may want to modify coverage to coordinate with new Part D;
- if you decide to reduce significantly or eliminate post-65 retiree Rx coverage, consider timing issues, HR communications and other current benefits issues, etc.; and
- contact your auditor and actuary to discuss the current reporting requirements under FAS 106 and whether to take the Act into account or to delay its impact on your financials.

II. Introduction

Prior to the passage of the Act,[2] which President Bush signed into law on December 8, 2003, the "buzz" in the benefits community was sharply focused on so-called "defined contribution" medical plans. For employer-sponsored retiree medical benefit plans, the following excerpt illustrates one of the reasons why consumer-driven models have enjoyed such intense discussion:

> [T]he total cost of providing retiree health benefits increased by an estimated 13.7 percent, on average, between 2002 and 2003…. This growth rate is slightly lower than the 14.7 percent growth in the cost of providing health benefits to

[2] All references to the term "Act" are to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173 (amending, among other federal laws, title XVIII (Medicare) of the Social Security Act of 1965, P.L. 89-97, as amended by, among other acts of Congress, the Act, (hereinafter "SSA")).

> active workers observed in a different sample of large employers, during the same time frame.[3]

Furthermore, "[t]he costs associated with retiree health obligations appear to be a significant concern for company CEOs, with 92 percent of all respondents reporting that their CEO is very or somewhat concerned about retiree health care costs."[4]

In response, many employers began asking whether they could convert traditional "defined benefit" medical plans to defined contribution medical plans. This approach was widely viewed as a way to inject some much-desired and arguably much-needed "consumerism" into group medical plans. Innovative service providers touted defined contribution health plans, often ignoring the proposed Treasury regulations governing medical flexible spending arrangements.[5] In 2002, the Internal Revenue Service ("Service") responded with Revenue Ruling 2003-41[6] and Notice 2002-45.[7]

With the passage of the Act, it is time to "strike while the iron is hot." The addition of new Part D of Medicare and the creation of "Health Savings Accounts" or "HSAs" afford at least some rationale for employers to reconsider the way in which they are providing retiree (and, at least insofar as HSAs are concerned, even active) medical benefits. Retirees satisfied with the status quo will nevertheless be inundated with information about the changes brought about because of the passage of the Act. There has already been extensive media coverage about the addition of prescription drug coverage to Medicare. Participants will be expecting change and employers who sponsor retiree medical programs could treat the creation of new Part D as the perfect reason to revisit retiree medical coverage. Prospective retirees, current retirees and perhaps even some unions will expect it.

III. Basic Plan Design Issues: A Smorgasbord of Choices

The two basic premises that underpin new Part D of Medicare are notions that underlie the "American" approach to employee benefits in general: Whether to provide a retiree medical benefit is a *voluntary* decision.[8] The other notion is the idea that basic plan design issues are largely left up to the plan sponsor.[9] By and large, the Act respects these two tenets.[10]

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[3] Frank McArdle, Terry Kirkland, Dale Yamamoto, Michelle Kitchman, Tricia Neuman, Retiree Health Benefits Now and In the Future: Findings from the Kaiser/Hewitt 2003 Survey on Retiree Health Benefits viii (2004).

[4] *Id.*

[5] *See* Prop. Treas. Reg. 1.125-2, Q&A-7(b)(3) (setting forth the regulatory requirement of a 12-month coverage period for medical flexible spending arrangements, which eliminates the ability to carry over pre-tax contributions withheld from an employee's compensation because of an election by the employee/participant to defer part of his/her pre-tax compensation).

[6] 2002-28 I.R.B. 75.

[7] 2002-28 I.R.B. 93.

[8] SSA § 1860D-22(a)(6)(A) (providing that "[n]othing in this subsection shall be construed as…precluding a Part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA-PD plan…"); SSA § 1860D-22(a)(6)(B) (providing that "[n]othing in this subsection shall be construed as … precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA-PD plan on behalf of such an individual…").

[9] SSA § 1860D-22(a)(6)(C) and (D).

[10] We note that the Act does not require employers to provide retiree prescription drug benefits and remains silent on a plan sponsor's ability to terminate existing retiree prescription drug coverage. For example SSA section 1860D-22(a)(6) provides that, even though an individual may be receiving employer-provided and government subsidized prescription drugs, individuals eligible for new Part D prescription drug coverage

Although the Act did not restrict a plan sponsor's ability unilaterally to reduce or terminate retiree medical benefits, many employers who sponsor such arrangements are (or at least should be) acutely aware of the legal limitations on the plan sponsors' ability to reduce or terminate retiree medical benefits unilaterally, including retiree prescription drug coverage. The central issue, which turns on traditional notions of contract interpretation, involves determining whether a sponsor unambiguously reserved the right to amend (*e.g.*, reduce) or terminate the plan or any portion of the plan at any time or from time to time.[11] While legal challenges by former non-union employees asserting that retiree medical benefits are vested and nonforfeitable have not met with much success,[12] former union employees who have challenged a plan sponsor's ability to unilaterally reduce or terminate retiree medical benefits have enjoyed greater success.[13] In some recent cases, however, retirees who were bargained employees when active have mounted legal challenges that have not fared as well.[14] Although a review of the many decisions addressing these issues is beyond the scope of this article, employers considering reductions to and/or the elimination of retiree prescription drug coverage would be well advised to consult with experienced benefits counsel prior to acting unilaterally.

A. Pre-65 Retirees: Between a Rock and a Hard Place

Retirees who have not yet reached age 65 will be left in a difficult position if an employer reduces or eliminates retiree prescription drug coverage. Unless a participant can otherwise become covered under new Part D,[15] a participant could be left without coverage. Moreover, the new Medicare prescription drug discount card, designed as "transitional relief," would not be available unless the individual is otherwise enrolled or entitled to enroll in coverage provided pursuant to Part A of Medicare, enrolled in coverage provided by Part B of Medicare or covered pursuant to Medicaid by virtue of an SSA section 1115 waiver.[16]

There are, however, some alternatives for an employer wishing to limit its liability for retiree prescription drug coverage for pre-65 retirees. As we will discuss more fully in Part III C below, it may be the case that the employer could implement a consumer-driven model using a "Health Reimbursement Arrangement" or "HRA" for current retirees and those active employees expected to retiree soon, but who have not yet reached age 65. For currently active employees expected to retire after some number of years of active service, perhaps an HSA could be used as a way to encourage them to save for their retiree medical needs. Either approach may enable plan sponsors to devise a way in which to wean current and future retirees from traditional defined benefit types of arrangements, but there is obviously no legal requirement to consider such approaches.

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may enroll for such prescription drug coverage. As is set forth in SSA section 1860D-15, Congress sought to encourage employers to provide retiree prescription drug benefit by offering a subsidy to plan sponsors who provide a prescription drug benefit that is at least "actuarially equivalent" to new Part D prescription drug coverage.

[11] *See, e.g.*, *Diehl v. Twin Disc*, 102 F.3d 301, 305-06 (7th Cir.1996).

