Retiree Welfare Benefits Litigation

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.10 The Basics

Retiree welfare benefits include non-pension benefits provided by employers to retired employees, primarily medical and life insurance benefits.[1] The vast majority of retiree welfare benefits litigation involves post-retirement medical benefits and most of the legal principles developed in retiree medical litigation apply to other post-retirement welfare benefits. Accordingly, this report focuses on retiree medical benefits.

Most of the recent activity in this area involves collectively-bargained retiree medical benefits. In *M& G Polymers USA, LLC v. Tackett*,[2] the seminal 2015 decision addressing the vesting of retiree medical benefits, the Supreme Court abrogated the retiree-friendly ''*Yard-Man* presumption,''[3] which the Sixth Circuit had used for 30 years to evaluate whether collectively-bargained retiree medical benefits were vested. The Court instructed that, instead of a presumption in favor of vesting, courts should apply ''ordinary principles of contract law'' when analyzing whether collectively-bargained retiree medical benefits survive the expiration of a collective bargaining agreement. The Court explained that, inter alia, the Sixth Circuit's refusal to give effect to general durational clauses in collective bargaining agreements was inconsistent with normal rules of contract construction.

Initially, lower courts reached different, and arguably conflicting, results when applying *Tackett*'s ''ordinary principles of contract law'' directive. For example, the Fourth Circuit concluded that a clause in a collective bargaining agreement limiting the duration of retiree medical benefits to the ''term of the agreement'' was dispositive evidence that the parties didn't intend to vest post-retirement medical benefits.[4] On the other hand, the Sixth Circuit held that a general durational clause (*i.e*., a clause defining the term of the bargaining agreement as a whole) wasn't controlling and that other provisions of the labor agreement rendered it ambiguous as to the duration of post-retirement medical benefits, opening the door for the consideration of extrinsic evidence.[5] Faced with these divergent interpretations of *Tackett*, the Supreme Court weighed in again in early 2018 to reaffirm the *Tackett* principles and stress the importance of general durational clauses in discerning the parties' intent regarding the duration of retiree medical benefits.[6] Following the Supreme Court's ruling in *Reese*, no court has found vested post-retirement medical benefits where the collective bargaining agreement contained a general or specific durational clause. These case law developments and others are discussed in further detail below.

.10.10 Historical Background

Employer provided post-retirement medical benefits are a relatively recent phenomenon. First offered in the 1940s by insurance companies for their employees, post-retirement medical benefits didn't become widespread until the 1960s.

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[1] ERISA § 3(1) defines a welfare benefit plan as: "Any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits...."

[2] *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 933, 2015 BL 16721, 59 EBC 1425 (2015).

[3] *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Yard-Man, Inc.*, 716 F.2d 1476, 4 EBC 2108 (6th Cir. 1983).

[4] *Barton v. Constellium Rolled Prods.-Ravenswood, LLC*, 856 F.3d 349 (4th Cir. 2017). Litigants refer to such provisions as "specific" durational clauses because they apply specifically to retiree medical benefits and not to the agreement as a whole.

[5] *Reese v. CNH Indus., N.V.*, 854 F.3d 877 (6th Cir. 2017), rev'd, 138 S. Ct. 761 (2018); *UAW v. Kelsey-Hayes*, 854 F.3d 862 (6th Cir. 2017).

[6] *CNH Indus., N.V. v. Reese*, 138 S. Ct. 761 (2018) (per curiam).

Employers generally found post-retirement medical benefits inexpensive when compared to pension benefits, and they became even less expensive with the introduction of federally-funded Medicare in the late 1960s. Employers providing medical coverage to their active employees often thought little about extending the coverage to retirees, especially since the relatively low cost of these benefits was accounted for on the same ''pay as you go'' basis as active employee medical expenses.

Beginning in the 1980s, several significant trends thrust post-retirement medical benefits to the forefront of employer cost concerns:

- Medical care cost inflation began to consistently outpace other inflation indices such as the Consumer Price Index and the Producer Price Index.
- Average retirement age declined, a trend that has accelerated due to widespread early retirement incentive programs and buyouts. Retirement before eligibility for Medicare (generally age 65) can dramatically increase the employer's retiree medical costs because Medicare pays approximately 60 percent of the cost that would otherwise be borne by employer-financed plans.
- As the cost of post-retirement medical benefits increased, the portion of the cost paid by Medicare decreased.
- The range of post-retirement medical benefits provided by employers expanded as employers moved from limited fee-for-service plans to largely unlimited indemnity plans covering all medical expenses beyond annual deductibles and out-of-pocket maximums. At the same time, federal and state governments passed laws requiring employers and insurance companies to provide certain kinds of coverage and extend coverage beyond termination of employment.[7]

Although these trends caused many employers to rethink and reduce or eliminate their commitment to providing post-retirement medical coverage, it wasn't until the introduction of Financial Accounting Standard (FAS) 106 in December 1990 that employers were forced to focus on post-retirement medical costs in a systematic way.[8] Prior to the introduction of FAS 106, most employers simply ''expensed'' each year's actual cost for post-retirement medical coverage on their financial statements in the same manner as active employee medical expenses. FAS 106 dramatically changed the accounting treatment of post-retirement medical benefits by requiring employers to ''pay'' for them over each employee's working lifetime through an annual expense charge on the employer's financial statements for the anticipated future post-retirement benefit. Thus, employers providing post-retirement medical benefits not only had to record the expense for current retirees on their books, they had to record the cost for future retirees (i.e., active employees) as well.

Employers were shocked at the sheer size of the FAS 106 liability estimates. Unlike pension or life insurance benefits, which generally are fixed at retirement, post-retirement medical benefit costs increase as medical costs rise. In valuing these liabilities, accountants and actuaries must assume that the liabilities will increase in the future, often at extremely high rates compounded over several decades. Although employers are permitted to reduce their post-retirement medical liabilities by amounts set aside to fund them, most employers were discouraged from prefunding these

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[7] *See* ERISA title I, subtitle B, part 6 (COBRA); part 7 (Portability, Mental Health Parity, etc.). State laws that mandate certain benefits generally aren't applicable to self-funded employer-sponsored plans; however, they can apply to employer plans that provide benefits through group insurance contracts. *See Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 6 EBC 1545 (1985). The Affordable Care Act of 2010 (ACA) contained several provisions that directly or indirectly affected retiree health plans, including the creation of a temporary Early Retiree Reinsurance Program to provide financial assistance to plan sponsors offering pre-65 retiree health benefits and the imposition of an excise tax on high-cost employer sponsored plans (so-called ''Cadillac plans''). At the same time, retiree-only plans were exempted from many ACA requirements for group health plans and market reforms. This exemption is important because it allows the use of health reimbursement arrangements (HRAs) to pay retiree premiums without running afoul of the ACA. Finally, the ACA made changes to Medicare that have the potential to reduce out-of-pocket expenses for Medicare beneficiaries and lower the costs of employer-sponsored Medicare supplemental plans. See The Henry J. Kaiser Family Foundation, ''Retiree Health Benefits At the Crossroads,'' April 2014.

[8] FAS 106 (now contained in Topic 715-60 of the Financial Accounting Standards Board's Accounting Standards Codification) applies to all non-pension post-retirement benefits (such as medical and life insurance). See FASB Accounting Standards Codification, Topic 715 Compensation—Retirement Benefits.

liabilities by congressional action in 1984 that eliminated favorable tax treatment for prefunding post-retirement medical benefits.[9]

These factors prompted employers to reevaluate their continuing commitment to post-retirement medical coverage, and in some instances to reduce or eliminate it altogether. But as employers moved to implement these cost-containment measures, they were confronted with lawsuits by retirees who claimed that their post-retirement medical benefits were, like their pensions, vested. But post-retirement medical benefits, unlike pension benefits, don't automatically vest by operation of law.[10] Nonetheless, employees often viewed post-retirement medical benefits in the same light as vested pensions, and employers usually did little to discourage these notions, often because management itself never expected that post-retirement medical benefits would need to be changed or eliminated.

In the wake of these legal challenges, employers seeking to reduce or terminate their post-retirement medical obligations have been forced to consider carefully whether they have the legal right to implement such measures for existing retirees. The financial stakes are huge. If the employer has the right to reduce or eliminate post-retirement medical benefits for existing retirees, it can take any such changes into account when it values such benefits liabilities for FAS 106 purposes.

If, on the other hand, the employer doesn't have the legal right to change coverage for existing retirees, it may be compelled to bear much of the cost itself or, in extreme cases, attempt to shed the liability through bankruptcy or a sale or reorganization of the business. Alternatively, the employer might decide to shift the cost-containment burden to current employees by reducing (or eliminating) the post-retirement medical benefits they will receive in the future. In that case, current employees will essentially bear the entire burden of post-retirement medical cost containment.[11]

.20 Determining Whether Retiree Medical Benefits Can Be Modified

Overview

ERISA established a comprehensive statutory scheme for regulating pension and welfare benefit plans. Significantly, ERISA doesn't require that private employers establish pension or welfare plans for their employees, nor does ERISA require that a particular level of benefits be offered once a plan is established, with some notable exceptions for medical plans.[12] Rather, employers who choose to establish benefit plans must comply with certain regulatory requirements. The voluntary nature of the benefit plan system is an important concept to consider when evaluating an employer's right to change or terminate post-retirement medical benefits, because it suggests that restrictions on this right shouldn't be presumed or favored. Doing so could discourage employers from adopting these type of plans.[13]

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[9] Internal Revenue Code § 419A was enacted in 1984 and precludes an employer from deducting amounts set aside to prefund future retiree medical cost inflation. Since the inflation component represents the largest portion of post-retirement medical liabilities, § 419A largely eliminated employer tax deductions for prefunding of retiree medical liabilities. At the same time, Congress decided to tax previously tax-exempt income earned on reserves set aside to fund post-retirement medical benefits. *See* I.R.C. § 512(a)(3)(E). Income on reserves set aside to fund pension benefits generally isn't subject to income tax.

[10] *See* ERISA § 201(1) (exempting "employee welfare benefit plan[s]" from the pension vesting rules set forth in ERISA § 203(a)).

[11] Legal challenges by current employees to changes in the post-retirement medical benefits they will receive in the future generally have been unsuccessful. *See Wise v. El Paso Natural Gas Inc.*, 986 F.2d 929, 16 EBC 1789 (5th Cir. 1993); *but see Miss. Power Co. v. NLRB*, 284 F.3d 605, 28 EBC 1498 (5th Cir. 2002) (holding that retiree welfare benefits of active employees couldn't be modified prospectively without first bargaining with the union).

[12] *M&G Polymers*, 135 S. Ct. at 933; *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85, 4 EBC 1593 (1983); *see also Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90, 96, 27 EBC 1139 (2d Cir. 2001); *Sejman v. Warner-Lambert Co.*, 889 F.2d 1346, 1348-9, 11 EBC 2262 (4th Cir. 1989), *cert. denied*, 498 U.S. 810 (1990); *Young v. Standard Oil (Ind.)*, 849 F.2d 1039, 1045, 9 EBC 2544 (7th Cir. 1988), *cert. denied*, 488 U.S. 981 (1988); *Phillips v. Amoco Oil Co.*, 799 F.2d 1464, 1471, 7 EBC 2246 (11th Cir. 1986), *cert. denied*, 481 U.S. 1016 (1987); *Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350, 1351-52 (8th Cir. 1985).

[13] *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (courts should take account of Congress's "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place").

