BNA, INC.

ERISA Compliance & Enforcement Library

BNA Employee-Owned Since 1947

Retiree Welfare Benefits Litigation

Gregory C. Braden
Morgan, Lewis & Bockius LLP
Washington, D.C.

Christopher A. Weals
Morgan, Lewis & Bockius LLP
Washington, D.C.

Introduction

Retiree welfare benefits[1] include non-pension benefits provided by employers to retired employees, primarily medical and life insurance benefits. 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, the focus of this report is retiree medical benefits.

Employer provided post-retirement medical benefits are a comparatively recent phenomenon. First offered in the 1940s by insurance companies for their employees, post-retirement medical benefits did not become widespread until the 1960s. Employers generally found post-retirement medical benefits cheap when compared to pension benefits, and they became even cheaper 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 late 1970s and accelerating through 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 was accelerated in the 1980s and 1990s by widespread early retirement incentive programs or buyouts. Retirement before eligibility for Medicare (generally age 65) can dramatically increase 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

[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...."

deductibles and out-of-pocket maximums. At the same time, the federal and state governments passed laws requiring employers and group insurers to provide certain kinds of coverage and extend coverage beyond termination of employment.[2]

Although these trends caused many employers to rethink and reduce or eliminate their commitment to providing postretirement medical coverage, it was not 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. Prior to the introduction of FAS 106, most employers simply "expensed" each year's actual expenditures for postretirement medical coverage on their financial statements in the same manner as active employee medical expenses. FAS 106 dramatically changed the accounting treatment of postretirement medical benefits[3] 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 (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 with medical cost inflation. In valuing these liabilities, accountants and actuaries must assume that the liabilities will increase in the future, often at extremely high inflation 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 liabilities by congressional action in 1984 that eliminated favorable tax treatment for prefunding post-retirement medical benefits.[4]

These factors, singly and in combination, prompted employers to critically evaluate their continuing commitment to postretirement 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, do not automatically vest by operation of law.[5] 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 carefully consider whether they have the legal right to implement such measures for existing retirees. The financial stakes are huge because, 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 its post-retirement benefits liabilities for FAS 106 purposes.[6]

If, on the other hand, the employer does not 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 more drastically 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.[7]

Determining Whether Retiree Medical Benefits Can Be Modified

Overview

The Employee Retirement Income Security Act of 1974 (ERISA) established a comprehensive statutory

[2] *See* ERISA title I, subtitle B, part 6 (COBRA); part 7 (Portability, Mental Health Parity, etc.). State laws that mandate certain benefits generally are not applicable to self-funded employer-sponsored plans; however, they can apply to employer plans that provide benefits through group insurance contracts. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 6 EBC 1545 (1985).

[3] FAS 106 applies to all nonpension post-retirement benefits (such as medical and life insurance). This note focuses on medical benefits, by far the most expensive of nonpension post-retirement benefits.

[4] 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 is not subject to income tax.

[5] Pension benefits are required to vest after specified periods of service. ERISA § 203(a).

[6] For example, the employer could assume that it had the legal right to increase the annual amount paid by retirees for coverage as necessary to allocate a specific percentage of the overall cost (20 percent, 50 percent, etc.) to retirees. This assumption could be used to reduce the employer's FAS 106 liability.

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

scheme for regulating pension and welfare benefit plans. Significantly, ERISA does not 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.[8] Rather, employers who choose to establish benefit plans must comply with certain regulatory requirements. The voluntary nature of the U.S. benefit plan system is an important concept to remember when evaluating an employer's right to change or terminate post-retirement medical benefits, because it suggests that restrictions on this right should not be presumed or favored. Doing so would likely discourage employers from adopting these plans.

Title I of ERISA establishes reporting, disclosure, vesting, funding, benefit accrual, and fiduciary requirements for all U.S. pension plans.[9] Title IV of ERISA establishes the Pension Benefit Guaranty Corporation, which guarantees the payment of pensions subject to certain limits. However, "welfare benefit plans," which include plans providing post-retirement medical benefits, are exempted from ERISA's vesting, funding, and benefit accrual requirements and are not guaranteed by the PBGC or any other government agency.[10] In fact, welfare benefit plans must comply only with ERISA's reporting, disclosure, and fiduciary requirements and certain coverage requirements.[11] These requirements are directly and indirectly at issue in much of the litigation over post-retirement medical benefits.