[12] *See*, *e.g.*, *Sprague v. General Motors Corp.*, 133 F.3d 388, 21 EBC 2267 (6th Cir.1998).

[13] *See*, *e.g.*, *UAW v. BVR Liquidating, Inc.*, 190 F.3d 768 (6th Cir.1999), *cert. denied*, 529 U.S. 1067, 120 S.Ct. 1674 (2000).

[14] *See*, *e.g.*, *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130 (2d Cir.1999).

[15] Stating a general proposition, an individual who has not yet reached age 65 cannot be eligible for coverage pursuant to Parts A or B of Medicare unless he/she is disabled or suffers from a permanent kidney disease.

[16] SSA § 1860D-31(b)(1).

B. Post-65 Retirees: Are You Going to Wait Until O-Six?

As was the case with the pre-65 retiree medical benefits, when deciding whether to modify or terminate post-65 retiree medical coverage the employer must ascertain whether the changes sought will be confined only to retiree prescription drug coverage.

Retiree medical coverage other than coverage for prescription drugs is beyond the scope of this article, but employers should nevertheless consider non-prescription retiree medical coverage changes for various reasons. First and foremost, in the Act Congress amended Part B of Medicare to include a means-based test for the level of Part B coverage.[17] Second, while employers are considering basic design issues with respect to post-65 retiree medical benefits, the various changes to Medicare and the heightened awareness of developments that affect the delivery of retiree medical benefits provides an opportune time to at least explore changing such coverage.

1. The Options: A Summary

With respect to retiree prescription drug coverage for post-65 retirees, there are a variety of choices to consider. Namely, employers should:

- consider eliminating prescription drug coverage altogether prior to or after January 1, 2006, when new Part D becomes effective, and
- consider, if prescription drug benefits are not to be eliminated:
  - whether seeking the government subsidy is worth the cost; and
  - the ways in which prescription drug coverage for post-65 retirees should be changed to better coordinate with new Part D.

We, however, do have two very important notes to add: Employers thinking about significantly reducing and/or eliminating retiree prescription drug coverage should carefully consider timing issues. First, if an employer terminates or so significantly reduces coverage (which we assume would necessarily cause retirees to elect to enroll in Part D coverage after they are initially eligible (*i.e.*, upon the expiration of an individual's "initial enrollment period")), such individuals may be subject to penalties.[18] Second, if an employer who offers retirees prescription drug coverage elects to delay taking into account the passage of the Act on the employer's booked Financial Accounting Standard No. 106 ("FAS 106") liability, modifying the arrangement could result in negating the election to delay taking into account the passage of the Act.

2. Terminating Retiree Rx Coverage[19]

As is explored briefly above, the Act did not limit an employer's ability to terminate retiree prescription drug benefits. Employers, however, should be aware of where retirees with no post-65 retiree prescription drug coverage will be left if retiree prescription drug benefits are terminated.

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[17] Act § 811.

[18] Although the regulatory framework for new Part D is not yet even in proposed form, it appears to us that participants who seek to enroll in new Part D after their initial enrollment period, may enroll by virtue of the "cancellation" of employer-sponsored retiree prescription drug coverage. *See* SSA § 1860D-1(b)(3)(A). We read –1 of new Part D to provide a "special enrollment period" in certain instances. However, we also read the relevant provisions of new Part D to result in the application of a late enrollment penalty. *See* SSA §§ 1860D-1(b)(6) and 1860D-13(b).

[19] *See* Part IV below for a more complete discussion.

a. Terminating Retiree Rx Coverage Prior to January 1, 2006

If an employer terminates post-65 retiree prescription drug coverage prior to January 1, 2006, retirees may be left with nothing but the new Medicare prescription drug discount card. Participants who elect to participate in the new Medicare prescription drug discount card will be expected to pay no more than a $30 annual enrollment fee for savings estimated to be anywhere from 20-25%.[20] The Center for Medicare & Medicaid Services ("CMS") expects enrollment to begin as early as May 2004. On Monday, December 15, 2003, Interim Final Rules implementing this arrangement were published in the Federal Register.[21]

For low-income individuals, there will be subsidies, which are summarized in a CMS Q&A as follows:

> *Q:* I've heard that I might be able to get a $600 credit to help pay for my prescription drugs. How does that work?
>
> *A:* If your income is no more than $12,123 as a single person, or no more than $16,362 for a married couple, you might qualify for a $600 credit to help pay for your prescription drugs. If you qualify, Medicare will put a $600 credit on your Medicare-approved Drug Discount Card that you can use when you get your prescriptions. You won't have to pay the annual enrollment fee for the discount card if you qualify for the $600 credit.
>
> To apply for this credit, you need to fill out an enrollment form for a prescription drug discount card and complete the part of the form for the $600 credit. Card sponsors are allowed to start enrolling people with Medicare as early as May 2004.
>
> You can't qualify for the $600 credit if you already have outpatient drug coverage from Medicaid, TRICARE for Life or an employer group health plan.[22]

In addressing whether social security income will be included when determining whether an individual is eligible for the federal government subsidy, CMS has provided as follows:

> 18. Will the income for purposes of determining eligibility for transitional assistance include social security income? Will the number of household members affect this amount? Is this amount total for the household or just the members on Medicare?
>
> A. The income threshold includes social security income. Income belonging to the application or, if the applicant is married, to both the applicant and spouse (whether spouse receives Medicare or not) will be counted. No other household members' income will be counted.[23]

An individual whose employer-provided retiree prescription drug coverage was terminated after such individual first became eligible to, but did not enroll for a Medicare

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[20] Center for Medicare & Medicaid Services, *The Facts about Upcoming New Benefits in Medicare*, Publication No. CMS 11034 (Feb. 2004), *available* at http://www.medicare.gov/MedicareReform/.

[21] 68 F.R. 69840.

[22] Center for Medicare & Medicaid Services, Answer ID 1492 (2003), *available* at http://medicare.custhelp.com.

[23] Centers for Medicare & Medicaid Services, *Responses to questions posed at the Drug Card Pre-Application Conference & email*, 8 (Dec. 29, 2003), *available at* http://www.cms.hhs.gov/discountdrugs/conres02-19.pdf.

prescription drug discount card, will neither be prevented from enrolling nor apparently penalized for being a late enrollee.[24]

b. Terminating Retiree Rx Coverage Prior To or After January 1, 2006

As we briefly discussed above, employers considering terminating (or significantly reducing) post-65 retiree prescription drug coverage should consider the timing of such actions. Setting aside the HR communications issues, individuals who seek to enroll during what is called a "special enrollment period" will presumably be subject to the so-called "late enrollment penalty."[25] From SSA section 1860D-13(b), it appears to us that the late enrollment penalty is somewhat akin to the creditable coverage provisions set forth in HIPAA,[26] except that, for periods during which a late enrollee did not have "creditable prescription drug coverage," he/she will be subject to a penalty.[27] The penalty is an increase in the monthly premium.[28]

The net result is that, for employers who sponsor retiree prescription drug benefits that are "actuarially equivalent" as of the initial enrollment period, but that later eliminate or reduce such coverage so that it is no longer actuarially equivalent, individuals in such a plan will be entitled to a special enrollment period.[29] However, to the extent that such an individual does not have "creditable coverage," the individual will be subject to the above-mentioned penalty.