Title I of ERISA establishes reporting, disclosure, vesting, funding, benefit accrual, and fiduciary requirements for all U.S. pension plans.[14] Title IV of ERISA establishes the Pension Benefit Guaranty Corporation (PBGC), which guarantees the payment of pensions subject to certain limits. However, ''welfare benefit plans,'' which include plans that provide post-retirement medical benefits, are exempted from ERISA's vesting, funding, and benefit accrual requirements and aren't guaranteed by the PBGC or any other government agency.[15] In fact, welfare benefit plans must comply only with ERISA's reporting, disclosure, and fiduciary requirements and certain coverage requirements.[16]

While Congress consciously chose not to require vesting of post-retirement medical benefits in ERISA, it did require that plan sponsors maintain welfare benefit plans pursuant to written plan documents,[17] and that covered participants be able to enforce these documents in accordance with their terms.[18] In addition, Congress required that employers communicate the plan terms to covered participants and beneficiaries in summary plan descriptions (SPDs) that are written in language understandable by the average plan participant.[19] Subject to these requirements, employers have discretion to determine the benefit levels provided to their employees and design the plans appropriately.[20]

Thus, when the courts are called upon to determine whether post-retirement medical benefits have vested, they focus first on the plan documents and SPDs. If these documents unambiguously answer the vesting question, the inquiry ends. If these documents are ambiguous or internally inconsistent, the courts look to ''extrinsic evidence'' to determine whether the employer intended to vest post-retirement medical benefits. Such evidence may take the form of letters, summaries, brochures issued by company human resources personnel, or oral statements by management personnel made years ago.

Although this contractual analysis appears straightforward, it often is complicated by separate contractual agreements outside the plan documents, such as collective bargaining agreements or early retirement buyout agreements, and by the existence of multiple versions of the governing plan documents and SPDs issued over many years. In practice, the contractual analysis provides a framework for what is otherwise a fact-intensive inquiry involving more art than science. Despite the absence of hard and fast rules, a few general observations can be made:

- The courts are often receptive to the retirees' claims at the pleadings stage. Retirees make sympathetic plaintiffs because they are elderly and usually live on modest fixed incomes. They often tell an appealing story of fulfilling their ''contract'' by working many years for the employer until retirement. Having retired, they have lost the bargaining leverage they had as employees to quit and work elsewhere if they believed they were being treated unfairly. Why then shouldn't the employer be required to keep its end of the bargain? It was precisely this logic that led one judge to hold an employer couldn't reduce post-retirement medical benefits even if the plan documents permitted it.[21] Although this case was reversed, it highlights the difficulty some judges have with the notion that retirement benefits can be unilaterally changed after an employee retires.
- A dichotomy has developed between the interpretation of collectively bargained and unilaterally established retiree medical plans. Collectively bargained plans are interpreted in accordance with labor law that focuses

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[14] Certain plans covering only top management, as well as church and governmental plans, are exempt. from these requirements. *See* ERISA § § 4(b), 201(2), 301(a)(3), and 401(a)(1).

[15] *See* ERISA § 201(1); ERISA § 301(a)(1).

[16] *See* ERISA Title I, Subtitle B, parts 1 and 4. Title I of ERISA also contains provisions compelling employers to offer former employees (including retirees) and their dependents the opportunity to continue medical coverage following termination of employment for specified periods of time, provided they pay the cost of coverage. Other provisions in Title I limit employers' ability to exclude coverage for certain conditions and require parity for mental health coverage and mastectomies. *Id.*, parts 6 and 7. These provisions generally have not been at issue in retiree medical litigation.

[17] ERISA § 402(a) states in relevant part: "(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan...."

[18] *See* ERISA § 502(a)(1).

[19] *See* ERISA § 102(a).

[20] *E.g.*, *M& G Polymers*, 135 S. Ct. at 933 ("[E]mployers have large leeway to design disability and other welfare plans as they see fit.") (citation omitted).

[21] *Hansen v. White Farm Equip. Co.*, 42 B.R. 1005, 5 EBC 2130 (Bankr. N.D. Ohio 1984), *rev'd sub nom. In re White Farm Equip. Co.*, 788 F.2d 1186, 7 EBC 1411 (6th Cir. 1986).

on whether post-retirement benefits terminate upon expiration of the collective bargaining agreement On the other hand, unilaterally established plans generally don't have expiration clauses and are interpreted in accordance with general rules of contract construction that can differ in subtle ways from the construction applied under labor law. Moreover, because employers draft the documents for unilaterally established plans without bargaining over their terms, those documents often contain ''reservation of rights'' clauses allowing the employer to amend or terminate the benefits at any time. In *Tackett*, the Supreme Court closed the gap between collectively-bargained and unilaterally-established plans but didn't eliminate it altogether.[22]

- There is often a disparity between what the governing plan documents say and what the retirees claim they were told about the duration of post-retirement medical benefits. Not only do retirees, like other parties to lawsuits, tend to remember what they want to remember, but their credibility can be enhanced by testimony from retired human resources personnel and top management who, as retirees themselves, stand to benefit by telling their story in a certain way. The notion that an employer could enforce a written plan document despite having made inconsistent or misleading representations outside the plan document has led some courts to ignore the contractual analysis and grant lifetime benefits based on breach of fiduciary duty, estoppel, and general equitable principles. However, *Tackett* arguably bars this approach to contract interpretation.

Again, these general observations alone don't answer the question of whether a post-retirement medical plan provides vested benefits. Rather, they simply serve to help practitioners form judgments when the proper interpretation of the plan isn't readily apparent.

Practice Tip: Employers should perform a thorough legal review of relevant material before making any changes to post-retirement medical benefits. This should include a review of SPDs, plan documents, employee and retiree communications and, for collectively bargained retiree benefits, collective bargaining agreements, side agreements, bargaining history, and communications with the union.

.30 Unilaterally Established Post-Retirement Medical Benefits

.30.10 The Framework—Traditional Contract Analysis

Litigation over unilaterally established post-retirement medical plans began in the early 1980s with several highly publicized federal district court decisions that ignored the governing plan documents and held that post-retirement medical benefits vested at retirement by operation of common law, even though the plan documents said otherwise.[23] The courts reasoned that the employers had offered unilateral contracts to their employees stating that, if the employees worked until retirement, the employer would provide lifetime post-retirement medical coverage. The employer couldn't refuse to perform its part of the ''bargain'' after the employee had performed hers or his.[24]

The ''unilateral contract'' theory was short-lived. In 1988, the Second and Sixth Circuits issued two of the more widely cited decisions in this area, *Musto v. American General Corporation*[25] and *Moore v. Metropolitan Life Insurance Company*,[26] which together form the foundation for much of the subsequent legal analysis in this area. The principles outlined in *Musto* and *Moore*—that an employer's intent is to be determined first from the official plan documents, and only if those documents are ambiguous should the court consider extrinsic evidence—still provide the basic framework that courts use to decide whether unilaterally established post-retirement medical benefits are vested. Subsequent decisions have relied on the absence of a statutory vesting requirement for welfare plans to hold that an intention to vest

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[22] Specifically, although *Tackett* embraced "ordinary principles of contract law," it stopped short of adopting the "clear and express" standard used to determine vesting under unilaterally established retiree medical plans. *See Tackett*, 135 S. Ct. at 937 (citing and quoting *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 400, 21 EBC 2267 (6th Cir. 1998) (en banc), but only to show contrast between *Yard-Man* standards and those applied outside of collective bargaining context).

[23] *Hansen*, 42 B.R. 1005; *Musto v. Am. Gen. Corp.*, 615 F. Supp. 1483, 6 EBC 2071 (M.D. Tenn. 1985).

[24] *Hansen*, 42 B.R. at 1005 (quoting *Cantor v. Berkshire Life Ins. Co.*, 171 N.E.2d 518 (Ohio 1960)).

[25] 861 F.2d 897, 10 EBC 1441 (6th Cir. 1988).

[26] 856 F.2d 488, 9 EBC 2685 (2d Cir. 1988).

retiree medical benefits must be stated in ''clear and express'' language in order for these benefits to vest.[27] The clear and express rule of construction makes it more difficult for retirees to establish that the plan documents provide vested benefits or, alternatively, to show that the plan documents are ambiguous. Not all courts have embraced this rule, and three federal appellate courts have expressly rejected it.[28]

.30.20 Reservation of Rights Clauses

Retirees often argue that language stating benefits ''shall continue,'' or using some variation of the word ''lifetime,'' reflects an intention to vest benefits. These claims have been made even when plan documents contain an unambiguous ''reservation of rights'' clause that gives the employer the right to modify, amend, or terminate benefits. Often the retirees contend that the reservation of rights language is rendered ambiguous by the inconsistent promise of ''lifetime'' coverage, requiring consideration of extrinsic evidence to determine the parties' intent.[29]

Where the plan documents or SPDs include an unambiguous reservation of rights clause, courts generally have held that plan language stating medical benefits ''shall continue'' or providing ''lifetime'' benefits doesn't conflict with the

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[27] *Fulghum v. Embarq Corp.*, 785 F.3d 395, 403, 2015 BL 47804, 59 EBC 1829 (10th Cir. 2015) ("In deciding whether an ERISA employee welfare benefit plan provides for vested benefits, we apply general principles of contract construction. ... A plaintiff can't prove his employer promised vested benefits unless he identifies 'clear and express language' in the plan making such a promise." (citing *Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1513, 22 EBC 1403 (10th Cir. 1996)); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 400, 21 EBC 2267 (6th Cir. 1998) (en banc) ("[T]he intent to vest 'must be stated in clear and express language' "); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855, 18 EBC 1897 (4th Cir. 1994) ("[C]ourts may not lightly infer the existence of an agreement to vest employee welfare benefits ... any participants' right to a fixed level of lifetime benefits must be ... 'stated in clear and express language' "); *Wise*, 986 F.2d 929, 16 EBC 1789 ("Such extra-ERISA commitments must be found in the plan documents and must be stated in clear and express language."); *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d 896, 902, 19 EBC 1545 (3d Cir. 1995) ("Extra-ERISA commitments, such as the right to receive free lifetime coverage, must be found in the plan documents and stated in clear and express language"); *Stearns v. NCR Corp.*, 297 F.3d 706, 712, 28 EBC 1769 (8th Cir. 2002) ("But there must be an affirmative indication of vesting in the plan documents to overcome an unambiguous reservation of rights"); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1160, 25 EBC 1769 (9th Cir. 2001) (same); *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 632, 33 EBC 1001 (7th Cir. 2004) (same); *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779, 784, 34 EBC 1875 (7th Cir. 2005) (same).

[28] *Balestracci v. NSTAR Elec. & Gas Corp.*, 449 F.3d 224, 231, 37 EBC 2422 (1st Cir. 2006) ("We reject the analysis used by the district court ... that there can never be vesting of retirement welfare benefits unless there is a clear and express statement of such vesting"); *Jones v. Am. Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1069-71, 32 EBC 2484 (11th Cir. 2004) (rejecting clear and express standard but finding that no ambiguity existed where plan contained both reservation of rights clause and durational language indicating that benefits continue after retirement); *Abbruscato*, 274 F.3d 90, 27 EBC 1139; *Am. Fed'n of Grain Millers, AFL-CIO v. Int'l Multifoods Corp.*, 116 F.3d 976, 980 (2d Cir. 1997) ("In this Circuit, to reach a trier of fact, an employee doesn't have to 'point to unambiguous language to support [a] claim. It is enough [to] point to written language capable of reasonably being interpreted as creating a promise on the part of [the employer] to vest [the recipient's] ... benefits.'' (citing *Schonholz v. Long Island Jewish Med. Ctr.*, 87 F.3d 72, 78, 28 EBC 1122 (2d Cir. 1996)). The "clear and express" standard is discussed further below in connection with collectively bargained post-retirement health benefits.