While Congress consciously chose not to require vesting of post-retirement medical benefits in ERISA, it did require that welfare benefit plans be maintained pursuant to written plan documents,[12] and that covered participants be able to enforce these documents in accordance with their terms.[13] In addition, Congress required that these written plans be communicated to covered participants and beneficiaries in summary plan descriptions (SPDs) that are written in language understandable by the average plan participant.[14] Subject to these requirements, employers have a free hand to determine the level of benefits provided under their welfare plans and the plan designs pursuant to which the benefits are provided.

Thus, when the courts are called upon to determine whether post-retirement medical benefits have vested, they focus primarily on the plan documents and SPDs. If these documents unambiguously answer the question, the inquiry usually ends there. If these documents are ambiguous or internally inconsistent, however, the courts will look to "extrinsic evidence" to determine whether the employer intended to vest the post-retirement medical benefits. Such evidence may take the form of letters, summaries, or brochures issued by company human resources personnel, and even oral statements made by management personnel that may have occurred many 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 usually receptive to the claims of retirees. Retirees make sympathetic plaintiffs because they are elderly, often infirm, 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 go to 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 that an employer could not reduce post-retirement medical benefits even if the plan documents permitted it.[15] Although this case has long since been reversed, it highlights the difficulty many judges have with the notion that retirement benefits can be unilaterally changed after retirement.
- There is often a great disparity between what the governing plan documents say and what the retirees

---

[8] *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 (Indiana)*, 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). *See* footnote 2, *supra*.

[9] 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).

[10] *See* ERISA § § 201(1), 301(a)(1), 4001(a)(3), (15).

[11] *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. These provisions generally have not been at issue in retiree medical litigation. *Id.*, parts 6 and 7.

[12] 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. . . ."

[13] *See* ERISA § 502(a)(1).

[14] *See* ERISA § 102(a).

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

claim they were told about the employer's intention to vest the 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 HR 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 vest post-retirement medical benefits based on notions of promissory estoppel and breach of fiduciary duty.

- A dichotomy has developed between the interpretation of collectively bargained and unilaterally established post-retirement medical arrangements. Collectively bargained plans are interpreted in accordance with labor law that focuses initially on whether post-retirement benefits terminate upon expiration of the collective bargaining agreement, and often considers such factors as prior bargaining history, past practices of continuing benefits after expiration of collective bargaining agreements, and the relationship between pension and welfare benefits. As a result, at least one federal appeals court has held that collectively bargained post-retirement medical benefits should be presumed to vest upon retirement.[16] On the other hand, unilaterally established plans generally do not 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 these plans, they often contain "reservation of rights" clauses allowing unilateral amendment or termination of the benefits at any time.

Again, these general observations alone do not 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 is not readily apparent.

Practice Tip: Employers should perform a thorough legal review that includes a historical review of communications with employees and retirees before making final decisions on how the cost-containment burden will be allocated. This should include a thorough review of SPDs, plan documents, and employee and retiree communications.

Unilaterally Established Post-retirement Medical Benefits

The Framework - Traditional Contract Analysis

Litigation over unilaterally established post-retirement medical plans began unevenly in the early 1980s with several highly publicized federal district court decisions that largely 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.[17] The courts reasoned that the employers had offered unilateral contracts to their employees essentially stating that, if the employees worked until retirement, the employer would provide post-retirement medical coverage. The employer could not refuse to perform its part of the "bargain" after the employee had performed his.[18]

The "unilateral contract" theory was short-lived, however. In 1988, appeals courts in New York and Cincinnati issued two of the more widely cited decisions in this area, *Musto v. American General Corp.*[19] and *Moore v. Metropolitan Life Insurance Co.*,[20] which together form the foundation for much of the subsequent legal analysis in this area. A brief review of the facts of these two cases is instructive.

Musto and *Moore* both involved retiree challenges to changes in their medical plans, including the introduction of required premium contributions, increases in deductibles and coinsurance, and changes in coordination of the coverage with Medicare. These changes materially increased the portion of medical expenses paid by retirees, and were typical of changes that many plan sponsors implemented in the pursuit of cost containment as medical insurance costs spiked in the 1980s.

The retiree medical plans at issue in *Musto* and *Moore* contained amendment and termination clauses that were described in the SPDs distributed to retirees. The retirees argued that, despite the language of the official plan documents, they were promised "lifetime" medical coverage that "would continue" into their retirement "at no cost," thus evidencing an intent by the employers to vest such benefits.[21]

Recognizing that ERISA does not require vesting of welfare benefits,[22] both courts looked to the language of the official plan documents and determined that the amendment clauses appearing in the plan documents and SPDs were unambiguous. Accepting the retirees' contentions as true, both courts nevertheless held that promises made outside the official plan documents could not give rise to a contractually enforceable vesting entitlement under the plans.[23]

The court in *Musto* noted:

---

[16] *Weimer v. Kurz-Kasch Inc.*, 773 F.2d 669, 6 EBC 2258 (6th Cir. 1985), *opinion amended on denial of reh'g*, 6 EBC 2795 (6th Cir. Oct. 30, 1985); *Policy v. Powell Pressed Steel Co.*, 770 F.2d 609, 6 EBC 2249 (6th Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986).