The way in which actuarially equivalent coverage and late enrollment penalties interact also illustrates another important point: Employers that sponsor retiree prescription drug coverage should very carefully monitor whether the coverage that will be in place as of January 1,

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[24] For example, it appears from SSA section 1860D-31(b)(2)(B) that a participant's ability to enroll is "continuous." Accordingly, it appears that the termination of post-65 retiree prescription drug coverage during the period in which the Medicare prescription drug discount card is in effect will not result in the participants not being able to take advantage of such a program simply because he/she did not enroll when first eligible. *See also* 42 C.F.R. 403.811(a)(5) and 68 F.R. 69842 (providing that "once a beneficiary has been determined eligible for the Medicare drug discount card program, he or she will remain eligible for the duration of the program unless he or she disenrolls from an endorsed program and is ineligible for a special election period that would allow the individual to enroll in another program in accordance with § 403.811(b)(6) of the regulations…."). We have not explored the effect of a late enrollment on an individual's ability to obtain the transitional subsidy.

[25] *See, supra,* at Note 18.

[26] All references to the term "HIPAA" are to the Health Insurance Portability & Accountability Act of 1996, as amended.

[27] SSA § 1860D-13(b).

[28] SSA § 1860D-13(b)(3).

[29] SSA § 1860D-1(b)(3)(A)(iv) (providing that the reduction of coverage that otherwise satisfies actuarially equivalent coverage as set forth in SSA section 1860D-13(b)(5) will result in an "involuntary loss of coverage"). We also note that it appears to us as though an involuntary loss of coverage is an inquiry with somewhat of a low standard. For example, merely losing actuarial equivalent coverage because of the non-payment of premiums appears to be about the only cause that will not meet the standard, which is a point that is made in SSA section 1860D-1(b)(3)(A)(iii). This, however, begs what could end up being a particularly thorny question for collectively bargained retiree prescription drug benefits. Even in spite of the seemingly low threshold, could it be the case that bargained-for reductions (or possibly even the elimination) of retiree prescription drug coverage after the first initial enrollment period rises to an "involuntary" loss of coverage? If so, employers providing retiree prescription drug coverage that will need to bargain over changes to such coverage should be cognizant of this rule and immediately begin preparing to bargain with the respective collective bargaining unit, as time will presumably be on the side of the unions. We would like to see this issue dealt with by CMS in forthcoming guidance.

2006, will be actuarially equivalent to standard Part D coverage. In part, our rationale for these words of warning should now be more than clear; however, there is an additional issue that makes this point even more important. As is set forth in SSA section 1860D-13(a)(6)(B), there are notice requirements, which provide as follows:

> (B) Disclosure by Entities Offering Creditable Prescription Drug Coverage. -
>
> (i) In General. – Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.
>
> (ii) Disclosure of Non-Creditable Coverage. – In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA-PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

This also serves to underscore the importance of participant communications.[30]

To sum up the situation for employers that sponsor retiree prescription drug coverage, timing will be crucial to participants. Hence, employers should closely monitor regulatory developments and stay in close contact with benefits counsel and actuaries.

3. Continuing Retiree Rx Coverage: More Options

a. Can the Discount Card Help?

We primarily note that it appears as though participants in employer-sponsored post-65 retiree prescription drug plans may avail themselves of the use of the Medicare prescription drug discount card.[31] For participants in employer-sponsored retiree prescription drug plans, the federal government subsidy will not be available.[32]

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[30] In light of this disclosure obligation, employers would be well advised to consider the implications of our discussion that will appear in Part IV A below. Also, an interesting query is the way in which such disclosures will be coordinated with the requirements governing summary plan descriptions, which appear in Labor regulation 2520.102-3. Perhaps the Secretary of Health and Human Services will coordinate with the Secretary of Labor on such matters. As a general proposition, reporting and disclosure obligations required by ERISA are fairly precise. Perhaps the Secretary of Health and Human Services could relieve some of the administrative burdens associated with such a notice requirement by coordinating with current Labor regulations addressing notices and disclosures.

[31] SSA § 1860D-31(b)(1). *See also* 68 F.R. 69842 (providing an explanation of the individuals ineligible to enroll for a Medicare prescription drug discount card); and Center for Medicare & Medicaid Services online enrollment tool, *available at* http://www.medicare.gov/maddc/Results.asp (providing that, when using the online eligibility tool assuming that an individual is eligible for Medicare Parts A and B and also enjoys prescription drug coverage through an employer-provided plan, "[y]ou are eligible to enroll in a Medicare-approved drug discount card. You cannot qualify for the $600 credit if you already have drug coverage from TRICARE for Life, FEHBP, or if you have other health insurance coverage that includes

Obviously, the threshold issue any employer should be asking itself is whether the savings of anywhere from 20-25% from standard retail prescription drug prices will end up saving the plan any money. If this is the case and the employer believes that the savings may be significant enough to warrant exploring ways in which to capitalize on the Medicare prescription drug discount card program, there are a variety of issues to be considered, some of which are as follows:

- How will the plan cause or encourage participants to enroll in and use the Medicare prescription drug discount card program?
- If substantial savings are anticipated, will the employer pay the annual enrollment fee?
- In what ways will plans monitor pricing differentials between the cost of prescription drugs to the plan through pre-existing arrangements versus the cost through a Medicare prescription drug discount card?
- Will the plan merely reimburse participants for the actual cost of drugs through a retail prescription drug program up to the amount the participant paid after applying the discount?

Obviously, any one person familiar with administering prescription drug benefits governed by ERISA[33] could ask countless additional questions. Suffice it to say, however, that these questions probably shouldn't even be asked unless it is anticipated that the savings will offset the costs, including the administrative burdens associated with making temporary changes. This is especially true in light of the fact that plan sponsors are also going to need to be considering the much larger issue, which is how they will react to the new Part D prescription drug coverage when it goes into effect on January 1, 2006.

b. Is the Subsidy Worth It?

For plan sponsors who will be continuing retiree prescription drug coverage, there is a very important threshold decision: Will the subsidy be worth it? In order to make an informed decision, employers need to understand two questions. First, how much of a subsidy will there be? Second, what are the basic requirements to get the subsidy? If it ends up that the subsidy is not worth it, in what ways can retiree prescription drug coverage be designed to accommodate new Part D prescription drug coverage?

i. How Much of a Subsidy?

As is discussed in Part III above, employers are *only encouraged* by the Act to continue providing prescription drug coverage. Congress sought to offer enough of an incentive to keep employers from terminating retiree medical coverage. As outlandish as this may sound in these days of benefits curtailment, perhaps there are employers that may be considering whether the subsidy is enough to cause them to adopt retiree prescription drug coverage. In our view, this will all turn on the amount of the subsidy.