[29] Indeed, retirees often argue the absence of reservation of rights language indicates intent to vest post-retirement medical benefits. The Second Circuit took this approach in a 2001 case, implying that a plan promising employees that they would have retiree benefits in the future if they remained employed could vest benefits in the absence of a reservation of rights clause. *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 27 EBC 1129 (2d Cir. 2001). Moreover, an employer can't insert a retroactive reservation of rights clause in a plan document for existing retirees unless the plan documents, as interpreted by the court, don't evince a clear intent to vest benefits. *Helwig v. Kelsey Hayes Co.*, 93 F.3d 243, 20 EBC 1767 (6th Cir. 1996) (employer couldn't undo language vesting benefits by issuing later versions of the SPD that included an amendment/termination clause); *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 18 EBC 2188 (8th Cir. 1994) (post-retirement medical benefits deemed vested where historical plan documents were ambiguous and extrinsic evidence indicated the

reservation of rights clause or otherwise create an ambiguity.[30] However, where the plan documents don't include an unambiguous reservation of rights clause, ''lifetime'' language in the documents may vest post-retirement medical benefits. For example, in *Helwig v. Kelsey Hayes Co.*,[31] the court held that language stating that medical benefits ''would be continued for the rest of your life without cost to you,'' resulted in vesting where the plan didn't include a reservation of rights clause.

Although the factual scenarios will differ from case to case, the common thread is the contractual analysis, with the fiercest battles being fought over the issue of ambiguity in the governing documents.[32] This should come as no surprise, since whoever wins this battle usually wins the war. Pre-*Tackett*,courts sometimes interpreted the plan documents on a sliding scale, showing a greater inclination to find ambiguity in the plan documents when the extrinsic evidence strongly indicated an intention to vest benefits, even though this ran contrary to the notion that a court shouldn't consider extrinsic

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employer's intent to vest the benefits, preventing the employer from adding and exercising the amendment/termination clause).

[30] *Bland*, 401 F.3d at 785-86 (collecting cases); *Vallone*, 375 F.3d at 633-34 (finding that durational language in retirement worksheets indicating benefits would continue until age 65 didn't create ambiguity); *Jones*, 370 F.3d at 1069-71 (no ambiguity where SPD indicated that retiree life "will continue" after retirement); *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d at 903-04 ("The fact that the ... plans used terms such as 'lifetime' or 'for life' to describe the duration of retiree medical benefits, while at the same time expressly reserving the company's right to terminate the plans under which those benefits were provided, didn't render the plans 'internally inconsistent' and therefore ambiguous ... ."); *Hughes v. 3M Retiree Med. Plan*, 281 F.3d 786, 792-93, 27 EBC 1878 (8th Cir. 2002) (language stating that company "intends to continue this Plan indefinitely, but reserves the right to change or discontinue it if necessary" wasn't ambiguous); *Wise*, 986 F.2d at 939-40; *Howe v. Varity Corp.*, 896 F.2d 1107, 1110, 11 EBC 2585 (8th Cir. 1990); *Musto*, 861 F.2d at 904 ("After your retirement, comprehensive Medical Expense Insurance Coverage will continue on you and your spouse...."); *In re Sears Retiree Group Life Ins. Litig.*, 90 F. Supp. 2d 940, 25 EBC 1928 (N.D. Ill. 2000)) ("[Y]ou will continue in the life insurance portion of the plan without further cost to you...."); *Center v. First Int'l Life Ins. Co.*, Civ. No. 94-11596-PBS, 1997 WL 136473 at *8 (D. Mass. Mar. 13, 1997) (form letters stating that health coverage "will continue" into retirement created no ambiguity in the defendants' plan); *Local 56, United Food & Commercial Workers Union v. Campbell Soup Co.*, 898 F. Supp. 1118, 1131, 19 EBC 1905 (D.N.J. 1995) ("[E]ven unambiguous assurances that all retirees would have health insurance benefits don't create vested benefits in the presence of a reservation of rights clause"); *Etherington v. Bankers Life & Cas. Co.*, 747 F. Supp. 1269, 1275-76 (N.D. Ill. 1990), *aff'd*, 968 F.2d 1218 (7th Cir. 1992). *See also Sprague*, 133 F.3d at 388 (SPD containing the promise of "lifetime" coverage didn't give rise to vested benefits even though the SPD didn't include an amendment/termination clause.).

[31] 93 F.3d 243, 20 EBC 1767 (6th Cir. 1996). The Seventh Circuit didn't go quite as far in *Bland*, 401 F.3d at 787, 34 EBC 1875, holding that the lack of an amendment and termination clause coupled with language describing the benefits as "lifetime" required a trial to determine whether the benefits were vested.

[32] In the collective bargaining context, the efficacy of a reservation of rights clause may depend on whether the language is found in a collectively bargained document or a document drafted and issued unilaterally by the employer. As the Fifth Circuit explained: "[a] reservation-of-rights clause in a plan document ... can't vitiate contractually vested or bargained-for rights. To conclude otherwise would allow the company to take away bargained-for rights unilaterally.'' *Int'l Ass'n of Machinists & Aerospace Workers, Woodworkers Div., AFL-CIO v. Masonite Corp.*, 122 F.3d 228, 233 (5th Cir. 1997) (citing *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1297, 14 EBC 1632 (6th Cir. 1991)); *accord Alday v. Raytheon Co.*, 693 F.3d 772, 787-88, 2012 BL 225671 (9th Cir. 2012) ("But none of these provisions allows the employer unilaterally to override express terms in the bilateral CBA, governing who is to be covered and who is to pay for coverages, whether by unilaterally writing conflicting language into the Plans referenced by the CBAs or otherwise. The Plans' reservation-of-rights provisions therefore can't qualify the CBAs' promise of premium-free healthcare coverage, as that promise isn't affected by the Plans."); *In re AMR Corp.*, 508 B.R. 296, 318-19, 2014 BL 108620 (Bankr. S.D.N.Y. 2014) ("On this motion for summary judgment, the Court declines to allow the language in the unilaterally-drafted Omnibus Plan Documents to override the bargained-for language in the CBA.").

evidence unless the agreement is ambiguous on its face.[33] This sliding scale approach undoubtedly reflected some courts' dissatisfaction with the strict contractual analysis, which forbids them from considering the extrinsic evidence as long as the governing documents were unambiguous.

Practice Tip: Ensure that all plan documents and SPDs include language reserving the employer's right to amend or terminate benefits at any time and for any reason. Avoid language that might be interpreted to limit the reservation of rights clause, such as language stating the employer intends to continue coverage or that changes will be made only in response to extrinsic events like legislation or business conditions. Also, avoid language suggesting that benefits continue for a specific duration, such as ''for life,'' ''lifetime'' or ''until death.''

.30.30 Inconsistencies Between the Plan Documents and SPD

A related issue involves inconsistencies between the plan documents and SPDs. Employers occasionally fail to include reservation of rights clauses in SPDs even though the clauses appear in the master plan documents. In general, courts have shown little sympathy for employers that fail to accurately summarize their complicated medical plans in the SPDs. As one court noted, the statutory language and legislative history of ERISA dictate that employers may not construct SPDs that mislead employees into thinking they have a right to benefits when other documents negate those rights.[34]

Thus, if the SPD omits reference to the master plan reservation of rights clause and suggests that post-retirement medical benefits are vested—perhaps by referring to them as ''lifetime'' benefits—then the SPD will generally prevail over the master plan's reservation of rights clause.[35] Note, however, that after *Cigna v. Amara*, SPD-based claims must be brought under ERISA § 502(a)(3). In *Amara*, the Supreme Court held that a participant can't sue under ERISA § 502(a)(1)(B) to enforce the terms of an SPD because statements in an SPD are *about* the plan but don't constitute the *terms* of the plan.[36]

Although these kinds of conflicts between the plan document and SPDs typically are resolved in favor of the SPD, one court has stated that the rule might not apply if the SPD is simply silent on the question of amendment or termination of coverage.[37] Nonetheless, these cases underscore the danger for employers that fail to recognize the legal significance of plan documents and SPDs or allow these documents to become outdated or contradictory.

Practice Tip: Employers increasingly use a ''wrap'' document that incorporates the SPD but doesn't attempt to duplicate its provisions, thereby eliminating any possibility of inconsistency between the two. The SPD should be

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[33] *See M&G Polymers*, 135 S. Ct. at 938 ("When the intent of the parties is unambiguously expressed in the contract, that expression controls, and the court's inquiry should proceed no further."); *Alexander v. Primerica Holdings, Inc.*, 967 F.2d 90, 15 EBC 1881 (3d Cir. 1992) (finding a questionable ambiguity in the plan's amendment/termination clause and ordering consideration of extrinsic evidence to determine employer intent); *Jensen*, 38 F.3d 945 (finding ambiguity in the master plan document in the face of "a wealth of extrinsic evidence supporting [plaintiffs'] contention that...medical benefits would vest").

[34] *Helwig*, 93 F.3d at 249.

[35] The *Helwig* court also held that the master plan, which consisted of an insurance policy, didn't contain an amendment/termination clause that was enforceable against the retirees. Although the insurance policy stated that it could be terminated at any time by the employer or insurance carrier, the court held that the clause was "included merely to reserve the right of the employer or the carrier to end their commercial relationship," not to reserve the right to terminate the retirees' coverage. *Id.* A number of other courts have reached the opposite conclusion on similar facts. *Etherington v. Bankers Life & Cas. Co.*, 747 F. Supp. 1269, 1275 (N.D. Ill. 1990), ("your insurance terminates on the ... date the Group Policy terminates"); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 57, 15 EBC 1865 (4th Cir. 1992) ("coverage 'will continue for as long as premiums are paid or until [the policy] is cancelled' "); *Musto*, 861 F.2d at 903, 10 EBC 1441 ("insurance of an employee under any of the coverages [sic] provided by the group policy ceases on ... 'the date of termination of the Group Policy' "); *Center*, 1997 WL 136473 ("the policy also stated that 'your insurance ends ... the date the group policy ends' "); *Local 56, Food & Commercial Workers*, 898 F. Supp. at 1123, 19 EBC 1905 ("Your insurance under the Plan will terminate immediately if the group policies are cancelled.").

[36] *Cigna Corp. v. Amara*, 131 S. Ct. 1866, 1878, 2011 BL 128629, 50 EBC 2569 (2011).

[37] *Sprague*, 133 F.3d 388, 21 EBC 2267 ("An omission from the summary plan description doesn't, by negative implication, alter the terms of the plan itself.... GM's failure to include in some summaries a notice of its right to change the plan doesn't trump the clearly stated right to do so in the plan itself.").

carefully reviewed to ensure that it meets the requirements of ERISA Section 102, including that it is "written in a manner calculated to be understood by the average plan participant, and [is] sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan."[38]

Another issue involves the practice of excluding existing retirees whenever post-retirement medical benefits are reduced or changed, which is commonly referred to as grandfathering. In *Howe v. Varity Corp.*,[39] the retirees urged the court to view this practice as evidence of the employer's intent to vest the benefits at retirement.[40] The court rejected the argument, stating that "merely because defendants chose to exempt retirees from plan changes in the past doesn't mean that the defendants considered themselves forever bound to do so."[41] Conversely, a consistent past practice of treating post-retirement medical benefits as vested can be evidence of an intent to vest the benefits if the employer has not clearly reserved its right to amend or terminate the benefits in the governing documents.[42]

Practice Tip: If an employer decides to exempt certain categories of retirees from amendment or termination of benefits, clarify in the plan documents and employee communications that the grandfathered retirees are subject to future changes.

.40 Collectively Bargained Post-Retirement Medical Benefits

Collectively bargained post-retirement medical benefits present a unique set of issues.