[17] *Hansen v. White Farm Equip. Co.*, 42 B.R. 1005, 5 EBC 2130 (N.D. Ohio 1984), *rev'd sub nom.*, *In re White Farm Equip. Co.*, 788 F.2d 1186, 7 EBC 1411 (6th Cir. 1986); *Musto v. American Gen. Corp.*, 615 F. Supp. 1483, 6 EBC 2071 (M.D. Tenn. 1985).

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

[19] 861 F.2d 897, 10 EBC 1441 (6th Cir. 1988).

[20] 856 F.2d 488, 9 EBC 2685 (2d Cir. 1988).

[21] *Moore*, 856 F.2d at 493; *Musto*, 861 F.2d at 907-8.

[22] *Moore*, 856 F.2d at 491; *Musto*, 861 F.2d at 901.

[23] *Musto*, 861 F.2d at 910; *Moore*, 856 F.2d at 492. *See also DeGeare v. Alpha Portland Indus. Inc.*, 837 F.2d 812 (8th Cir. 1988) (rejecting testimony of former vice president that it was company "policy" to provide lifetime vested post-retirement medical benefits), *cert. granted, judgment vacated on other grounds sub nom. DeGeare v. Slattery Group, Inc.* , 489 U.S. 1049 (1989).

> It is not always easy to determine exactly what a benefit plan says even when the language of the plan has been reduced to writing. If the terms of these often complex plans could be made to depend on evidence as to oral statements that may not have been worded very precisely in the first place, may have been made many years earlier, and that cannot be proved except through the testimony of lay witnesses whose memories will seldom be infallible and who, being human, might have tended to hear what they wanted to hear, the degree of certainty that Congress sought to provide for would be utterly impossible to attain.[24]

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 plan documents must clearly and affirmatively state an intention to vest retiree medical benefits in order for these benefits to become nonforfeitable.[25] 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.[26]

Reservation of Rights Clauses and the Search for "Ambiguity"

Much of the recent litigation over post-retirement medical benefits involves the interpretation of language appearing in plan documents, insurance contracts and SPDs stating that the medical coverage will continue after retirement.

Retirees argue that this language reflects an intention to vest the benefits, especially when the word "lifetime" is used. These claims have been made even in the face of plan documents having a clear "reservation of rights" clauses that give the employer the express right to modify, amend, or terminate the coverage, with retirees contending that the reservation of rights language is rendered ambiguous by the inconsistent promise of continued post-retirement coverage, requiring consideration of extrinsic evidence to determine the employer's intent.[27]

Where the official plan documents and SPDs include an unambiguous reservation of rights clause, the courts generally have held that plan language stating medical benefits "continue" beyond retirement does not conflict with the reservation of rights clause or otherwise create an ambiguity in the plan language.[28] The courts have

---

[24] *Musto*, 861 F.2d at 910, 10 EBC at 1454.

[25] *Int'l Union, United Auto., Aero. & Agric. Implement Workers of Am. v. Skinner Eng. Co.*, 188 F.3d 130, 139 (3rd Cir. 1999); *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 v. El Paso Natural Gas Co.*, 986 F.2d 929, 16 EBC 1789 (5th Cir. 1993), *cert. denied,* 510 U.S. 870 (1993) (citing *Alday v. Container Corp. of Am.*, 906 F.2d 660, 665; *In re Unisys Corp. Retiree Med. Ben. ERISA Litig.*58 F.3d 896, 902 (3rd 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"); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 400 (6th Cir. 1998) (en banc) ("[T]he intent to vest 'must be stated in clear and express language' "); *Stearns v. NCR Corp.*, 297 F.3d 706, 712 (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 (9th Cir. 2001) (same); *Chiles v. Ceridian Corp.*, 95 F.3d 1505, 1513 (10th Cir. 1996) (same); *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 632 (7th Cir. 2004) (same); *Bland v. Fiatallis N. Am., Inc.*, 401 F.3d 779, 784 (7th Cir. 2005) (same).

[26] *Balestracci v. NSTAR Elec. & Gas Corp.*, 449 F.3d 224, 231 (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 (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); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 83 (2d Cir. 2001) (rejecting clear and express standard, holding that specific written language reasonably susceptible to interpretation as promise sufficient to defeat summary judgment); *Abbruscato v. Empire Blue Cross and Blue Shield*, 274 F.3d 90 (2d Cir. 2001) (same).

