OPINION OF TRUSTEES

In Re

Complainant: UMWA, International Union
Respondent: Employer
ROD Case No: 02-029 – May 3, 2006

Trustees: Micheal W. Buckner, A. Frank Dunham, Michael H. Holland, and Elliot A. Segal.

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of benefits under the terms of the Employer Benefit Plan.

Background Facts

Pursuant to the terms of the National Bituminous Coal Wage Agreement of 2002, Employers provide comprehensive health benefits, including prescription drug and vision care, to eligible coal mining industry Employees and Pensioners and their eligible Dependents. In 2003, Congress enacted the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"). Under the MMA, plan sponsors who provide prescription drug coverage to their Medicare-eligible beneficiaries are eligible to receive a retiree drug subsidy from Medicare if, beginning January 1, 2006, the coverage offered is "creditable coverage," i.e., actuarially equivalent, to the standard prescription drug benefit offered by Medicare under Medicare Part D. The MMA does not, however, require an employer-sponsored plan that provides prescription drug coverage to its Medicare-eligible beneficiaries to continue to do so. Under Medicare Part D, individuals who are eligible for Medicare Part A and Part B and who do not have the option of creditable coverage from a retiree drug plan which qualifies for the Retiree Drug Subsidy, may choose a prescription drug plan provided through a private company.

In general, Medicare Part D requires payment of a monthly premium, a deductible, coinsurance and other graduated payments, coverage of at least two drugs in every drug category, and that certain drugs be excluded from the list of covered drugs provided under the Part D standard plan. An individual receiving Medicare Part D drug coverage may request that the plan grant him or her an "exception," under which the plan agrees to pay for a drug not otherwise covered by the plan, or appeal the plan's denial decision. An individual may also enroll in a Medicare Part D prescription drug plan that offers coverage in addition to the standard coverage, generally for a higher premium than the premium for standard Medicare Part D prescription drug coverage. Depending on the prescription drug plan selected, the actuarial value of such plan may be less than the actuarial value of the prescription drug benefit offered under the Employer Benefit Plan, the Medicare Part D prescription drug plan may cover fewer drugs than those covered under the Employer Benefit Plan and an individual will have out-of-pocket expenses greater than those required under the Employer Benefit Plan.

The Respondent notified its Medicare-eligible beneficiaries by letter dated August 2005, that effective January 1, 2006, Medicare would offer a prescription drug benefit known as Medicare Part D. The Respondent also informed them that, "your benefit plan requires enrollment in any Medicare plan for which you are eligible; therefore, you are required to enroll in a Medicare Part D plan to qualify for prescription drug coverage under your [Respondent's name] benefit plan." The Respondent further stated that its Medicare-eligible beneficiaries would receive additional information concerning enrollment and premium information in the near future.

In November 2005 the Respondent sent a second letter advising its Medicare-eligible beneficiaries that the Respondent was offering to enroll automatically all Medicare-eligible beneficiaries in a Medicare approved group drug plan and that the monthly premium charge would be $30.00 per member.

In December 2005 a third mailing was sent to the Respondent's Medicare-eligible beneficiaries advising them that "group enrollment would take care of any enrollment responsibilities as long as the beneficiary elected to remain in the Medicare Part D plan offered by Prescription Solutions from PacifiCare" [the Respondent's Medicare Part D pharmacy drug provider]. The Respondent also informed such beneficiaries that the monthly premium charge would be $10.00.

The Respondent states that "[a]lmost 99% of the pharmacies (26,906) in the [Respondent's name] employer plan network also participate in the Medicare Part D plan offered through Prescription Solutions from PacifiCare." The Respondent notified its most active pharmacies that effective January 1, 2006, beneficiaries would begin presenting two prescription drug identification cards: a Medicare Part D pharmacy card and a card for the Respondent's pharmacy carrier.

Dispute

Can the Respondent require Medicare-eligible Pensioners and Surviving Spouses to enroll in a Medicare Part D plan and to pay such plan's premiums, deductibles, copayments and other graduated payments as a condition of continuing to receive the prescription drug coverage under the Employer Benefit Plan that is not covered by Part D?

Positions of the Parties

Position of the Complainant: The Respondent's unilaterally imposed requirement that Medicare-eligible beneficiaries enroll in Medicare Part D at their own cost is a violation of the National Bituminous Coal Wage Agreement and the Employer Plan Document for many reasons, including but not limited to the following: 1) There is no authority for the Employer's threat to terminate health care for beneficiaries who do not enroll in Part D; 2) The Part D premium represents a prohibited additional cost; 3) Beneficiaries will be required to pay prohibited up-

front costs for Part D copayments and deductibles; 4) Information regarding Part D has been poorly communicated by the employer, making it unreasonable with the likely result that beneficiaries will lose coverage; 5) The manner in which the employer's formulary program will coordinate with the Part D provider's formulary program will impose prohibited additional costs on beneficiaries; and 6) The number of pharmacies that will be able to provide both the Part D benefit and the employer's prescription drug benefit will be too small to satisfy the PPL rules.