First, under applicable labor law, retirees are neither members of the bargaining unit nor covered by labor laws requiring good-faith bargaining.[43] Therefore, unions have no obligation to represent retirees or negotiate on their behalf.[44] This presents the possibility that unions will bargain away retiree benefits to gain concessions for current union members, since the unions have no obligation to bargain on behalf of the retirees, and retirees often terminate their active union membership (and payment of union dues) on retirement.[45] Although there are few concrete examples of unions trading retiree benefits for active employee enhancements, this possibility has contributed to the protective attitude often displayed by the courts in collectively bargained benefit cases.

Second, collectively bargained cases draw heavily from a well-developed body of law under § 301 of the Labor Management Relations Act (LMRA). Collective bargaining agreements usually are negotiated to take effect for a

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[38] ERISA § 102(a).

[39] *Howe*, 896 F.2d at 1110, 11 EBC 2585.

[40] *Howe*, 896 F.2d at 1110, 11 EBC 2585. Many employers choose not to apply changes to post-retirement medical benefits to employees who already have retired and instead simply continue these retirees' benefits unchanged. This is done for a variety of reasons, not the least of which is a concern for the fairness of the reduction as to individuals whose benefits might have remained unchanged for many years.

[41] *Howe*, 896 F.2d at 1110; *see also In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d 896, 19 EBC 1545 (3d Cir. 1995) ("merely because the company had never chosen to exercise its reservations of rights prior to this litigation didn't mean that the company had waived its right to terminate the plans..."); *Alexander*, 967 F.2d 90, 15 EBC 1881; *Etherington*, 747 F. Supp. at 1279).

[42] *Jensen*, 38 F.3d 945, 18 EBC 2188; *Eardman v. Bethlehem Steel Corp. Employee Welfare Benefit Plans*, 607 F. Supp. 196, 5 EBC 1985 (W.D.N.Y. 1985).

[43] *Allied Chem. & Alkali Workers of Am. Local Union No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 1 EBC 1019 (1971). Although post-retirement medical benefits for existing retirees are a permissive subject of bargaining, parties can voluntarily agree to make such benefits a mandatory subject. *M& G Polymers*, 135 S. Ct. at 936.

[44] In light of this rule, some employers have refused to arbitrate grievances involving retiree medical benefits. In *Rossetto v. Pabst Brewing Co.*, 128 F.3d 538, 21 EBC 2053 (7th Cir. 1997), the court ruled that a union lacked standing to compel arbitration of a dispute over the discontinuation of retiree benefits, since the union didn't represent the retirees unless each retiree separately consented to representation. Distinguishing *Rossetto*, the Seventh Circuit ordered an employer to arbitrate a grievance over unilateral changes to retiree benefits because, unlike in *Rossetto*, the arbitration clause wasn't limited to grievances between the company and an "employee," but rather covered "any dispute...between the Company and the Union." *Exelon Generation Co. v. Elec. Workers IBEW Local 15*, 540 F.3d 640, 2008 BL 197266, 44 EBC 2316 (7th Cir. 2008).

[45] *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 609, 16 EBC 2217 (7th Cir. 1993) (*en banc*).

specified number of years, after which the agreements expire. Thus, these cases usually turn on whether the post-retirement medical benefits expire with the collective bargaining agreement. However, the contractual analysis applied under the LMRA often looks to the surrounding circumstances to determine the parties' intent and takes into account the policies behind the labor laws, even when the contractual language at issue is unambiguous. These factors led courts to adopt different approaches to determining whether collectively bargained post-retirement medical benefits are vested: (1) applying a vesting inference when interpreting the contract; (2) applying normal principles of contract construction, which is similar to the approach applied in cases involving unilaterally established plans; and (3) applying a no-vesting inference when a contract is silent on the issue of vesting.

Third, many courts have held that LMRA § 301 provides for jury trials, which aren't generally available under ERISA.[46] This is an important difference, since juries generally will be more sympathetic to the claims of retirees and more easily influenced by extrinsic evidence.

Over the years, the Sixth Circuit emerged as the most retiree-friendly jurisdiction after its 1998 decision in *UAW v. Yard-Man*,[47] which adopted an inference or presumption in favor of vesting. Other circuits followed different approaches to the vesting question.[48] This inconsistency in legal standards spawned forum-shopping by both retirees and employers, which is facilitated by ERISA's liberal jurisdiction and venue provisions.[49] Venue transfer motions became commonplace in these cases, with the outcome of the motion often proving dispositive of the merits in the pre-*Tackett* years.[50]

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[46] *Stewart v. KHD Deutz of Am. Corp.*, 75 F.3d 1522, 152, 19 EBC 2697 (11th Cir. 1996); *Senn v. United Dominion Indus.*, 951 F.2d 806, 813-14, 14 EBC 2238 (7th Cir. 1992); *Leannah v. Alliant Energy Corp.*, No. 07-169, 2008 BL 243784, 45 EBC 2695 (E.D. Wis. Oct. 28, 2008); *Stamps v. Mich. Teamsters Joint Council No. 43*, 431 F. Supp. 745, 1 EBC 1734 (E.D. Mich. 1977). *But see Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 659, 19 EBC 2457 (6th Cir. 1996) (suit under LMRA § 301 alleging employer breached collective bargaining agreement when it imposed deductibles and co-payments for retiree health benefits sought relief that was equitable in nature, and plaintiffs were therefore not entitled to jury trial).

[47] *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Yard-Man, Inc.*, 716 F.2d 1476, 4 EBC 2108 (6th Cir. 1983).

[48] *See Bidlack*, 993 F.2d at 608 (rejecting *Yard-Man* and adopting a presumption that retiree medical benefits don't vest under collective bargaining agreements that are in effect for a specified term, although retirees can rebut this presumption by pointing to language unambiguously vesting benefits or showing contract is ambiguous); *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Skinner Eng. Co.*, 188 F.3d 130, 139, 23 EBC 2022 (3d Cir. 1999) (employer's commitment to vest post-retirement health benefits must be stated in clear and express language); *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 134, 22 EBC 2755 (2d Cir. 1999) (retirees must be able to identify specific written language that is reasonably susceptible to interpretation as a promise to vest retiree health benefits).

[49] *See* ERISA § 502(e), 29 U.S.C. § 1132(e). Under this section, retirees can sue wherever a retiree affected by the employers' action resides. Employers often attempt to preempt retirees' forum selection by filing actions under ERISA and LMRA for declaratory judgments on the legality of their amendment or termination of the retiree benefits. *See, e.g.*, *Maytag Corp. v. UAW Local 997*, No. 4:08-cv-00291-JEG, 2009 BL 27582, 46 EBC 1114 (S.D. Iowa Feb. 11, 2009); *Newell Operating Co., Inc. v. UAW*, No. 06-cv-50010, 2007 BL 303328 (N.D. Ill. Mar. 27, 2007), *aff'd*, 532 F.3d 583, 2008 BL 139922, 44 EBC 1307 (7th Cir. 2008); *In re John Amendt*, No. 05-2458, 169 F. App'x. 93 (3d Cir. Feb. 16, 2006); *ACF Indus. LLC v. Chapman*, No. 4:03-CV-1765, 2004 BL 3679, 34 EBC 1329 (E.D. Mo. 2004). There has been much litigation over the question on whether the courts have jurisdiction over these declaratory judgment actions by employers, and such litigation is beyond the scope of this report.

[50] *Newell Operating Company* offers an example of "dueling" venue motions. There, both the union and the employer sought to transfer venue to a more favorable district. The employer, Newell, filed a declaratory judgment suit in the Northern District of Illinois soon after amending its retiree benefit plan. *UAW v. Newell Operating Co.*, No. 06-cv-50010 (N.D. Ill.). The UAW and a group of retirees responded by filing an action in the Western District of Michigan and moving to dismiss the Illinois action for lack of subject matter jurisdiction or to transfer venue to Michigan. Recognizing Newell's strategy to influence the forum choice, the court in Illinois dismissed the suit in favor of the pending suit in Michigan, and the Seventh Circuit affirmed. *Newell*

In recent years, the Supreme Court has weighed in to resolve these differing approaches, first with its decision in *M&G Polymers USA, LLC v. Tackett*.[51] The question presented was whether, when construing collectively bargained post-retirement medical benefits, courts should presume that silence as to the duration of those benefits means the parties intended the benefits to vest, as the Sixth Circuit held in *Yard-Man*, or whether a different set of interpretive rules should apply. In a unanimous decision, the Supreme Court rejected the *Yard-Man* approach and remanded the case to the Sixth Circuit ''to apply ordinary principles of contract law in the first instance.''[52] Understanding what those principles are requires a closer examination of the Court's opinion and Justice Ginsberg's concurrence.

.40.10 M& G Polymers v. Tackett: Background

The plaintiffs in *M& G Polymers* sued their former employer under ERISA and the LMRA claiming they had been promised free, lifetime healthcare benefits.[53] The post-retirement medical benefits were contained in a separate insurance agreement negotiated at the national level between the Steelworkers and several large employers, then adopted at the local plant where the plaintiffs had worked. The district court dismissed the case on a Rule 12(b)(6) motion, holding that the language of the insurance agreement didn't evince an intent to vest benefits.[54] Applying *Yard-Man*, the Sixth Circuit reversed, holding that a provision of the insurance agreement granting retirees a ''full Company contribution towards the cost of benefits'' stated a plausible claim that the benefits were vested.[55] On remand, the district court conducted a bench trial and ruled that the benefits vested.[56] Notably, the district court declined to revisit whether the insurance agreement created a vested right to retiree benefits, concluding that the Sixth Circuit had definitively resolved that issue.

The Sixth Circuit affirmed.[57] While disagreeing that the meaning of the insurance agreement was resolved in the first appeal, the court of appeals nevertheless agreed with the district court that, ''in the absence of extrinsic evidence to the contrary, the agreements indicated an intent to vest lifetime contribution-free benefits.''[58] Because the district court had found the extrinsic evidence inapplicable, the Sixth Circuit concluded, it had properly found the insurance agreement created vested benefits.

.40.20 "Ordinary Principles of Contract Law"

The Supreme Court granted M&G's request for certiorari and subsequently abrogated the *Yard-Man* presumption. Writing for a unanimous Court, Justice Thomas reaffirmed the basic framework for interpreting collective bargaining agreements that define rights to welfare benefits. First, ERISA treats welfare plans and pension plans differently with respect to vesting.[59] Second, employers are generally free under ERISA to adopt, modify, or terminate welfare plans at any time for any reason.[60] Third, the rule that contractual provisions should be enforced as written is especially appropriate when enforcing ERISA welfare benefit plans, where the ''focus on the written terms of the plan is the linchpin of a system that isn't so complex that administrative costs, or litigation expenses, unduly discourage employers

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Operating Co. v. UAW, 532 F.3d 583 (7th Cir. 2008). Despite this setback, Newell filed a venue transfer motion with the Michigan court in an attempt to transfer the case to Illinois, but the Michigan court denied Newell's request. *Bender v. Newell Window Furnishings, Inc.*, No. 1:06-CV-113, 2007 BL 73818 (W.D. Mich. July 9, 2007).

[51] 135 S. Ct. 926, 2015 BL 16721, 59 EBC 1425 (2015).

[52] 135 S. Ct. at 930.

[53] *Tackett v. M&G Polymers USA, LLC*, 561 F.3d 478, 2009 BL 67477, 46 EBC 1901 (6th Cir. 2009).

[54] *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684, 2007 BL 154741, 42 EBC 2984 (S.D. Ohio 2007).

[55] *Tackett v. M&G Polymers USA, LLC*, 561 F.3d 478, 2009 BL 67477, 46 EBC 1901 (6th Cir. 2009) at 490.