[27] Most unilaterally established retiree medical plans now contain a reservation of rights clause. Indeed, the absence of reservation of rights language may indicate an 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 may not be terminable if it did not have a reservation of rights clause. *Devlin*, 274 F.3d 76. Moreover, an employer cannot retroactively insert a reservation of rights clause in a plan document for existing retirees unless the plan documents, as interpreted by the court, do not evince a clear intent to vest the benefits. *Helwig v. Kelsey Hayes Co.*, 93 F.3d 243, 20 EBC 1767 (6th Cir. 1996) (employer could not undo language indicating vesting of 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 employer's intent to vest the benefits, preventing the employer from adding and exercising the amendment/termination clause).

[28] *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 did not create ambiguity); *Jones*, 370 F.3d at 1069-71 (no ambiguity where SPD indicated that retiree life "will continue" after retirement); *Howe v. Varity Corp.*, 896 F.2d 1107, 1110, 11 EBC 2585 (8th Cir. 1990); *Skinner Engine Co.*, 188 F.3d at 140-41 ("A plain reading of the phrases 'will continue' and 'shall remain' does not unambiguously indicate that the benefits will continue ad infinitum...it cannot be said that the phrases clearly and expressly indicate vesting..."); *Musto*, 861 F.2d at 904 ("After your retirement, comprehensive Medical Expense Insurance Coverage will continue on you and your spouse...."); *Utility Workers Local 369 v. NSTAR Elec. & Gas Corp.*, 317 F. Supp. 2d 69, 74, 32 EBC 2774 (D. Mass. 2004) (phrase "will be covered" cannot mean lifetime or unalterable coverage because plan contained reservation of rights clause); *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

also generally held that a promise of "lifetime" coverage in plan documents will not conflict with, or create ambiguity in, an otherwise clear reservation of rights clause.[29] However, where the plan documents do not include an unambiguous reservation of rights clause, lifetime language in the documents has been held to require vesting of post-retirement medical benefits. In *Helwig v. Kelsey Hayes Co.*,[30] 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 did not include a reservation of rights clause.[31]

Although the factual scenarios will differ from case to case, the common thread is the contractual analysis. Students of these cases will note that the fiercest battles are fought over the issue of ambiguity in the official plan documents. This should come as no surprise, since whoever wins this battle usually wins the war. Close observers also will note that the courts sometimes interpret the plan documents on a sliding scale, showing a greater inclination to find an ambiguity in the plan documents when the extrinsic evidence strongly indicates an intention to vest the benefits.[32] This sliding scale undoubtedly reflects some courts' dissatisfaction with the strict contractual analysis, which forbids them from considering the extrinsic evidence as long as the official plan documents are clear.

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

Inconsistencies Between the Plan Documents and SPD

A closely related issue involves inconsistencies between the plan documents and SPDs. Employers occasionally have failed to include descriptions of reservation of rights clauses in SPDs even though the clauses appear in the master plan documents. In general, the courts have shown little sympathy for employers that fail at the daunting task of accurately summarizing their complicated medical plans in the SPDs. As one court noted:

> [T]he statutory language and legislative history of ERISA dictate that employers may not construct SPDs in such a manner that they mislead employees into thinking they have a right to benefits when other documents obliquely negate those rights.[33]

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—the SPD will generally prevail over the master plan's reservation of rights clause.[34]

---

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 do not 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).

[29] *See Schoonejongen v. Curtiss-Wright Corp.*, 18 F.3d 1034, 18 EBC 1225, (3rd Cir. 1994), *rev'd on other grounds*, 514 U.S. 73, 18 EBC 2841 (1995). *See also Hughes v. 3M Retiree Med. Plan*, 281 F.3d 786, 792-93, 27 EBC 1878 (8th Cir. 2002); *Abbruscato*, 274 F.3d at 96; *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d 896 ("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, did not render the plans 'internally inconsistent' and therefore ambiguous...."); *Wise*, 986 F.2d 929; *Sprague*, 133 F.3d at 388 (SPD containing the promise of "lifetime" coverage did not give rise to vested benefits even though the SPD did not include an amendment/termination clause.); *In re Sears Retiree Group Life Ins. Litig.*, 90 F. Supp. 2d 940.