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prescription drugs (such as employer or retiree plans). If you already have prescription drug coverage through your current health insurance, or you already get discounts on your prescriptions, review your coverage closely to see if you may be able to save money on your prescription drugs by enrolling in a Medicare-approved drug discount card.").

[32] SSA § 1860D-31(b)(2)(B).

[33] All references to "ERISA" are to the Employee Retirement Income Security Act of 1974, as amended.

SSA section 1860D-22 addresses what employers that want to consider sponsoring a government-subsidized retiree prescription drug benefit need to know.

> Subsidy payments will equal 28% of gross covered retiree plan-related prescription drug costs greater than $250 but not greater than $5,000, adjusted annually by the percentage increase in Medicare per capita prescription drug costs.[34]

The costs that will be allowed to be reimbursed are the "gross covered retiree plan-related prescription drug costs" that are "actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan."[35] The "gross covered retiree plan-related prescription drug costs" will be, "with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during year."[36]

It appears from SSA section 1860D-22(a)(3)(A) that the subsidy is available only on a participant-by-participant basis. For example, the Joint Explanatory Statement provides that "payments are to be made on behalf of an individual covered under the retiree plan…."[37] We read this to mean that employers cannot aggregate the costs of prescription drug benefits for all retirees. There are also additional complicated rules governing costs that are reimbursable.[38]

There is more good news! The Act added new Code section 139A.[39] New Code section 139A provides that an employer's:

> [g]ross income shall not include any special subsidy payment received under SSA section 1860D-22. This section shall not be taken into account for the purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.

The Act included other amendments to the Code, but they are beyond the scope of this article.

ii. Basic Requirements for Federal Subsidization

Although there are a variety of technical rules governing the class of individuals whose coverage may be subsidized[40] and the type of plan that must be provided,[41] these requirements should be relatively easy to understand. In our minds, the larger issue on which an employer considering its options should focus is the *quid pro quo*.

At first glance, the toll exacted doesn't appear to be too heavy. In particular, if the subsidy is sought, the plan sponsor (or, in some cases, an administrator designated by the plan sponsors) must:

- provide the Secretary with a "certification" of "actuarial equivalence" at least annually and as may be required by the Secretary;

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[34] Joint Explanatory Statement at 53 (2004) (hereinafter *JES*). *See* SSA § 1860D-2(b).
[35] SSA § 1860D-22(a)(3)(C)(i).
[36] SSA § 1860D-22(a)(3)(C)(ii).
[37] *JES* at 53.
[38] Section 1860D-2(d).
[39] All references to the term "Code" are to the Internal Revenue Code of 1986, as amended.
[40] SSA §§ 1860D-22(a)(1) and (4).
[41] SSA § 1860D-22(a)(2).

- provide "records" required by the Secretary for audit and "other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under" new Part D of Medicare;
- provide a certain disclosure to the Secretary and the participant, which must "provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage…" is actuarially equivalent and, if the coverage is not actuarially equivalent, such a disclosure "shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA-PD plan and that such enrollment is subject to a late enrollment penalty under this subsection;[42] and
- conform with the system for payments as established by the Secretary of Health and Human Services and to provide information in order to obtain the payment of the subsidy.[43]

On balance, it may appear as if these are only a "few" requirements; however, plan sponsors considering whether to seek the subsidy should keep in mind that Part D is brand new and the predilection to add myriad regulatory requirements is always strong. This is especially the case when the Federal government is handing out tax dollars. Accordingly, plan sponsors should plan on expending significant resources in an effort to get the subsidy. We will cover a few examples of ways in which a seemingly simple issue can mushroom into a nightmare.

Complying with the actuarial equivalency test will be fraught with administrative burdens. The actuarial equivalency standards are primarily set forth in SSA section 1860D-11(c) and are surely to be the subject to voluminous and complex regulatory guidance. Setting aside the issue of the cost associated with making such determinations, which will surely be expensive; there is the threshold issue of whether a plan sponsor will be willing to subject the amount of money it wants to spend providing retiree prescription drug coverage to the scrutiny of the Federal government. While basic plan design issues appear to be well within the discretion of the employer who can basically choose to reduce or eliminate such coverage, agreeing to provide floor levels of coverage could be said to be somewhat akin to vesting a given set of benefits, because there will be at least some loss of control.

To compound this loss of autonomy, employers that seek the subsidy will also be subject to audit and other oversight activities. This will surely necessitate that employers closely monitor the data that must be collected to support a claim for a subsidy payment. Accordingly,

[42] SSA § 1860D-22(a)(2) and SSA § 1860D-13(b)(6)(B). The importance of this rule cannot be overstated, because the participant will face some dire consequences when the sponsor of a retiree prescription drug benefit fails to meet the "actuarial equivency" test set forth in SSA section 1860D-13(b)(6)(C). Such a participant may ultimately be forced to apply to the Secretary of Health and Human Services for an exception to the creditable coverage provisions, which operate much like those required by HIPAA's creditable coverage provisions and are addressed in detail in Treasury regulation 54.9801-5 and Labor regulation 2590.701-4.

[43] SSA § 1860D-22(a)(5). With respect to the payment systems, SSA section 1860D-15(d)(1) gives the Secretary of Health and Human Services the ability to determine the rules applicable to payments. Likewise, the Secretary of Health and Human Services appears to have by virtue of SSA section 1860D-15(d)(2)(A) broad authority to established the type of information required.

plan sponsors will need to work closely with third party administrators to ensure that the data captured is correct and easily accessible. This will add yet another layer of cost.[44]

Perhaps more importantly, however, we have to ask ourselves the following questions: What is the scope of an audit? What are the penalties for non-compliance? SSA section 1860D-22(a)(2)(B) provides that a plan sponsor providing subsidized coverage is subjecting itself to an audit requirement to "protect against fraud and abuse."[45] Although fraud and abuse prevention in Medicare is beyond the scope of this article, any sane person should be scared by such provisions, because it can only mean that plan sponsors will be exposed to yet more liability. What is "fraud and abuse" is not always crystal clear.

c. Running from the Subsidy

Employers that don't conclude that the subsidy is worth the headache, an issue explored in Part III B 2 c above, are not prohibited by the Act from designing retiree prescription drug benefits that complement the new Part D benefits; but, to repeat the point again, they will not be able to receive the Federal subsidy. SSA section 1860D-22(a)(6) includes several important rules that govern the construction of SSA Section 1860D-22. These rules are as follows:

> (6) Construction. Nothing in this subsection shall be construed as -
>
> (A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA-PD plan;
>
> (B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA-PD plan on behalf of such an individual;
>
> (C) preventing such employment-based retiree health coverage from providing coverage-
>
> (i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or
>
> (ii) that is supplemental to the benefits provided under a prescription drug plan or an MA-PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA-PD plan; or
>
> (D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

[44] It appears to us that it may ultimately turn out to be the case that such administrative costs will not be the type of costs that will be recoverable through the Federal subsidy. *See, supra*, at Note 35.
[45] SSA § 1860D-2(d)(3).