[56] *Tackett v. M&G Polymers USA, LLC*, 853 F. Supp. 2d 697, 2012 BL 45978, 52 EBC 1935 (S.D. Ohio 2012).

[57] *Tackett v. M&G Polymers USA, LLC*, 733 F.3d 589, 2013 BL 208178, 56 EBC 1829 (6th Cir. 2013).

[58] *Tackett v. M&G Polymers USA, LLC*, 733 F.3d 589, 2013 BL 208178, 56 EBC 1829 (6th Cir. 2013) at 600.

[59] 135 S. Ct. at 933.

[60] 135 S. Ct. at 933 (citing *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78, 18 EBC 2841 (1995)).

from offering [welfare benefits] plans in the first place.''[61] Finally, courts must interpret collective bargaining agreements, including those establishing ERISA plans, ''according to ordinary principles of contract law, at least when those principles aren't inconsistent with federal labor policy.''[62] As with any contract analysis, the parties' intent controls. Quoting *Williston on Contracts*, the Court observed that ''[w]here the words of a contract in writing are clear and unambiguous, its meaning is to be ascertained in accordance with its plainly expressed intent.''[63]

The balance of the opinion was a point-by-point refutation of the *Yard-Man* presumption and the rationales that supported it, including:

- The Sixth Circuit's refusal to give effect to general durational clauses in collective bargaining agreements was inconsistent with normal rules of contract construction;[64]
- Post-retirement medical benefits aren't a form of deferred compensation, and;
- The fact that a collective bargaining agreement provides medical benefits to some retirees but not others doesn't violate the ''illusory promise doctrine'';

Two statements in the *Tackett* opinion are likely to generate debate. First, the Court criticized the Sixth Circuit for having ''failed even to consider the traditional principle that courts shouldn't construe ambiguous writings to create lifetime promises.''[65] The precise meaning of this statement is unclear; ambiguity in a written agreement normally requires the consideration of extrinsic evidence to resolve the ambiguity, and such evidence may lead to the conclusion that the parties intended to create a lifetime obligation. The statement could be read to preclude a finding of vesting whenever the agreement is ambiguous, but this seems to run counter to the ''ordinary principles of contract law'' the Court trumpeted.

Second, the Court rebuked the Sixth Circuit for failing to consider the ''the traditional principle that 'contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.' ''[66] As the Court explained:

> That principle doesn't preclude the conclusion that the parties intended to vest lifetime benefits for retirees. Indeed, we have already recognized that ''a collective-bargaining agreement [may] provid[e] in explicit terms that certain benefits continue after the agreement's expiration.'' But when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life.[67]

Unpacking this passage proved daunting. While *Litton* says that a collective bargaining agreement may contain ''explicit'' language extending obligations beyond the term of the agreement, the decision also recognizes that a contractual obligation may survive contract expiration due to ''implicit'' terms—as the concurrence pointed out. This suggests the absence of a bright-line rule that collectively bargained obligations automatically cease at contract expiration unless explicitly extended, which some lower courts seized on in subsequent opinions.

In her concurring opinion, Justice Ginsberg offered her thoughts on perceived gaps in the unanimous Court's decision, reiterating that: (1) the ''cardinal principle'' in contract interpretation is that the parties' intention must prevail; (2) in determining the parties' intent, courts must examine the entire agreement ''in light of relevant industry-specific 'customs, practices, usages, and terminology,' '' and; (3) when a contract is ambiguous, courts may consider extrinsic

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[61] 135 S. Ct. at 933 (quoting *Heimeshoff v. Hartford Life & Accident Ins. Co.,* 134 S. Ct. 604, 611-12, 2013 BL 345916, 57 EBC 1265 (2013)).

[62] 135 S. Ct. at 933.

[63] 135 S. Ct. at 933 (quoting 11 R. Lord, Williston on Contracts § 30:6, p. 108 (4th ed. 2012)).

[64] 135 S. Ct. at 935-37.

[65] 135 S. Ct. at 935-37 at 936 (citing 3 A. Corbin, Corbin on Contracts § 553, p. 216 (1960)).

[66] 135 S. Ct. at 937 (quoting *Litton Financial Printing Div., Litton Bus. Sys., Inc. v. NLRB*, 501 U.S. 190, 207 (1991)).

135 S. Ct. at 937 (quoting *Litton Financial Printing Div., Litton Bus. Sys., Inc. v. NLRB*, 501 U.S. 190, 207 (1991)).

[67] 135 S. Ct. at 937

evidence of the parties' intentions.[68] Justice Ginsberg also explicitly rejected M&G's argument that vesting requires ''clear and express'' language. ''Contrary to M&G's assertion,'' Justice Ginsberg concluded ''no rule requires 'clear and express' language in order to show that parties intended health-care benefits to vest.''[69]

.40.30 Lower Court Responses to M&G Polymers

In the immediate aftermath of *M&G Polymers*, lower federal courts struggled to apply its holding, often with disparate results. Courts followed two lines of reasoning when a collective bargaining agreement lacked explicit language regarding the duration of post-retirement medical benefits. First, some courts held that general durational clauses controlled the duration of retiree medical benefits. In other words, the collective bargaining agreement's general termination clause provided a default termination date, and all contractual obligations expired with the agreement unless there is specific language to the contrary. The second line of thought held that a general durational clause doesn't say *everything* about the duration of post-retirement medical benefits, and a court can't presume that the absence of explicit vesting language evinces an intent *not* to vest benefits. This approach parallels Justice Ginsburg's concurrence in *M&G Polymers.*

In early 2016, the Sixth Circuit reentered the debate, first in the *M&G Polymers* remand,[70] then in *Gallo v. Moen, Inc.*[71] These two decisions, issued by different Sixth Circuit panels, epitomize the initial disagreement over the scope and meaning of the *M&G Polymers* opinion.

In the *M&G Polymers* remand decision, the panel set forth its interpretation of the ''ordinary principles of contract law'' identified in the Supreme Court's unanimous opinion, including:

- [C]ourts shouldn't construe ambiguous writings to create lifetime promises.... [C]ontracts that are silent as to their duration will ordinarily be treated not as ''operative in perpetuity'' but as ''operative for a reasonable time.''
- Contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.
- When a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life.[72]
- Observing that the Supreme Court in *M&G Polymers* didn't purport to discuss *all* of the ordinary principles of contract law, the panel supplemented the list with ''additional'' principles from Justice Ginsburg's concurrence:
- [W]hen the contract is ambiguous, a court may consider extrinsic evidence to determine the intentions of the parties .... [F]or example, the parties' bargaining history.
- No rule requires ''clear and express'' language in order to show that parties intended health-care benefits to vest.
- Constraints upon the employer after the expiration date of a collective-bargaining agreement ... may be derived from the agreement's ''explicit terms,'' but they may arise as well from implied terms of the expired agreement.[73]

Ultimately, however, the panel refused to decide the vesting issue given the procedural posture of the case and remanded it to the district court to apply ordinary contract principles in light of any additional evidence or arguments.[74]

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[68] 135 S. Ct. at 937-38.

[69] 135 S. Ct. at 938.

[70] *Tackett v. M&G Polymers USA, LLC*, 811 F.3d 204, 2016 BL 15624 (6th Cir. 2016).

[71] 813 F.3d 265 (6th Cir. 2016)), *pet. for rehearing en banc denied* (6th Cir. Mar. 16, 2016).

[72] 811 F.3d at 208 (alterations in original).

[73] 811 F.3d at 208-09 (alterations in original).

[74] 811 F.3d at 210. Following remand, M&G filed for bankruptcy protection and the dispute was settled in the bankruptcy court. The district court dismissed the case based on the bankruptcy court settlement.

The panel in *Gallo v. Moen* took a different approach, though again under the rubric of ''ordinary contract principles.'' The relevant collective bargaining agreements stated that ''continued hospitalization, surgical and medical coverage will be provided without cost'' to retirees who retired prior to a certain date.[75] The panel noted that ''nothing in this or any of the other CBAs says that Moen committed to provide unalterable healthcare benefits to retirees and their spouse for life. That is what matters, and that is where the plaintiffs fall short.''[76] Not only did the collective bargaining agreements contain no such commitment, but ''everything they say about the topic was contained in a *three-year* agreement.''[77] The panel continued: ''If we don't expect to find 'elephants in mouseholes' in construing statutes, we shouldn't expect to find lifetime commitments in time-limited agreements.''[78] Thus, absent a longer time limit in the context of a specific provision, the agreement's general durational clause supplied a concrete date of expiration for the retiree health benefits. The court vacated the district court's grant of summary judgment in favor of the plaintiffs, with directions to enter summary judgment for the employer.[79]

The Fourth Circuit spoke to the issue of durational clauses in *Barton v. Constellium*.[80] The collective bargaining agreements in *Constellium* stated that retiree medical benefits ''shall remain in effect for the term of the Labor Agreement.''[81] Although the *Constellium* retirees argued that the collective bargaining agreements provided vested benefits, the Fourth Circuit concluded that this language plainly indicated that retiree medical benefits didn't vest. As the court explained, *M&G Polymers* requires ''a clear signal that parties intend for benefits to vest'' and ordinary contract principles ''foreclose holding that retiree health benefits have vested unless unambiguous evidence indicates that the parties intended that outcome.''[82] Although the Constellium retirees contended that other provisions vested their benefits, including one stating that dependent coverage cancelled ''upon retiree's death,'' such language didn't overcome the collective bargaining agreement's explicit provision limiting post-retirement medical benefits to the term of the agreement.[83]

Subsequently, in a trio of decisions by different panels, the Sixth Circuit issued conflicting interpretations of *M&G Polymers*, creating an intra-circuit split regarding the contract interpretation rules set out by the Supreme Court. *Cole v. Meritor* reached a result similar to *Moen.*[84]In *Meritor*, the retirees argued that their benefits vested based on language stating that the health care coverage a retiree has at the time of retirement ''shall be continued thereafter.''[85] *Meritor* relied on language providing that the retiree medical insurance agreement ''shall continue in effect until the termination of the CBA of which this is a part.''[86] The panel concluded that the latter provision explicitly tied Meritor's obligation to provide retiree medical benefits to the existence of the collective bargaining agreement, and thus the retirees' benefits were not vested.[87]

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[75] 813 F.3d at 269, 2016 BL 34063.

[76] 813 F.3d at 269, 2016 BL 34063.

[77] 813 F.3d at 269, 2016 BL 34063.

[78] 813 F.3d at 269, 2016 BL 34063 (quoting *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001)).

[79] Judge Stranch dissented, concluding that the agreements were ambiguous and extrinsic evidence resolved the case in favor of the retirees. 813 F.3d at 269, 2016 BL 34063 (quoting *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001)).

[80] 851 F.3d 349.

[81] 851 F.3d at 354.

[82] 851 F.3d at 354, 356.

[83] 851 F.3d at 357.

[84] 855 F.3d 695 (6th Cir. 2017).

[85] 855 F.3d at 699.

[86] 855 F.3d at 699.

[87] 855 F.3d at 702. Simply because the agreement used "the future tense—without words committing to retain the benefits for life—doesn't guarantee lifetime benefits." 855 F.3d at 700.

Conversely, the Sixth Circuit's two other opinions echoed Justice Ginsburg's concurrence and *Yard-Man*. In *UAW v. Kelsey-Hayes*,[88] the employer unilaterally moved retirees from a company-sponsored health plan to a health reimbursement account, which the retirees argued violated collective bargaining agreement provisions requiring the union's assent to any new retiree medical benefits or plans. The Sixth Circuit panel explained that just as *M&G Polymers* didn't ''put a thumb on the scale'' in the retirees' favor, there is no ''reverse *Yard-Man* presumption'' where benefits vest only when there is clear and explicit vesting language.[89] The panel found the agreement ambiguous as to vesting because it didn't specify how long retiree healthcare ''shall be continued'' and mandated the parties' mutual agreement to change the contract's terms or terminate it. As a result, the court looked to extrinsic evidence, which indicated that the retirees' benefits were vested and the company lacked the right to make unilateral changes to post-retirement medical benefits.