[30] 93 F.3d 243, 20 EBC 1767 (6th Cir. 1996). The Seventh Circuit did not go quite as far in *Bland v. Fiatallis N. Am. Inc.*, 401 F.3d 779, 787, 34 EBC 1875 (7th Cir. 2005), holding that failure to include an amendment and termination clause coupled with language describing the benefits as "lifetime" in duration required a trial to determine whether the benefits were vested.

[31] A few courts have found that promises of lifetime benefits contained in letters to a select class of retirees can evidence an intent on the part of the employer to establish a second plan under which such benefits have in fact vested. *See Deboard v. Sunshine Min. & Ref. Co.*, 208 F.3d 1228, 1240, 24 EBC 1289 (10th Cir. 2000).

[32] *See 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").

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

[34] In an interesting twist, the *Helwig* court also held that the master plan, which consisted of an insurance policy, did not 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 from 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' "); *UAW v. Skinner Engine Co.*, 15 F. Supp. 2d 773 (W.D. Pa. 1997), *aff'd,* 188 F.3d 130, 23 EBC 2022 (3d Cir. 1999) ("Your insurance under the group policy will also terminate upon discontinuance of the group policy."); *Musto*, 861 F.2d at 903, 10 EBC 1441 ("insurance of an employee under any of the coverages [sic] provided by

Although these kinds of conflicts between the master plan and SPDs typically are resolved in favor of the SPDs, 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.[35] Nonetheless, these cases underscore the danger for employers who, by failing to recognize the legal significance of plan documents and SPDs or by simple neglect, allow these documents to fall into disrepair.

Practice Tip: Consider combining the master plan document and SPD so that there is only one document and no inconsistency between the two. Alternatively, use a "wrap" document which incorporates the SPD but does not attempt to duplicate its provisions, thereby eliminating any possibility of inconsistency between the two.

Another issue, addressed in *Howe v. Varity Corp.*,[36] involves the practice of excepting (grandfathering) prior retirees whenever post-retirement medical benefits are reduced or changed. In *Howe*, the retirees urged the court to view this practice as evidence of the employer's intent to vest the benefits at retirement.[37] The court rejected the argument, stating that "merely because defendants chose to exempt retirees from plan changes in the past does not mean that the defendants considered themselves forever bound to do so."[38] Conversely, a consistent past practice of treating post-retirement medical benefits as vested benefits 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.[39]

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

Breach of Fiduciary Duty Claims Seeking Retiree Welfare Benefits

ERISA imposes fiduciary duties on parties charged with responsibility for plan administration.[40] 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 challenges by retirees to employer reductions in post-retirement medical benefits often were based on the contention that the reductions were in the interest of the employer rather than plan participants and therefore violated ERISA's fiduciary rules. The courts rejected these early fiduciary claims for two reasons:

First, the courts reasoned that employers, who also usually served as plan administrators and ERISA fiduciaries, were not acting in their fiduciary capacities when they made decisions relating to the establishment, termination, or level of benefits offered under ERISA plans.[41]

Second, the courts held, based on a somewhat arcane series of statutory interpretations, that plan participants could not obtain relief on their own behalf in suits for breach of fiduciary duty; rather, they could only recover losses incurred by the plan for the plan itself. Since reductions in the plan benefits payable to participants do not cause losses to the plan, participants suing over benefit reductions had no claim for breach of fiduciary duty.[42] In the late 1980s and early 1990s, however, courts began to deviate from this logic, finding that ERISA fiduciary duties extended to communications with plan participants.[43] In other words, ERISA fiduciaries had a fiduciary duty to communicate accurate

---

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.").

[35] *Sprague*, 133 F.3d 388, 21 EBC 2267 (6th Cir. 1998) (*en banc*) (An omission from the summary plan description does not, 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 does not trump the clearly stated right to do so in the plan itself.).

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

[37] Many employers choose not to apply changes in post-retirement medical benefits to employees who already have retired and 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 for individuals whose benefits might have remained unchanged for many years.

[38] *Howe*, 896 F.2d at 1110; *see also In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 58 F.3d 896, 19 EBC 1545 (3rd Cir. 1995) ("merely because the company had never chosen to exercise its reservations of rights prior to this litigation did not 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).

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

[40] 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."

[41] *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 (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); *Amato v. Western Union Int'l Inc.*, 596 F. Supp. 963, 968, 5 EBC 2718 (S.D.N.Y. 1984), *modified by* 773 F.2d 1402 (2d Cir. 1985), *cert. dismissed*, 474 U.S. 1113 (1986).

[42] *McLeod v. Oregon Lithoprint Inc.*, 46 F. 3d 956 (9th Cir. 1995), *cert. granted, judgment vacated*, 517 U.S. 1116 (1996); *Simmons v. Southern Bell Tel. and Tel. Co.*, 940 F. 2d 614 (1991).