Also, the Joint Explanatory Statement provides that "[t]he PDP or MA-PD plan would constitute primary coverage, not the employer."[46]

These broad statements leave plan sponsors with a great deal of flexibility. For example, a plan sponsor can provide retiree prescription drug coverage by paying for the participants' premiums. An employer may also design a retiree prescription drug plan that merely enhances the new Part D prescription drug benefits. In short, the employer does not seem to be prohibited by the Act from turning its back on the obligations that will surely come with the subsidy and implementing a retiree prescription drug plan that builds on the new Part D coverage.

For instances where a participant is reliant upon new Part D coverage, there appears to be one significant way in which employer-provided coverage serves as a limitation on maximizing new Part D coverage. SSA section 1860D-1(b)(4)(C)(ii) provides that, to reach the point at which catastrophic coverage commences, "such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual), under section 1860D-14, or under a State Pharmaceutical Assistance Program and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs."[47] We read this to mean that amounts paid by employer-provided retiree prescription drug coverage will not count toward at least the barrier at which an individual incurs enough prescription drug costs to trigger the catastrophic coverage.[48]

d. Leaving Current Benefit Structures in Place

Many employers that currently provide retiree prescription drug benefits may ask whether they can just leave their existing arrangements in place. In order to answer such an inquiry, one must compare new Part D coverage with the sponsor's current arrangement.

Set forth below is the basic structure of new Part D prescription drug coverage:

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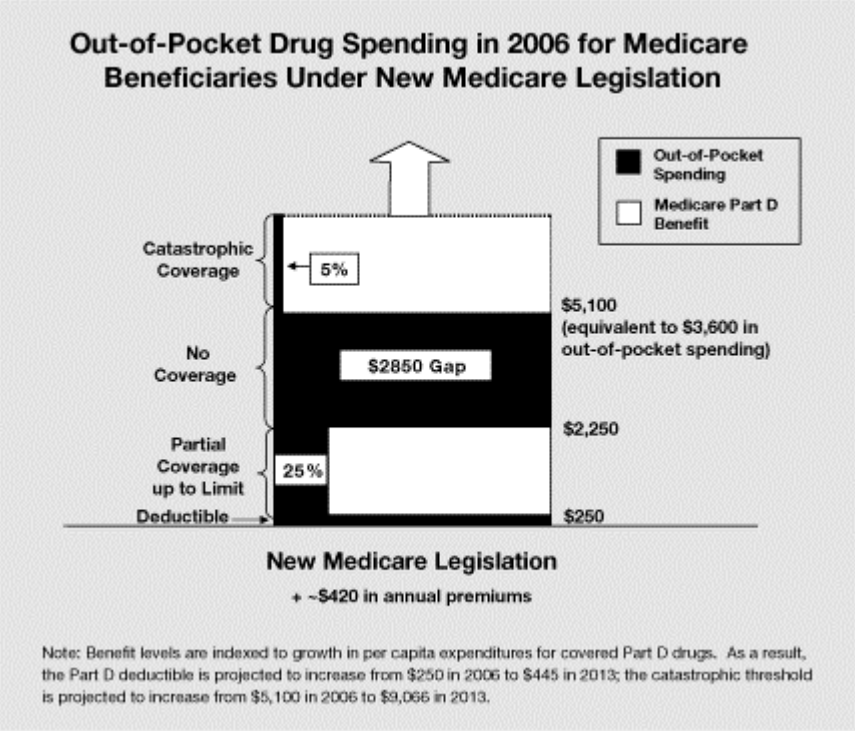
[46] *JES* at 53.

[47] *See also JES* at 13 (providing that, "[a]ny costs for which the individual was reimbursed by insurance or otherwise would not count toward incurred costs."). We assume this means that amounts paid by an employer-sponsored retiree medical plan will serve to do nothing more than to ratchet up the point at which a particular individual would be entitled to catastrophic coverage. In addition, we note that, if our reading of the Act is correct, SSA section 1860D-2(b)(4)(D)(ii) provides that the Secretary of Health and Human Services "is authorized, in coordination with the Secretary of the Treasury and the Secretary of Labor…" to establish a means by which to monitor the level at which individuals are being reimbursed "through insurance or otherwise, a group health plan, or other third-party payment arrangement…." This information gathering system may also include questioning an individual about other coverage. SSA § 1860D-2(b)(4)(D)(ii). In addition to applying to so-called "basic prescription drug coverage," it also appears that, by virtue of SSA section 1860D-2(c)(3), these rules also apply equally to "alternative prescription drug coverage."

[48] Because all the various thresholds in new Part D build upon each other to result finally in an individual's satisfying the catastrophic limit and the language of SSA section 1860D-2(b)(4)(D)(i), it could be the case that amounts that are not "incurred costs" (*i.e.*, because the participant is reimbursed by insurance or otherwise) could result in an individual's not being able to reach even the "initial coverage limit," which is the beginning of the donut hole. However, the reference in SSA section 1860D-2(b)(3)(A) to the limitations set forth in SSA section 1860D-2(b)(4), which presumably includes the "costs incurred" limitations, could be interpreted to mean that a participant's ability to reach the donut hole also requires "incurred costs." On the other hand, SSA section 1860D-2(b)(4)(B)(i) could be read to mean that all the various thresholds could be met only with "incurred costs." We would like for these issues to be dealt with clearly in regulatory guidance.



Source: Kaiser Family Foundation, *New Medicare Benefit At-A-Glance Chart* (2003), *available at* http://www.kff.org/medicare/medicarebenefitataglance.cfm?.

Assuming an employer's existing arrangement follows standard design patterns, the existing arrangement might closely parallel a common "fee-for-service" paradigm. Namely, there may be a deductible, co-pays or coinsurance and caps on coverage, either on an annual or lifetime basis. Superimposing existing benefit structures on new Part D will present challenging issues, only a few of which are as follows:

- If the annual individual deductible for the employer-provided prescription drug coverage is $150, will the employer-provided prescription drug plan provide coverage only insofar as it is necessary for participants to meet the new Part D deductible, which will initially be set at $250?
- If the employer-provided prescription drug coverage reimburses participants for the difference between the two deductibles, will amounts paid by the employer-provided coverage count toward the participant's new Part D annual deductible?
- If the post-deductible employer-provided coverage includes a coinsurance feature, will the employer-provided prescription drug coverage pay only 80% (or another coinsurance amount)?
- Once a participant reaches the new Part D coinsurance/co-pay threshold, will the employer-provided coverage provide an additional source of coverage, and, if so, how will coinsurance versus co-pay requirements be reconciled?
- Assuming a participant hits the new Part D donut hole, will the employer-provided coverage simply step in and apply coverage subject to pre-existing coinsurance and co-pay standards, and, if so, will this stretch the point at which the participant will reach the out-of-pocket cap on this part of new Part D coverage?