Reese v. CNH likewise found the parties' agreement ambiguous.[90] The *CNH* collective bargaining agreement stated that employees who retired under the employer's pension plan were eligible for contribution-free medical coverage, which the panel concluded ''tied'' healthcare benefits to pension eligibility. Such language created an ambiguity regarding the parties' intent to vest, according to the panel, although the group benefit plan explained that it was part of the collective bargaining agreement and ran ''concurrently'' with it. ''Silence as to the duration of retiree healthcare benefits, when combined with those benefits' coupling to pensioner status . . . overcomes any presumption that the general durational clause should govern.''[91] *M&G Polymers* didn't preclude this analysis, according to the panel, because the Supreme Court didn't adopt an ''explicit language'' requirement for vesting and ''[t]here is surely a difference between finding ambiguity from silence and finding vesting from silence.''[92] Consequently, the panel considered extrinsic evidence and determined that the benefits were vested.[93]

In short, two years after the *M&G Polymers* decision, the Sixth Circuit's case law on vesting was ''a mess.''[94]

The Supreme Court sought to remedy the confusion by granting certiorari in *CNH v. Reese*,[95] reversing the Sixth Circuit's decision, and reiterating the principles previously set out in *M&G Polymers*. The Court found that the Sixth Circuit panel essentially inferred vested benefits by using ''the same *Yard–Man* inferences it once used to presume lifetime vesting . . . to render a collective-bargaining agreement ambiguous as a matter of law.''[96] The Court admonished the panel, as that ''analysis can't be squared with'' *M&G Polymers*, and instead amounted to ''*Yard-Man* re-born, re-built and re-purposed for new adventures.''[97] The Court reiterated the defects in the *Yard-Man* analysis, noting that it ''erroneously refused to apply general durational clauses to provisions governing retiree benefits'' and ''incorrectly inferred lifetime vesting whenever a contract is silent as to the duration of retiree benefits.''[98] The Court again rejected the argument that language ''tying'' retiree benefits to pensioner status confers vested benefits. In fact, ''shorn of Yard-Man inferences,'' the case was ''straightforward'' because the agreement's general durational clause applied to all

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[88] 854 F.3d 862 (6th Cir. 2017), *judgment vacated and remanded by Kelsey-Hayes Co. v. Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am.*, 138 S. Ct. 1166 (2018).

[89] 854 F.3d at 872.

[90] 854 F.3d 877 (6th Cir. 2017).

[91] 854 F.3d at 883.

[92] 854 F.3d at 765.

[93] The panel acknowledged that even if post-retirement medical benefits are vested, an employer can make reasonable changes to those benefits, and set forth a number of factors to be considered when deciding whether such changes are reasonable.

[94] *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Kelsey-Hayes Co.*, 872 F.3d 388, 390 (6th Cir. 2017) (Griffin, J., dissenting from denial of rehearing en banc).

[95] 138 S. Ct. 761 (2018) (per curiam).

[96] 138 S. Ct. at 763.

[97] 138 S. Ct. at 763.

[98] 138 S. Ct. at 763.

benefits, and there was no provision specifying that health care benefits were subject to a different durational clause.[99] Consequently, the ''only reasonable interpretation'' of the agreement is that retiree health benefits expired when the collective bargaining agreement expired.[100]

Within a week of issuing its decision in *CNH*, the Supreme Court vacated the Sixth Circuit's *Kelsey-Hayes* decision in a summary order, remanding it for further consideration in light of *CNH*.

Since then, the Sixth Circuit has fallen in line, consistently holding that post-retirement benefits were not vested.[101] These opinions recognize ''a clear rule—a CBA's durational clause applies to healthcare benefits unless it contains clear, affirmative language indicating the contrary,'' such as a specific alternative end date.[102] For instance, in *Cooper v. Honeywell Int'l*, the court rejected the retirees' argument that contract language stating that retirees ''will continue to be covered under the Plan until age 65'' vested their benefits, as the phrase ''until age 65'' didn't function as an alternative end date overriding the general durational clause. And in *Fletcher v. Honeywell Int'l*, the panel held that language providing that ''[u]pon the death of a retiree, the Company will continue coverage for the spouse and dependent children for their lifetime,'' neither indicated nor implied that the agreement provided healthcare to retirees until their deaths.[103] Rather, it meant that the agreement provided ''lifetime healthcare for surviving spouses and dependents'' but not to the retirees themselves.[104]

In light of the recent Supreme Court authority, to prevail, retirees bringing such litigation will have to demonstrate contract language that says ''something more'' specific as to the duration of post-retirement medical benefits—''for example, 'retirees will continue to be covered under the plan until age 65, *regardless whether this CBA expires before they reach that age*'''.[105]

.50 Communication-Based Claims Seeking Retiree Welfare Benefits

A subset of post-retirement medical benefit cases involves claims based not on the language of an ERISA plan or collective bargaining agreement, but on oral or written communications made to employees and/or retirees about the duration of such benefits. These claims arise under one or more legal theories: (1) breach of fiduciary duty, (2) the court's power under ERISA § 502(a)(3) to grant equitable relief for violation of ERISA's disclosure requirements, or (3) estoppel.

.50.10 Fiduciary Breach Claims Based on Misrepresentations or Omissions

ERISA imposes fiduciary duties on parties charged with responsibility for plan administration.[106] In short, when administering a plan, ERISA plan fiduciaries must act in the exclusive interest of the plan's participants and not in the interest of others, such as the sponsoring employer. Early on, retirees challenged employer reductions in post-retirement

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[99] 138 S. Ct. at 766.

[100] 138 S. Ct. at 766.

[101] *Cooper v. Honeywell Int'l, Inc.*, 884 F.3d 612 (6th Cir. 2018); *Fletcher v. Honeywell Int'l, Inc.*, 892 F.3d 217 (6th Cir. 2018), *cert. denied*, No. 18-467, 2018 WL 4954073 (U.S. Nov. 13, 2018); *IUE-CWA v. Gen. Elec. Co.*, No. 17-3885, 2018 WL 3949188, at *9 (6th Cir. Aug. 16, 2018) (unpublished).

[102] *Fletcher*, 892 F.3d at 223; *see also Cooper*, 884 F.3d at 618; *General Electric*, 2018 WL 3949188 at *10.

[103] 892 F.3d at 226.

[104] 892 F.3d at 226.

[105] *Cooper*, 884 F.3d at 620.

[106] ERISA § 404(a) states in relevant part, "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—(A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan; (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; ... (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV."

medical benefits on the grounds that the reductions were in the interest of the employer rather than plan participants and therefore violated ERISA's fiduciary rules, but courts generally rejected these claims.[107]

Subsequently, however, courts began to deviate from this logic, finding that ERISA fiduciary duties extend to communications with plan participants.[108] In other words, ERISA fiduciaries have a duty to communicate accurate information to plan participants, and the failure to do so may give rise to claims by a participant harmed by the miscommunications.

The U.S. Supreme Court addressed the question of fiduciary misrepresentations in *Varity Corp. v. Howe*.[109] In this landmark decision, the employer, a farm equipment manufacturer, transferred its money-losing operations to a newly formed subsidiary and induced many older employees to accept transfers to the new subsidiary by telling them that their post-retirement medical and other benefits would remain unchanged. However, the new subsidiary was insolvent from the date of its formation, and the trial court found that the employer intended to ''dump'' employee benefit (and other) liabilities into the subsidiary, knowing it had no chance of survival. This intentional deception, reasoned the Court, was a breach of the employer's fiduciary duty, and the affected employees could bring an action for individual equitable relief to redress the breach under ERISA § 502(a)(3).

In many respects, *Varity* opened the floodgates to claims by plan participants that the employer breached fiduciary duties by making intentional misrepresentations concerning the plan or failing to disclose material information that retirees need to know. To establish such a claim, a plaintiff must show that: (i) the defendant was acting in a fiduciary capacity; (ii) the defendant made affirmative misrepresentations or failed to adequately inform plan participants and beneficiaries; (iii) the misrepresentation or omission was material; and (iv) the plaintiff detrimentally relied on the misrepresentation or inadequate disclosure.[110] The Seventh Circuit requires ''some deliberate misstatement before it finds a violation of the ERISA duty to disclose information.''[111] Other circuits hold that mere negligence in fulfilling the duty of disclosure is actionable.[112]

Some breach of fiduciary duty claims allege that the employer made oral misrepresentations that were inconsistent with the written plan documents and disclosures. Although many courts have shown embraced these claims,[113] the Seventh Circuit has observed that entertaining claims for breach of fiduciary duty based on oral statements in the face of unambiguous reservation of rights clauses in the plan and SPD raises a host of practical and policy issues:

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[107] *Lockheed Corp. v. Spink*, 517 U.S. 882, 20 EBC 1257 (1996); *Leuthner v. Blue Cross & Blue Shield of NE Pa.*, 454 F.3d 120, 127, 38 EBC 1449 (3d Cir. 2006); *Musto,* 861 F.2d at 912; *Sutton v. Weirton Steel Div. of Nat'l Steel Corp.*, 724 F.2d 406, 411, 5 EBC 1033 (4th Cir. 1983).

[108] *Berlin v. Mich. Bell Tel. Co.*, 858 F.2d 1154, 10 EBC 1217 (6th Cir. 1988); *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 16 EBC 2413 (3d Cir. 1993); *Bixler v. Cent. Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 17 EBC 1934 (3d Cir. 1994).

[109] 516 U.S. 489, 19 EBC 2761 (1996).

[110] *See, e.g.*, *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.*, 579 F.3d 220, 228, 2009 BL 192563, 47 EBC 1929 (3d Cir. 2009) (examining claim that employer made material misrepresentations about lifetime medical benefits and inadequately disclosed its right to modify or terminate such benefits); *Bouboulis v. Transp. Workers Union of Am.*, 442 F.3d 55, 66, 37 EBC 1007 (2d Cir. 2006) (examining claims that union made material misrepresentations about lifetime medical benefits); *Jones*, 370 F.3d at 1071 (examining claims that insurance company materially misrepresented that benefit wouldn't be changed during retirement); *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439, 449, 28 EBC 2601 (6th Cir. 2002) (examining, inter alia, claims that human resource representative materially misrepresented employer's right to change benefits); *Devlin*, 274 F.3d at 88 (examining claims that employer violated duty to deal honestly with plan beneficiaries when describing duration of life insurance benefits); *see also Kerber*, 647 F.3d at 968 (refusing to adopt a test for breach of fiduciary duty claims for misrepresentation and affirming denial of claim that life insurance benefits couldn't be reduced where the plaintiffs failed to allege a material misrepresentation).

[111] *Howell v. Motorola, Inc.*, 633 F.3d 552, 2011 BL 16211, 50 EBC 1865 (7th Cir. 2011).

[112] *Pfahler v. Nat'l Latex Prods. Co.*, 517 F.3d 816, 830, 2007 BL 171526, 42 EBC 1769 (6th Cir. 2007); *Mathews v. Chevron Corp.*, 362 F.3d 1172, 118, 32 EBC 1684 (9th Cir. 2004).

[113] *See* note 89, *supra*.