[43] *Berlin v. Michigan 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. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 17 EBC 1934 (3d Cir. 1994).

information to plan participants, and failure to do so could give rise to claims by a participant harmed by the miscommunications.

It did not take long for the courts to apply these principles to retiree medical cases. In *In re Unisys Corp. Retiree Medical Benefit ERISA Litigation* ,[44] the court held that retirees could assert claims for breach of ERISA fiduciary duties in response to reductions in their post-retirement medical benefits, despite an unambiguous reservation of rights clause in the governing plan documents because of the employer's repeated communication of the benefits as "lifetime":

> [t]he message that medical benefits would last for life was confirmed repeatedly and systematically throughout the [employers'] organization, by all levels of management, in writing and verbally.[45]

Indeed, the lower court had held:

> Defendant could have easily (1) put in explicit [reservation of rights clause] in each informal communication given to employees rather than only use the lifetime language; and (2) when employees made specific inquiries to benefit counselors during exit interviews and at group retirement sessions, the Company could have instructed the counselors to tell prospective retirees that although the word "lifetime" is used, the Company always reserves its right to terminate the plans. . . .[46]

The U.S. Supreme Court affirmed this approach in *Varity Corp. v. Howe*.[47] In this landmark case, 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 § 502(a)(3) of ERISA.

Shortly after the Supreme Court issued its decision, the lower courts began to find breaches of fiduciary duty by plan administrators who, without any intent to deceive, simply misstated the terms of their employee benefit plans,[48] creating a powerful weapon for retirees who sought to base their claims on communications inside and outside the scope of official plan documents.

Fiduciary Breach Claims Based on Affirmative Representations

The first post-*Varity* cases generally involved affirmative misrepresentations and held that, to prove an affirmative misrepresentation, a plaintiff must establish that: (i) the defendant acted in a fiduciary capacity, (ii) made a material misrepresentation about post-retirement medical benefits, and (iii) that the plaintiff reasonably relied on the misrepresentation to his or her detriment.[49]

Of course, the focus of these claims is the alleged misrepresentation, and many of the affirmative misrepresentation claims allege oral misrepresentations that are inconsistent with the written plan documents and disclosures. Although many courts have shown little reluctance to embrace these claims,[50] 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:

> 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.[51]

---

[44] *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 1994 WL 284079, 18 EBC 1257 (E.D. Pa. 1994), *aff'd*, 57 F.3d 1255, 19 EBC 1556 (3d Cir. 1995)("*Unisys II*").

[45] *Unisys II*, 57 F.3d 1255, 19 EBC at 1560; *accord Jones v. Am. Gen. Life & Acc. Ins. Co.*, 370 F.3d 1065, 1072-73 (11th Cir. 2004).

[46] *In re Unisys*, 1994 WL 284079, 118 EBC at 1286.

[47] *Varity Corp. v. Howe*, 516 U.S. 489, 19 EBC 2761 (1996).

[48] *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 27 EBC 1129 (2d Cir. 2001); *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90, 96, 27 EBC 1139 (2d Cir. 2001); *Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5, 21 EBC 1384 (2d Cir. 1997); *In re Unisys Corp. Retiree Med. Benefit ERISA Litig.*, 57 F.2d 1255, 19 EBC 1556 (3d Cir. 1995); *Shea v. Esenstein*, 107 F.3d 625, 20 EBC 2561 (8th Cir. 1997); *Schmidt v. Sheet Metal Workers' Nat'l Pension Fund*, 128 F.3d 541, 21 EBC 1937 (7th Cir. 1997); *Adamczyk v. Lever Bros. Co., Div. of Conopco*, 991 F. Supp. 931 (N.D. Ill. 1997); *Degnan v. Publicker Indus. Inc.*, 42 F. Supp. 2d 113, 121, 23 EBC 1245 (D. Mass. 1999) (negligence can, at least under some circumstances, rise to the level of breach of fiduciary duty under *Varity*).

[49] *See, e.g.*, *Pell v. E. I. DuPont De Nemours & Co.*, 539 F.3d 292, 300-301 (3d Cir. 2008) (examining claims that employer made material misrepresentations about amount of pension benefits); *Bouboulis v. Transp. Workers Union of Am.*, 442 F.3d 55, 66 (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 would not 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); *Daniels v. Thomas & Betts Corp.*, 263 F.3d 66, 73 (3d Cir. 2001) (examining claims that employer materially misled employee about amount of supplemental life insurance); *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); *Adams v. Freedom Forge Corp.*, 204 F.3d 475, 493, 24 EBC 1696 (3rd Cir. 2000) (examining claims that employer materially misrepresented longevity of medical benefits, allegedly inducing plaintiffs to retire); *McMunn v. Pirelli Tire, LLC*, 161 F. Supp. 2d 97, 126 (D. Conn. 2001) (same).