- If a participant hits the out-of-pocket maximum under new Part D, will the employer-provided prescription drug coverage pay the covered amount using standard coinsurance and co-pay amounts, and, if so, how will coinsurance versus co-payment requirements be reconciled?

These are but a few issues. There are many more unanswered questions. For example, what will happen if the new Medicare Part D provider in a particular region uses a different retail prescription drug program than the one used by the employer-provided coverage? Also, what will be the differences between the ways in which disputed claims for coverage under new Part D and the employer-provided coverage are handled? These are all issues that will need to be explored, and we think are factors that should lead employers to closely considering whether to build supplemental coverage around new Part D in a "wrap-around" fashion.

e. Basic Plan Design Issues: Designing a Wrap-Around Retiree Rx Drug Feature

A pure wrap-around plan could obviously be designed in a variety of ways and would presumably be limited only by the cost that the plan sponsor is willing to incur. Sponsors should keep in mind that it might well be the case that the rule embodied in SSA section 1860D-1(b)(4)(C)(ii) will serve to stretch the point at which an individual otherwise receiving new Part D coverage will reach the level that catastrophic coverage begins to apply. This would undoubtedly add to the cost of the arrangement. It also means that, to obtain any benefit from new Part D, a participant must experience at least some out-of-pocket expenses.

With this in mind, it is clear that employers will be free to include cost-sharing features. For example, contributions toward coverage could be implemented or continued. Likewise, a wrap-around plan could be designed so that the participant bears some or all of the burden of the $250 deductible. Coinsurance or co-pays for coverage in excess of $250 but not greater than $2,850 could cover the amounts not otherwise covered by new Part D. However, amounts paid by an employer-sponsored plan seemingly increase as a participant is "reimbursed" by a group medical plan. The donut hole could also be filled, but not by too much. Again, for a participant to reach the point at which he/she is entitled to catastrophic coverage, his/her out-of-pocket costs must reach the threshold. Thus, any employer-sponsored retiree prescription drug benefit appears to increase the total costs that must actually be incurred for the participant to meet the threshold. Once the catastrophic threshold is reached, the employer-provided coverage can cover costs not covered by new Part D, but those costs should largely be negligible.

Comparing costs will inevitably lead to a variety of difficult issues. For example, the number of so-called "alternative prescription drug coverage" arrangements does not appear to be limited. Employers seeking to design wrap-around plans will probably find plan designs that are flexible enough to keep up with the various cost-sharing arrangements to be overly complex. For example, how will a retiree prescription drug feature based upon co-insurance address payments in instances where a participant only incurs a copayment?

From an HR perspective, the indexing of the various thresholds will cause additional administrative hassles. Each time the threshold amounts in new Part D are changed by legislation or the index feature, a wrap-around plan will probably need to be changed. While this could be avoided by simply providing 100% coverage for a participant's out-of-pocket costs for covered Part D prescription drugs and non-covered Part D prescription drugs, the plan sponsor will necessarily be gearing its costs to coverage provided by new Part D. We do note, however, that an annual cap on coverage could effectively limit what would otherwise be a generous benefit. On the other hand, those plan sponsors that want at least some cost sharing, deductibles

and the payment of out-of-pocket costs will probably need to change their plans each time new Part D thresholds change. In light of this, it will be incumbent upon plan sponsors to effectively reserve the right to amend the benefits structure.[49]

C. Ameliorating Potential Harm: Can HSAs and/or HRAs Help?

For employers seeking to get out of the business of providing retiree prescription drug coverage (and potentially even retiree medical benefits altogether), the problem is how to do so without leaving retirees "out in the cold." If an employer is willing to use or, in the alternative, encourage the use of HSAs and/or credit (or set aside amounts, perhaps using a "Voluntary Employees' Beneficiary Association" or "VEBA" trust) into HRAs, amounts against which a participant may draw for unreimbursed prescription drug benefits (and potentially other medical benefits) during retirement, it may be able to use the enactment of new Part D as the point at which to roll out a consumer-driven medical plan. One of the more notable problems is how this can be accomplished by January 1, 2006, when new Part D takes effect.

Even though amounts held in a participant's HSA may be carried over from one year to the next and remain available for reimbursement during an individual's retirement,[50] the usefulness of HSAs as a tool to transition retirees to a consumer-driven healthcare model is extremely limited for current and near-term retirees. There are two factors that cause this problem. First, the amount of money that may be contributed to an HSA is limited.[51] Second, no more contributions may be made to an individual's HSA when he/she becomes "entitled to benefits under title XVIII of the Social Security Act…." (*i.e.*, entitled to Part A Medicare benefits at age 65).[52] Setting aside the earnings on HSAs, these two provisions essentially render HSAs useless because it is impossible to get enough money into an HSA for current retirees and active employees who will soon be retiring. Accordingly, the elimination of retiree prescription drug benefits for those participants eligible for coverage under new Part D will leave participants inside the now-infamous donut hole.

Even though an HSA may not provide a useful way in which to provide current retirees and those active employees who will soon retire with a way in which to build up enough of a cushion to fill the donut hole in new Part D, it could nevertheless be a viable tool for

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[49] This will expose employers that need to collectively bargain over such minute issues to some careful soul searching. The difficult nut to crack will be developing and bargaining over flexibility. To a certain degree, the cost to those individuals who will receive standard Part D prescription drug coverage will only increase. In a sense, this could "play" to the employer's advantage, because caps on employer-provided coverage could be bargained. On the other hand, to the extent that such an arrangement begins to take on the characteristics of a separate plan (*i.e.*, it has different deductibles, coinsurance and co-pay amounts), the same administrative problems that we believe will be experienced when employers retain existing plans will simply reappear. Thus, careful consideration must be given to the way in which the wrap-around features are designed.

[50] New Code § 223(d)(2) (defining "qualified medical expenses" properly payable from an HSA without regard to rules similar to proposed Treasury regulation 1.125-2, Q&A-7(b)(3)) and new Code § 223(f) (providing for limitations on distributions from an HSA; however, ignoring the 12-month rule applicable to so-called "Flexible Spending Arrangements").

[51] New Code § 223(b)(2) and (3). Although there will be cost-of-living adjustments as described in new Code section 233(g), the amount set forth as the limit for individuals is the lesser of "the annual deductible under such coverage" or $2,250 for self-only coverage or the lesser of "the annual deductible under such coverage" or "$4,500 for family coverage. In any "taxable year" in which an individual has reached age 55, he/she may increase the limitation by a stated amount.

[52] New Code § 223(b)(7).

currently active employees who are expected to retire in the more distant future.[53] Obviously, the longer the time the participant has until retirement (*i.e.*, he/she becomes entitled to Medicare), the more likely it will be that participants could plan for retirement by accumulating as much of an account balance as possible. Although there are some "downsides," HSAs could be of at least some use in this instance.