> Havoc would ensue if plans meant different things for different participants, depending on what someone said to them years earlier. Memory is weak compared to the written word, and there is a substantial risk that participants will not recall what was said, will exaggerate (in their favor) what they heard, or will simply prevaricate in order to improve their position.[114]

Following the rule that oral modifications of an ERISA plan aren't permitted,[115] courts in the Seventh Circuit generally reject attempts to bring claims for post-retirement medical benefits based on oral misrepresentations of benefit eligibility absent a showing of intent to deceive.[116] The Seventh Circuit, however, applies a narrower interpretation of *Varity* than most circuits.[117]

Two subsidiary issues raised by oral misrepresentation claims are: (1) whether the person making the alleged statement—for instance, an administrative employee in the human resources department—was acting in a fiduciary capacity when making the misrepresentation, and (2) whether the plaintiff's reliance on a misrepresentation was reasonable in light of an express reservation of rights language contained in the plan documents.

Fiduciary Status. Although the plan documents are the primary source for determining fiduciary status, ERISA also recognizes ''functional'' fiduciaries. ''[U]nder ERISA, a person 'is a fiduciary with respect to a plan' only 'to the extent' that 'he has any discretionary authority or discretionary responsibility in the administration of such plan.' ''[118] Although communicating with employees about plan benefits may be considered a fiduciary act, performing ministerial acts, such as answering employees' questions, generally doesn't amount to the exercise of discretion that would cause a person to become a fiduciary under ERISA.[119] Thus, to determine whether an individual is acting in a fiduciary capacity when making a representation that is the subject of a claim, courts conduct a fact-specific inquiry that takes into account, among other things, the information being communicated, relevant plan documents, and the scope of any delegated

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[114] *Frahm v. Equitable Life Assurance Soc'y*, 137 F.3d 955, 960, 21 EBC 2679 (7th Cir. 1998) ("The district court's finding that the Equitable didn't set out to deceive or disadvantage plan participants therefore forecloses plaintiffs' claim under § 1104(a)(1)."); *Vallone*, 375 F.3d at 641, 33 EBC 1001 ("here there is no evidence of any intent to purposefully mislead employees").

[115] *Brines v. XTRA Corp.*, 304 F.3d 699, 701-02, 28 EBC 2517 (7th Cir. 2002) (where the plan is written, oral modifications to that plan aren't permitted); *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795, 797, 24 EBC 1661 (7th Cir. 2000).

[116] *E.g., Vallone*, 375 F.3d at 642 ("negligence in fulfilling the duty [to disclose] isn't actionable"); *Powers v. Corn Prods. Int'l, Inc.*, 557 F. Supp. 2d 928, 2008 BL 100682, 44 EBC 2372 (N.D. Ill. 2008); *but see Kenseth v. Dean Health Plan, Inc.,* 610 F.3d 452, 2010 BL 146683, 49 EBC 1652 (7th Cir. 2010) (allowing a negligent misrepresentation claim to proceed in light of ambiguous plan language and the plan's invitation to participants to seek advice from a plan agent who was negligently trained to explain the information, although note this wasn't a retiree medical case and the plaintiffs didn't allege oral misrepresentations).

[117] *See Vallone*, 375 F.3d at 642 (noting that "*Frahm* demonstrates a narrower interpretation of *Varity* than exists in other circuits" such that an employer "must have set out to disadvantage or deceive its employees").

[118] *Varity*, 516 U.S. at 527.

[119] *See Adams v. Brink's Co.*, 261 F. App'x. 583, 2008 BL 7301, 42 EBC 2337 (4th Cir. 2008), *cert. denied*, 128 S. Ct. 2936, 44 EBC 1288 (2008) ("The Court agrees that an employer/plan administrator doesn't exercise discretionary authority or control over the administration of the plan merely when employees tell each other about plan benefits."); *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 14 EBC 1331 (6th Cir. 1991) (person without the power to make plan policies or interpretations but who performs purely ministerial functions such as applying plan eligibility rules, communicating with employees, and calculating benefits, doesn't act in a fiduciary capacity under ERISA); *Hansen v. North Trident Reg'l Hosp., Inc.*, 60 F. Supp. 2d 523 (D.S.C. 1999) (explaining that the Supreme Court in *Varity* didn't say that any time an employer makes representations regarding a benefit plan it constitutes an administrative act and imposes fiduciary status where none previously existed; instead, such opinions or representations fall more properly within the specific functions which the regulations hold aren't fiduciary in nature). *See also* 29 C.F.R. § 2509.75-8, D-2, subpara. (7) ("[o]rientation of new plan participants and advising participants of their rights and options under the plan" isn't a fiduciary function if performed "within a framework of policies interpretations, rules, practices and procedures made by other persons").

responsibility to communicate with participants.[120] Where the inquiry leads to the conclusion that a misrepresentation wasn't made by a fiduciary, courts often dismiss the claim.[121] On the other hand, some courts have found that a fiduciary may be bound by the acts of its non-fiduciary agents where the agent possesses actual or apparent authority to act on the fiduciary's behalf.[122]

Detrimental Reliance. Courts have also generally held that plaintiffs must show that they reasonably relied to their detriment on the fiduciary misrepresentation. Because reliance must be established through ''individualized proof,''[123] courts have generally declined to allow fiduciary misrepresentation claims to proceed as class actions.[124] Thus, it appears that, for now, fiduciary misrepresentation claims aren't a particularly effective tool for enforcing retiree medical benefit rights in the class context. However, in at least two cases, retirees deemed unable to pursue class action claims chose to pursue individual claims through ''mass joinder'' actions by hundreds of retirees.[125] But, the ultimate viability of these mass joinder actions is unclear as each retiree will have to individually prove the elements of his claim (a misrepresentation by a fiduciary and reasonable reliance), making it difficult to efficiently adjudicate the claims of hundreds or thousands of retirees.

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[120] *Adams,* 261 F. App'x. 583; *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, MDL No. 969, 29 EBC 2473 (E.D. Pa. Feb. 4, 2003); *see also Jump v. Speedway LLC*, 23 F. Supp. 3d 1024, 1030-31, 2014 BL 135957, 58 EBC 1095 (D. Minn. 2014).

[121] *See Adams*, 261 F. App'x. 583 (statements by company employees weren't made in fiduciary capacity where employees lacked discretionary authority to alter terms of plan or to determine eligibility for benefits); *Deas v. Nat'l Sheet Metal Workers Union Nat'l Pension Fund*, 114 F. Supp. 2d 1259, 1276 (S.D. Ala. 2000) (manager wasn't a fiduciary, in part, because plaintiffs received written information, including SPDs that directed plaintiffs to approved sources of information about benefits); *Lower v. Albert*, 187 F.3d 636 (6th Cir. 1999) (holding that employer wasn't acting in a fiduciary capacity because alleged misrepresentations ''didn't represent the sort of detailed plan information intended to help participants determine whether to remain in the plan'').

[122] *Taylor v. Peoples Natural Gas Co.*, 49 F.3d 982, 989-99, 19 EBC 1033 (3d Cir. 1995) (supervisor of benefits had apparent authority to counsel employees about possible plan changes); *In re Unisys Retiree Med. Benefit ERISA Litig.*, MDL 969, 2007 BL 254953, 41 EBC 2609 (E.D. Pa. July 16, 2007) (human resources staff and other managers and supervisors had actual or apparent authority to communicate with participants about benefits); *Broga v. NE Util.*, 315 F. Supp. 2d 212, 245, 32 EBC 2136 (D. Conn. 2004) (human resources staff and other officers and supervisors had apparent authority to counsel employees about retirement benefits).

[123] *In re Unisys Corp. Retiree Med. Benefit Litig.*, MDL No. 969, 29 EBC 2473 (E.D. Pa. Feb. 4, 2003).

[124] *Brubaker*, 664 F. Supp. 2d at 991 (noting that the court didn't certify the plaintiffs' breach of fiduciary duty claim for misrepresentation, which proceeded brought by the individual named plaintiffs); *Sprague*, 133 F.3d 388, 21 EBC 2267; *Hudson v. Delta Air Lines Inc.*, 868 F. Supp. 1383 (N.D. Ga. 1994) (denying class certification because of different representations applicable to individual retirees) *aff'd*, 90 F.3d 451 (11th Cir. 1996); *Alday v. Container Corp. of Am.*, No. 87-488, 1988 WL 236038 (M.D. Fla. 1988) (class certification denied where claims based on widely varying oral and written representations that retiree medical benefits were vested), *aff'd*, 906 F.2d 660, 12 EBC 2211 (11th Cir. 1990); *Frahm*, 137 F.3d at 957, 21 EBC 2679 (7th Cir. 1998); *In re Unisys Corp. Retiree Med. Benefits ERISA Lit.*, 29 EBC 2473 (E.D. Pa. Feb. 4, 2003); *In re Sears Retiree Group Life Ins. Litig.*, 198 F.R.D. 487, 25 EBC 1936 (N.D. Ill. 2000); *UAW v. Ivaco, Inc.*, 216 F.R.D. 693, 29 EBC 1888 (N.D. Ga. 2002) (denying class certification, based on the necessity of establishing individual detrimental reliance); *Devine v. Combustion Eng'g*, 760 F. Supp. 989 (D. Conn. 1991); *Spencer v. Cent. States S.E. & S.W. Am. Pension Fund*, 778 F. Supp. 985 (N.D. Ill. 1991).

[125] Following decertification of the class in *In re Unisys Corp. Retiree Med. Benefits Litig.*, No. 969, 29 EBC 2473 (E.D. Pa. Feb. 4, 2003), many of the class members pursued claims individually. Similarly, in *Jones v. Am. Gen.*, 370 F.3d 1065, 32 EBC 2484 (11th Cir. 2004), approximately half of the putative class members filed individual claims under the umbrella of six ''mass joinder'' actions. The claims were consolidated for pretrial proceedings by the Panel on Multi-District Litigation. *In re Am.Gen. Life & Accident Ins. Co. Retiree Benefits Litig.*, 387 F. Supp. 2d 1361 (MDL 2005).

.50.20 Misrepresentation Claims Based on Equitable Theories

The Supreme Court's decision in *Cigna v. Amara*[126] opened the door to a new claim for equitable relief grounded in a violation of ERISA's disclosure provisions. In *Amara*, the plaintiffs alleged that the employer violated ERISA § 102(a) by making false and misleading statements in an SPD about the conversion to a cash balance plan. Section 102(a) requires SPDs to be ''written in a manner calculated to be understood by the average plan participant,'' and to be ''sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.''[127] If an SPD is inaccurate or misleading, it doesn't meet these requirements, and a participant can seek equitable relief under ERISA § 502(a)(3) to remedy the violation.

Not surprisingly, this theory of liability has found some traction in cases that traditionally would have been litigated only as breaches of fiduciary duty.[128] There are few examples of the theory being applied to post-retirement medical claims, perhaps because such claims tend to be based on affirmative representations or promises rather than inaccurate or misleading statements in an SPD. For example, in *Collins v. Teamsters Benefit Trust*,[129] the plaintiffs challenged a modification requiring them to contribute to the cost of their health coverage. They claimed that the SPD violated ERISA § 102 because, while it allowed the defendant to change or terminate the plan at any time for any reason, it simultaneously stated that the monthly contribution was subject to change ''based on the number of employees'' in the plan and the plan's experience. The court dismissed the claim because of the SPD's explicit reservation of rights language and found that the plaintiffs failed to explain how the language was inconsistent. As litigants continue to test the boundaries of *Amara*'s ''equitable'' remedies, it would not be surprising to see more such cases in the future.