Position of the Respondent: Medicare-eligible Pensioners and Surviving Spouses are required to enroll in Medicare Part D in order to continue to receive coverage under the Respondent's Employer Benefit Plan for the following reasons: 1) Since 1978, the governing plan documents collectively bargained by the UMWA and BCOA have consistently excluded all benefits provided under Medicare, and have required Medicare-eligible beneficiaries to enroll in Medicare as a precondition to eligibility; 2) the Plan provisions that address enrollment in Medicare and exclusions under the Plan are broadly drafted and not limited to Medicare Parts A and B; 3) A condition of "enrollment" in Medicare Part D is the payment of a monthly premium; and 4) Based on plan language (Art. III.A(10)(d)) and prior Trustee decisions (see RODs 88-650 and CA-071) the benefits provided under the Plan do not have to be provided if a Medicare-eligible beneficiary refuses to sign up for Medicare Part D.

The Respondent further states that beneficiaries will not be required to pay prohibited up-front costs for co-payments and deductibles when using a pharmacy in the Prescription Solutions network. Finally, the Respondent asserts that its program has been widely and effectively communicated to its beneficiaries, and that the number of pharmacies in its network (over 27,180) is adequate to meet the requirements of the PPL rules.

Pertinent Provisions

Article III. A. (10)(d) of the Employer Benefit Plan provides:

ARTICLE III BENEFITS

A. Health Benefits

(10) General Provisions

* * *

(d) Medicare

1. For Pensioners, and surviving spouses, the benefits provided under the Plan will not be paid to a Beneficiary otherwise eligible if such

Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

2. For Employees age eligible for Medicare the benefits provided under the Plan will be paid to a Beneficiary unless the company is furnished written notice of electing coverage under Medicare rather than coverage under the Plan. Alternatively, the participant may elect to enroll for Medicare as secondary payer.

The Plan Administrator shall give written notification of the obligation to enroll with respect to 1. above and of the options to enroll with respect to 2. above. For active Employees such notice shall be given prior to their Medicare-eligibility birthdays, but subsequent to their immediately preceding birthdays. Said notice shall explain the limited annual enrollment period and the effect of failing to enroll if retirement should occur prior to the next enrollment period. Failure to provide such notification shall not remove any obligation to enroll.

Article III. A. (11) (a) 3. of the Employer Benefit Plan states:

ARTICLE III BENEFITS

A. Health Benefits

(11) General Exclusions

(a) In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:

* * *

3. Services furnished by any governmental agency, including benefits provided under Medicaid, Federal Medicare and Federal and State Black Lung Legislation for which a Beneficiary is eligible or upon proper application would be eligible.

ARTICLE IV MANAGED CARE, COST CONTAINMENT

A. (1) The Employer may adopt Participating Provider Lists (PPL's) of physicians, hospitals, pharmacies and other providers, subject to the requirements set forth in C., below.

(2) In addition, the Employer may implement certain other managed care and cost containment rules, which may apply to benefits provided both by PPL providers and by non-PPL sources, but which (except for the deductibles and co-payments specifically provided for in the Plan) will not result in a reduction of benefits or additional costs for covered services provided under the Plan.

* * *

C. The following requirements apply to a PPL implemented under this Plan:

* * *

3. Criteria--A PPL established by an Employer must meet the necessary criteria. The following is a general statement of the required elements:

4. Choice--Each covered individual will have the freedom to select any provider within the PPL, regardless of whether that provider is a generalist or specialist.

5. Reduction of Paperwork and Prohibition on Prepayment--Eligible individuals utilizing PPL providers shall, to the extent possible, not be required to fill out or submit claims forms. In addition, such individuals shall not be required to pay a PPL provider any amount other than the copayment and any outstanding annual deductible permitted under this Agreement.

6. Quality Certification—All providers must meet quality standards.

7. Accessibility

a. Providers will be available within a reasonable distance. Where possible, this means that a covered individual will not have to travel more than 20 to 30 minutes to receive general medical care.

b. There will be adequate numbers of providers in the different specialties to ensure that each member will have a sufficient choice.

c. Providers must be available to see covered individuals within a

reasonable period, depending upon the nature of the problem.

* * *

12. Beneficiaries Outside PPL Area--A Beneficiary who lives outside an area served by the PPL shall be permitted to utilize non-PPL providers without incurring additional deductibles and copayments. For purposes of determining the Beneficiary's deductibles and copayments, utilization of such non-PPL providers shall be considered to be within the PPL.

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Discussion

The Trustees deadlocked on this matter. Trustees Holland and Buckner found for the Complainant. Trustees Dunham and Segal found for the Respondent. Under the ROD procedures approved by the Trustees of the UMWA 1993 Benefit Plan, the matter was referred to a neutral interest arbitrator, Robert E. Nagle, for resolution. The arbitrator was directed to choose one of the two draft opinions proposed by the Trustees. The arbitrator's choice is printed below as the Opinion of the Trustees.

Opinion of the Trustees

The Employers' requirement that their beneficiaries enroll, at the beneficiaries' own cost, in Medicare Part D is a violation of the Employer Benefit Plan and the National Bituminous Coal Wage Agreement.