[50] *See* footnote 48, *supra*.

[51] *Frahm v. Equitable Life Assurance Soc'y*, 137 F.3d 955, 960 (7th Cir. 1998) ("The district court's finding that the Equitable did not set out to deceive or disadvantage plan participants therefore forecloses plaintiffs' claim under § 1104(a)(1).").

Following the rule that oral modifications of an ERISA plan are not permitted,[52] courts in the Seventh Circuit continue to reject attempts to bring claims for post-retirement medical benefits based on oral misrepresentations of benefit eligibility absent a showing of intent to deceive.[53]

Two subsidiary issues raised by the affirmative misrepresentation claims are 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 whether the plaintiff's reliance on a misrepresentation could be reasonable in light of an express reservation of rights language in the plan documents.

Fiduciary Status. The plan documents are normally the primary source for determining a person's fiduciary status but 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.' "[54] Although communicating with employees about plan benefits may be considered a fiduciary act, performing administrative acts, such as answering employees' questions, generally does not amount to the exercise of discretion that would cause a person to become a fiduciary under ERISA.[55] Thus, to determine whether an individual is acting in a fiduciary capacity when making a representation that is the subject of a claim, the court conducts a fact-specific inquiry that takes into account, among other things, the information being communicated, relevant plan documents, and the scope of any delegated responsibility to communicate with participants.[56] Where the inquiry leads to the conclusion that a misrepresentation was not made by a fiduciary, the courts have dismissed the claims.[57]

On the other hand, some courts have also 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.[58]

Detrimental Reliance. The courts have also generally held that claimants must show that they reasonably relied to their detriment on a fiduciary misrepresentation. Because reliance must be established through "individualized proof,"[59] , courts have generally declined to allow fiduciary misrepresentation claims to proceed as class actions.[60] Thus, it is unclear at this point how effective fiduciary misrepresentation claims will be as a tool for enforcing retiree rights in welfare benefits litigation which depends to a large extent on the ability to band many claims together and prove them through a few class representatives. In at least two recent cases

---

[52] *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 are not permitted); *Sandstrom v. Cultor Food Science, Inc.*, 214 F.3d 795, 797, 24 EBC 1661 (7th Cir. 2000).

[53] *E.g.*, *Powers v. Corn Prods. Int'l, Inc.*, 557 F. Supp. 2d 928, 44 EBC 2372 (N.D. Ill. 2008).

[54] *Varity Corp. v. Howe*, 516 U.S. 489, 527 (1996).

[55] *See Adams v. Brink's Co.*, 261 Fed. App'x. 583 (4th Cir. 2008), *cert. denied*, 128 S. Ct. 2936 (2008) ("The Court agrees that an employer/plan administrator does not 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 (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, does not 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* did not 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 are not 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" is not a fiduciary function if performed "within a framework of policies interpretations, rules, practices and procedures made by other persons").

[56] *Adams,* 261 Fed. App'x. 583; *In re Unisys Corp. Retiree Med. Ben. ERISA Litig.*, MDL No. 969, 2003 WL 252106, at *4 (E.D. Pa. 2003).

[57] *See Adams*, 261 Fed. App'x. 583 (statements by company employees were not made in fiduciary capacity where employees lacked discretionary authority to alter terms of plan or to determine eligibility for benefits); *Deas v. Nation Sheet Metal Workers Union Nat'l Pension Fund*, 114 F. Supp. 2d 1259, 1276 (S.D. Ala. 2000) (manager was not 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 was not acting in a fiduciary capacity because alleged misrepresentations "did not represent the sort of detailed plan information intended to help participants determine whether to remain in the plan").

[58] *Taylor v. Peoples Natural Gas Co.*, 49 F.3d 982, 989-99 (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 WL 2071876, *7-8 (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. Northeast Util.*, 315 F. Supp. 2d 212, 245 (D. Conn. 2004) (human resources staff and other officers and supervisors had apparent authority to counsel employees about retirement benefits).

[59] *In re Unisys Corp. Retiree Med. Benefit Litig.*, MDL No. 969, 2003 WL 252106 (E.D. Pa. Feb. 4, 2003).