.50.30 Promissory Estoppel Claims

In response to the perceived harshness of a rule that excuses inaccurate or inconsistent communications outside the official plan documents, some courts attempted to fashion a remedy for retirees under the doctrine of promissory or equitable estoppel, a legal theory grounded in contract law. The doctrine holds that a party who makes promises to another with the intention of inducing the other to act upon the promises should be bound if the other acts reasonably to his detriment in reliance on the promises.[130]

In recent years, however, breach of fiduciary duty and *Amara*-based equitable theories have largely replaced promissory estoppel as the basis for misrepresentation claims, although promissory estoppel still shows up in the case law.[131] While the law varies from circuit to circuit, to state a claim for promissory estoppel in the ERISA context, a plaintiff generally must establish: (1) a material misrepresentation of fact; (2) reasonable and detrimental reliance on the

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[126] 131 S. Ct. 1866, 2011 BL 128629, 50 EBC 2569 (2011).

[127] ERISA § 102(a).

[128] *See, e.g., Skinner v. Northrop Grumman Ret. Plan B*, 673 F.3d 1162, 1167, 2012 BL 61849, 52 EBC 2089 (9th Cir. 2012) (concluding that plaintiff failed to present evidence sufficient to support claim that the SPD was ambiguous and shouldn't be enforced in light of more favorable provision in plan, given lack of fraudulent intent or unjust enrichment by employer); *Osberg v. Foot Locker, Inc.*, No. 1:07-cv-01358-KBF, 2015 BL 317497 (S.D.N.Y. Sept. 29, 2015) (finding § 102 violation and breach of fiduciary duty based on employer's materially false, misleading, and incomplete descriptions of cash balance plan to employees including in SPD).

[129] No. 4:12-CV-2984 YGR, 2013 BL 93554, 55 EBC 2491 (N.D. Cal. Apr. 5, 2013).

[130] Generally, an ERISA beneficiary may recover benefits under an estoppel theory upon establishing (1) a material misrepresentation, (2) reasonable and detrimental reliance, and (3) extraordinary circumstances. *Unisys I*, 58 F.3d at 907; *Schonholz v. Long Island Jewish Med. Ctr.*, 87 F.3d 72, 78, 28 EBC 1122 (2d Cir. 1996).

[131] *See Kepner v. Weyerhaeuser Co.*, No. 6:16-cv-01040-AA, 2016 WL 5939153 (D. Ore. Oct. 10, 2016) (dismissing promissory estoppel claim due to absence of clear and unambiguous promise to vest employees with irrevocable lifetime healthcare benefits); *Bell v. Xerox Corp.*, 52 F. Supp. 3d 498, 516, 60 EBC 1949 (S.D.N.Y. 2014) (refusing to dismiss promissory estoppel claim where plaintiffs alleged they were told they would be provided with lifetime coverage but subsequently the employer sought to add reservations of rights language in plan materials); *Boban v. Bank Julius Bear Postretirement Health & Life Ins. Program*, 723 F. Supp. 2d 560, 567-68, 2010 BL 163465, 49 EBC 2664 (S.D.N.Y. 2010) (refusing to dismiss promissory estoppel claim where the plaintiffs sufficiently alleged they were induced to sign severance agreements that promised their

misrepresentation; and (3) extraordinary circumstances justifying enforcement of the promise.[132] Most estoppel claims fail to clear this hurdle and are dismissed.[133]

.50.40 Remedies for Misrepresentation and Other Non-Disclosure Claims

Fiduciary misrepresentation and other nondisclosure claims are typically brought pursuant to ERISA § 502(a)(3), which limits plaintiffs to ''appropriate equitable relief.''[134] The Supreme Court and other courts held that ''appropriate equitable relief'' under ERISA § 502(a)(3) generally doesn't include recovery of money damages.[135] Claimants who allege fiduciary breaches based on misrepresentation typically seek reinstatement of the medical coverage that retirees have lost and recovery of medical expenses that would have been paid by the plan if the coverage had not been terminated or reduced.

In the *Unisys* retiree medical litigation, the district court conducted a bench trial on 14 retiree plaintiffs' claims that reductions in retiree medical coverage were inconsistent with representations made to them before and after their retirements. The district court found that 12 of the 14 retirees had proved their misrepresentation claims and awarded equitable relief in the form of reinstatement of the medical coverage they received before the changes.[136] However, the court declined to award monetary reimbursement for medical expenses incurred by the prevailing retirees from the date the coverage was reduced, finding that retroactive reinstatement wasn't ''appropriate equitable relief'' because it simply required the payment of money damages. The Third Circuit affirmed, explaining that the relief plaintiffs sought wasn't ''traditionally available in equity.''[137]

Unisys is arguably contrary to a line of cases in the Sixth Circuit that deny jury trials on LMRA claims seeking to recover out of pocket costs incurred by retirees following termination of benefits. Although not directly addressing whether the requested remedy constitutes appropriate equitable relief under § 502(a)(3), those cases reason that the

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health and dental insurance plans would continue so long as they paid the required contributions). The diminishing number of promissory estoppel suits may be due, in part, the Sixth Circuit's decision in *Sprague* that promissory estoppel claims can't be asserted in a class action lawsuit because the plaintiffs' theories of recovery concerned many different representations made to many people, so there was lack of commonality and typicality. 133 F.3d 388; *see also Jensen v. SIPCO, Inc.*, 38 F.3d 945, 18 EBC 2188 (8th Cir. 1994) (suggesting that ERISA equitable estoppel claim wouldn't be suitable for class-wide relief because it would require ''factual precision'' regarding whether a material misrepresentation was made on which a beneficiary reasonably relied to his detriment).

[132] *Nichols v. Alcatel USA, Inc.*, 532 F.3d 364, 2008 BL 130621, 44 EBC 1001 (5th Cir. 2008); *Devlin*, 274 F.3d at 86; *Combs v. Ky. Wesleyan Coll.*, No. 05-139, 2008 BL 5538, 42 EBC 2322 (W.D. Ky. Jan. 11, 2008).

[133] *See, e.g., Nichols*, 532 F.3d at 375 (no material misrepresentation because plan documents clearly allowed amendment or modification, no reasonable reliance); *Kerber v. Qwest Group Life Ins. Plan*, 544 F. Supp. 2d 1187, 2008 BL 131015, 43 EBC 2454 (D. Colo. 2008) (reservation of rights clause gave company right to reduce benefits and plaintiff failed to allege lies, fraud, or intent to deceive); *Powers*, 557 F. Supp. 2d at 936 (rejecting estoppel claims as oral modifications of plan documents); *Combs*, 2008 BL 5538, (health plan was unambiguous and foreclosed estoppel claim).

[134] ERISA § 502(a)(3).

[135] *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356, 37 EBC 1929 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 27 EBC 1065 (2002); *Coan v. Kaufman*, 457 F.3d 250, 38 EBC 1609 (2d Cir. 2006); *Crosby v. Bowater Ret. Plan for Salaried Employees of Great No. Paper, Inc.*, 382 F.3d 587, 33 EBC 1769 (6th Cir. 2004); *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401, 34 EBC 1001 (10th Cir. 2004).

[136] *In re Unisys Corp. Retiree Med. Benefits Litig.*, MDL No. 969, 2007 BL 254953, 41 EBC 2609 (E.D. Pa. July 16, 2007). The Third Circuit decision upholding dismissal of the breach of contract claims is *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d 896, 19 EBC 1545 (3d Cir. 1995).

[137] *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.*, 579 F.3d 220, 2009 BL 192563, 47 EBC 1929 (3d Cir. 2009).

recovery of out of pocket costs in such circumstances is an equitable remedy and therefore the retirees aren't entitled to a jury trial under the Seventh Amendment.[138]

Cigna Corp. v. Amara identified several remedial theories that permit monetary recovery under § 502(a)(3)—notably, surcharge—and may have opened the door to additional relief that was previously foreclosed.[139] The authors are unaware of any reported decisions that address whether retirees who incurred out of pocket costs following benefit termination are entitled to monetary relief under § 502(a)(3) based on a surcharge theory. However, one case suggests that such an argument may have legs. In *Gearlds v. Entergy Services, Incorporated*,[140] the plaintiff took early retirement based on assurances that he was covered by the plan and would receive continued health benefits. When the defendant discontinued his medical benefits after determining he was ineligible, the plaintiff filed suit, alleging breach of fiduciary duty under § 502(a)(3). The district court dismissed the fiduciary duty claim because the plaintiff sought only compensatory damages, finding such damages were not available under § 502(a)(3). The Fifth Circuit, however, reinstated the claim in light of *Amara*, even though the plaintiff didn't plead surcharge in the complaint and instead sought make-whole relief and all other relief available.

> ***Practice Tip:*** The uncertain direction in the development of future claims for misrepresentation and nondisclosure underscores the need to ensure that a uniform message is delivered in governing documents and all extrinsic communications. If an employer doesn't intend to vest retiree benefits, it should ensure that benefit summaries, brochures, letters to employees and retirees, as well as oral communications, are consistent and contain an explicit reservation of rights clause in the governing plan documents. Moreover, any language addressing an employer's intent or expectation to provide the plans should be removed from all plan documents and communications.

.60 Conclusion

As medical costs have soared, the question of whether an employer can reduce or terminate post-retirement medical benefits has become important to employers and retirees alike. Employers seeking to contain their medical costs by amending or terminating retiree coverage often are fought at every turn by retirees facing the same plight—skyrocketing medical expenses that can threaten financial survival. Active nonunion employees, who usually are unrepresented in this fight, have a significant stake in its outcome because they often will be required to bear the retirees' share of the cost if the employer is prevented from changing (or decides not to change) the retirees' benefits.

As the cases indicate, these conflicts are resolved through a determination of the employer's intent, or the parties' intent where collective bargaining is involved. This determination is made first by reference to the written plan documents, SPDs, and collective bargaining agreements. If these documents don't clearly indicate whether post-retirement medical benefits are vested, then the courts will determine intent from evidence outside the plan documents, such as written and oral statements by the employer's management, the history of changes in post-retirement medical coverage, the history of collective bargaining, and whether benefits have been continued after expiration of collective bargaining agreements. However, the courts have also recognized that where a plan administrator has breached its duty to truthfully communicate benefits, it may be held liable even if the plan documents are unambiguous.

In each case, the determination is based on the facts presented to the court, which will inevitably vary from case to case. It is therefore dangerous for practitioners to formulate generalized conclusions based on these cases, because each involves a combination of unique facts and circumstances, some but not all of which might be present in other cases, and the outcomes can be dramatically affected by the varying approaches to contract construction adopted by different jurisdictions.

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[138] *See, e.g.*, *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 661, 19 EBC 2457 (6th Cir. 1996) ("The monetary award the plaintiffs seek is to compensate them for the amount of loss they incurred between January 1 and March 17. Most of this loss is probably in the form of premiums and Special Age 65 Benefits withheld from pension checks by Kelsey–Hayes during this period. The balance would be the out-of-pocket expenses incurred in increased deductibles and co-payments. Such damages are exactly the type of monetary relief that courts, and the Restatement, envision as equitable relief; they are incidental to the grant of equitable relief, yet are necessary to afford complete relief. A court doesn't err in denying a jury trial where the monetary award sought is incidental to, or intertwined with, equitable relief.").

[139] 563 U.S. 421, 444, 2011 BL 128629, 50 EBC 2569 (2011).

[140] 709 F.3d 448, 2013 BL 45043, 55 EBC 2688 (5th Cir. 2013). Other circuit court decisions have interpreted *Amara*, albeit not in the retiree medical context. *See Gabriel v. Alaska Elec. Pension Fund*, 755 F.3d 647, 2014 BL 158469, 58 EBC 1633 (9th Cir. 2014); *Skinner v. Northrup Grumman Ret. Plan B*, 673 F.3d 1162, 2012 BL 61849, 52 EBC 2089 (9th Cir. 2012); *McCravy v. Metro. Life Ins. Co.*, 690 F.3d 176, 2012 BL 166368, 53 EBC 2605 (4th Cir. 2012).