An HRA, unlike the HSA, seems to be much better suited to being used as a tool to transition current retirees and those actives expected to retire soon into a consumer-driven medical arrangement that takes advantage of new Part D. Like an HSA, an HRA may reimburse a participant for properly reimburseable medical expenses once he/she has retired.[54] HRAs, however, appear to us to incorporate features that are more conducive to providing transitional assistance. For example, an employer may set aside any amount it desires and may do so even after the individual becomes Medicare eligible.[55] For example, an employer seeking to implement a consumer-driven health care model could estimate the cost of providing coverage that fills in the donut hole. Ratably over a period of year, the employer could credit the retiree's notional (or funded) HRA with an amount equal to what the employer determines the retiree should need to help offset out-of-pocket costs for prescription drugs. Likewise, an employer will not necessarily need to fund HRA contributions and could explore permissible ways in which a participant's HRA may be forfeited. Last, the employer is not required to extend specialized coverage (*i.e.*, the requirement for a "high deductible health plan" that applies when a contribution is made by and/or on behalf of an individual into an HSA) to participants in order to set a notional amount into a participant's HRA. Although an HRA is subject to the nondiscrimination standards set forth in Code section 105(h), that requirement should not be so bothersome that it cannot be overcome. In short, an HRA could be used as a vehicle to wean current and future retirees from rich retiree prescription drug coverage.

This approach offers several benefits. First, the employer's liability for retiree prescription drug coverage could be fixed, because the employer could fix the amount of its contributions. It also provides an interim system through which participants could be transitioned into an arrangement where they have a set amount they may use to fill the donut hole in new Part D. Perhaps most importantly, the use of an HRA in this manner could provide for enough transitional relief to begin implementing a viable HSA that has the chance of being in place long

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[53] We hasten to add that implementing HSAs partly as a tool intended to fill in the donut hole may not be that reliable and we are inclined to view HSAs as a tool to inject "consumerism" into employer-provided group medical benefits as a whole. For example, relying on HSAs as a stand-alone funding vehicle which enable participants to save to provide for retiree medical benefits may result in the sickest participants being left with little or no protection, because their HSAs would presumably be more consumed than an HSA for a healthy individual. In addition, new Code section 233(f), which addresses the tax treatment of distributions, provides in subsection (2) that distributions not used for qualified medical expenses during a taxable year shall be included in the gross income of the distributee and subsection (4)(A) provides for a 10% excise tax for amounts not used for qualified medical expenses during a taxable year. Except for the exception set forth in new Code section 233(f)(4)(B), which provides an exception to the 10% excise tax when a participant is disabled or dies, there is an exception to the 10% excise tax set forth in new Code section 233(f)(4)(C) when an individual reaches age 65. Accordingly, one of the large disincentives that encourages individuals to leave the HSA account balance in place is removed at precisely the time that we would like for the money to be available, which runs counter to the tendency to rely on such an arrangement to stand in the place of coverage for prescription drugs for retirees. Nevertheless, we do note that HSAs coupled with a "high deductible health plan" that provides retiree medical coverage could be a way in which to deliver pre- and post-65 retiree medical benefits.

[54] Notice 2002-41, III.

[55] The ability to set aside or make contributions after a participant retires appears to be a fundamental characteristic of HRAs. This is based upon the application of Code section 105 and 106 to retirees.

enough for future retirees to accumulate enough of an account balance to last them through their retirement.

IV. FAS 106: To Delay or Not to Delay

On January 12, 2004, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position Financial Accounting Standard ("FAS") No. 106.1 in response to the passage of the Act (hereinafter "FSP 106.1"). Because of the effective date of the Act, the government subsidization of prescription drug benefits provided in retiree medical plans could have a current effect on the FAS 106 liability booked by sponsoring employers.[56] Because of uncertainties regarding the impact of the passage and implementation of the Act on a sponsor's accumulated postretirement benefit obligation and net periodic postretirement benefit cost,

> a plan sponsor may elect to defer recognizing the effects of the Act in the accounting for its plan under Statement 106 and in providing disclosures related to the plan required by FASB Statement No. 132 (revised 2003), Employers' Disclosures about Pension and Other Postretirement Benefits, until authoritative guidance on the accounting for the federal subsidy is issued, or until certain other events … occur.[57]

FSP 106.1 sets disclosure obligations for sponsors of plans providing retiree prescription drug coverage who elect to delay reflecting the passage of the Act into law. Such a plan sponsor,

> should disclose in annual or interim financial statements (a) the existence of the Act and the fact that, in accordance with this FSP, any measures of the APBO or net periodic postretirement benefit cost in the financial statements or accompanying notes do not reflect the effects of the Act on the plan and (b) the fact that specific authoritative guidance on the accounting for the federal subsidy is pending and that guidance, when issued, could require the sponsor to change previously reported information.[58]

Moreover, FASB will issue issue transitional guidance for those employers who elect to delay.[59]

In part, the rationale for providing such a delay is based upon the difficulty in determining "actuarial equivalence," because the Secretary of Health and Human Service has obviously not yet published final regulations on this particular issue.[60] There are additional reasons for this position, but, clearly, without standards, it would be difficult to take into account the effect, if any, of employee contributions toward such coverage, the effect of limits such as caps on an employer's obligations and other issues that affect an employer's obligations.[61]

FSP 106.1 also provides guidance for employers who sponsor retiree prescription drug coverage and don't elect to delay reflecting the impact of the passage of the Act on booked FAS 106 liabilities. In particular, it provides as follows:

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[56] FSP 106-1 at ¶¶ 3, 4 and 5.
[57] *Id* at ¶ 9.
[58] *Id* at ¶ 10 (citation omitted).
[59] *Id* at note 6.
[60] *Id* at ¶ 4.
[61] *Id* (noting other factors, including the "magnitude of the subsidy for a sponsor depends on how many Medical-eligible retired plan participants choose not to enroll in the *voluntary* Medicare Part D plan…" and, thereby, necessarily certain plan design issues (*e.g.*, whether sponsors, as an issue of plan design, require participants to elect to participate in new Part D prescription drug benefits) (emphasis in original).

> A plan sponsor that does not elect the deferral provided by this FSP should disclose in annual or interim financial statements (a) the effects, if any, of the Act on the reported measure of the accumulated postretirement benefit obligation; (b) how that effect has been, or will be reflected, in the net postretirement benefit costs of current or subsequent periods; (c) the effects of any changes in estimates of participation rates or per capita claims costs as a result of the Act; and (d) the fact that specified authoritative guidance on the accounting for the federal subsidy is pending and that guidance, when issued, could require the sponsor to change previously reported information. To the extent a plan sponsor's accounting recognizes the effect of the federal subsidy, the sponsor should disclose the basis for concluding that its plan is at least "actuarially equivalent" (as defined in the Act) to Medicare Part D. In addition, if the plan sponsor concludes that some or all of the federal subsidy related to prescription drug costs included in the APBO should be recognized immediately as a component of income from continuing operations, any amount so recognized should be reported as a separate line item on the face of the income statement or statement of activities. For purposes of this requirement, current period amortization of amounts measured but initially deferred as of the date of enactment of the Act does not constitute immediate recognition.[62]

Given the fact that the effect of the Act on an employer's FAS 106 liability is required to be taken into account for interim or financial statements of fiscal years ending after December 7, 2003,[63] employers are encourage to consult with their auditors and actuaries. There are also rules governing the election to defer. They are as follows:

> The election to defer accounting for the Act is a one-time election that must be made before the net periodic postretirement benefit costs for the period that includes the Act's enactment date are first included in reported financial information pursuant to the requirements of Statement 106. If an entity elects deferral, that election may not be changed, and the deferral continues to apply until authoritative guidance on the accounting for the federal subsidy is issued, or until the guidance in the following sentence applied. The election to defer expires if, subsequent to January 31, 2004, but prior to the issuance of additional authoritative guidance, a significant event occurs that ordinarily would call for a remeasurement of a plan's assets and obligations – for example, a plan amendment, settlement or curtailment. *Upon the occurrence of such an event, the sponsor would account for that event pursuant to the guidance in Statement 106 and also should reflect in its accounting for the plan its best estimates of the Act, including the federal subsidy (if applicable based on the terms of the plan and the sponsor's analysis of generally accepted accounting principles) and any effects on participation rates and health care cost estimates*.[64]

Obviously, the last sentence should give rise to some valid concerns for employers that elect to delay and to amend their retiree medical plans prior to the time when the sponsor's financials are supposed to reflect the passage of the Act. We note that we are aware of least one major

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[62] *Id* at ¶ 11 (citations omitted).

[63] *Id* at ¶ 12 (noting that "[w]hen those costs are reported depends on the measurement date selected by the plan pursuant to paragraph 72 of Statement 106. For example, if a public company with a December 31 fiscal year-end uses a September 30 measurement date, the net periodic postretirement benefit costs for the period that includes the Act's enactment date, the net periodic post retirement benefit costs for the period that includes the Act's enactment date would be reported in the first interim period of 2004.").

[64] *Id* at ¶ 12 (emphasis added).

accounting firm, PricewaterhouseCoopers, which has recommended that employers elect to delay.[65]

IV. Special Considerations: Avoiding Some Particularly Nasty Pitfalls

A. The Duty to Disclose: Don't Forget *Varity*!

Standing alone, the addition of the discount program and Part D should cause current and future retirees to begin asking questions sooner rather than later. It will be easy to find a naysayer willing to provide a quote that the Act will mean the death of retiree medical benefits. The questions will inevitably start with a participant asking for advice about enrolling in new Part D, but that same participant may also ask whether the employer is planning to kill off the retiree medical plan. From an "HR" perspective, a unified message must be developed. How will the sponsor respond to these changes? However, it will probably be the case that, whether or not current and future retirees ask questions, the plan sponsor will probably be exposed to at least some liability.

In a widely publicized series of cases that, at least most noticeably, began with the Supreme Court's decision in *Varity v. Howe*,[66] employers have been required not to lie to participants. While the lines of the various tests dictating what can and cannot said and when it must be said are beyond the scope of this article, plan sponsors will be well served by heeding the message of *Varity* and other cases exploring the ever-evolving duty to disclose.[67]

What does this all mean? Plan sponsors have a twofold duty. Not only must plan sponsors deal with the plan design issues, but they must also deal with the participants. We recommend that employers who sponsor retiree medical programs begin considering the ways in which they are planning to respond. Whether an employer plans to do nothing at all or to amend or terminate retiree prescription drug coverage, consult with benefits counsel regarding the *Varity*-type duties so that any communications will minimize any legal exposure to which ERISA fiduciaries are exposed.

B. COBRA Continuation Coverage[68]

As is made clear by Treasury regulation section 54.4980B-3, Q&A-2(b), a retiree receiving group medical benefits is subject to the COBRA continuation coverage rules.[69] If a participant experiences the "event" part of the qualifying event (other than "a proceeding in bankruptcy under Title II of the United States Code with respect to an employer from whose

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[65] PricewaterhouseCoopers, *Understanding the Accounting and Disclosure Requirements Related to the New Medicare Act*, 04 HRS Insight 03 (2004).

[66] 516 U.S. 489, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996).

[67] *Vartarian v. Monsanto Co*., 131 F.3d 264 (1st Cir.1997); *Pocchia v. NYNEX Corp.*, 81 F.3d 275 (2d Cir.1996); *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130 (3d Cir.1993); *Fischer v. Philadelphia Elec. Co.*, 96 F.3d 1533 (3d Cir.1996); *Muse v. IBM Corp.*, 103 F.3d 490 (6th Cir.1996); *Wilson v. Southwestern Bell Tel. Co.*, 55 F.3d 399 (8th Cir.1995); *Bins v. Exxon Co. U.S.A.*, 189 F.3d 929 (9th Cir.1999); *Bins v. Exxon Co. U.S.A.*, 220 F.3d 1042, (9th Cir.2000); *Maez v. Mountain States Telephone & Telagraph Co.*, 54 F.3d 1488 (10th Cir. 1995); *Hocket v. Sun Co.*, 109 F.3d 1515 (10th Cir.1997); *Barnes v. Lacy*, 927 F.2d 539 (11th Cir.1991); *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747 (DC Cir.1990).

[68] All references to the term "COBRA" are to the Consolidated Omnibus Budget Reconciliation Act of 1985.

[69] (providing that "a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment.").

employment a covered employee retired at any time")[70] and, within a certain time limit, a "loss of coverage," which is defined to mean virtually any change to the "terms and conditions as in effect immediately before the qualifying event," he/she will be entitled to elect COBRA continuation coverage.[71] Employers would be well served by considering COBRA continuation coverage obligations when making changes to retiree medical plans. Moreover, there may be some timing issues. For example, will a COBRA beneficiary's COBRA continuation coverage be cut short by virtue of his/her becoming entitled to new Part D after an affirmative COBRA continuation coverage election?[72] Last, employers that have recently sought bankruptcy protection under Title 11 of the United States Code have additional considerations, which could result in so-called "lifetime" COBRA continuation coverage.[73] In any event, employers considering reductions to and/or the elimination of retiree prescription drug coverage should carefully consider whether a COBRA continuation coverage issue has been raised.

V. Future Trends

As part of the Act, Congress commissioned two studies to investigate employer-provided retiree medical coverage and the ways in which the passage of the Act affect such coverage. This means that Congress will be monitoring the ways in which employers react to the passage of the Act. However, it will be difficult to asses the effects of the Act on employer-sponsored retiree prescription drug benefits until the regulatory framework is in place and employers have had ample opportunity to assess the Act and respond. Nevertheless, that doesn't mean that Congress won't be tinkering with new Part D in the meantime. The best we can hope for is that everyone remains flexible.

[70] Treas. Reg. 54.4980B-4, Q&A-1(b).
[71] Treas. Reg. 54.4980B-4, Q&A-1(c).
[72] Treas. Reg. 54.4980B-7, Q&A-3
[73] Treas. Reg. 54.4980B-7, Q&A-4(e).