[60] *Sprague v. General Motors Corp.*, 133 F.3d 388, 21 EBC 2267 (6th Cir. 1998); *Hudson v. Delta Air Lines Inc.*, 793 F. Supp. 366 (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 Amer. Inc.*, No. 87-488, 1988 U.S. Dist. Lexis 18421 (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 (11th Cir. 1990); *Frahm*, 137 F.3d at 957, 21 EBC 2679 (7th Cir. 1998); *In re Unisys Corp. Retiree Med. Benefits Litigation*, 2003 WL 252106 (E.D.Pa. Feb. 4, 2003); *In re Sears Retiree Group Life Ins. Litig.*, 198 F.R.D. 487 (N.D. Ill. 2000); *United Steelworkers of Am. v. Ivaco, Inc.*, 216 F.R.D. 693 (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. Central States S.E. & S.W. Am. Pension Fund*, 778 F. Supp. 989 (N.D. Ill. 1991).

retirees deemed unable to pursue class action claims chose to pursue individual claims through "mass joinder" actions by hundreds of retirees.[61] But the ultimate viability of these mass joinder actions is unclear since each retiree would 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.

Fiduciary Breach Claims Based on Omissions or Inadequate Disclosures

As noted, the early decisions that followed *Varity Corp. v. Howe* generally held that a simple failure to mention the reservation of rights clause in a retiree medical plan SPD was not sufficient to constitute a breach of fiduciary duty.[62] In the *Unisys* retiree medical litigation, however, the Third Circuit went a step further, embracing a theory of liability for breach of fiduciary duty based on "inadequate disclosure." Building on prior case law, the court held that a plaintiff could prove a breach of fiduciary duty by showing that a fiduciary failed to adequately inform the participant of important facts where the fiduciary knew or should have known that its silence would be confusing or misleading.[63] As the court explained, "the fiduciary's duty to inform 'entails not only a negative duty not to misinform, but also an affirmative duty to inform when the trustee knows that silence may be harmful.' "[64] Although the Third Circuit did not apply this "omission" standard in *Unisys II*, the court returned to the issue in *Unisys III*, holding that an employer has an obligation to disclose the existence of a reservation of rights clause to prospective retirees if the employer is on notice that the employees "could be expected to make retirement decisions based on the mistaken belief that their health benefits were guaranteed for life."[65] On the other hand, the Sixth Circuit took a dim view of the failure to inform claim in the General Motors retiree medical litigation.[66] While the Third Circuit appears to stand alone in recognizing a breach of fiduciary duty claim based on a failure to disclose a reservation of rights clause, the *Unisys* litigation highlights the diminishing importance of plan language in breach of fiduciary duty cases alleging employer misrepresentations about retiree medical coverage. Indeed, the purpose of these claims often appears to be to avoid unambiguous plan language permitting plan amendment or termination.

Remedies for Breach of Fiduciary Breach Misrepresentation Claims

Another important issue in retiree benefits fiduciary litigation is whether the courts can award monetary relief. Fiduciary misrepresentation claims are typically brought pursuant to ERISA § 502(a)(3), which limits the relief available for fiduciary misrepresentation claims to "appropriate equitable relief."[67] Several courts, including the Supreme Court, have held that "appropriate equitable relief" under ERISA § 502(a)(3) generally does not include recovery of money damages.[68] Claimants who allege fiduciary misrepresentation typically seek reinstatement of the medical coverage retirees have lost and recovery of money reflecting medical expenses that would have been paid by the plan if the coverage had not been terminated or reduced. In the continuing *Unisys* retiree medical litigation, the district court conducted a bench trial on fourteen 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 twelve of the fourteen retirees had proved their misrepresentation claims and awarded equitable relief in the form of reinstatement of the medical coverage they received before the changes.[69] 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 rein-

---

[61] Following decertification of the class in *In re Unisys Corp. Retiree Med. Benefits Litig.*, 2003 WL 252106 (E.D. Pa. 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).

[62] *See, e.g., Sprague*, 133 F.3d 388.

[63] *In re Unisys Corp. Retiree Med. Benefit Litig.*, 57 F.3d 1255, 19 EBC 1556 (3d Cir. 1995) ("*Unisys II*").

[64] *Id.* at 1264 (quoting *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1994)).

[65] *In re Unisys Corp. Retiree Med. Benefit Litig.*, 242 F.3d 497, 509 (3d Cir. 2001) ("*Unisys III*").

[66] "GM's failure, if it may properly be called such, amounted to this: the company did not tell the early retirees at every possible opportunity that which it had told them many times before--namely, that the terms of the plan were subject to change. There is, in our view, a world of difference between the employer's deliberate misleading of employees in *Varity Corp.* and GM's failure to begin every communication to plan participants with a caveat." *Sprague*, 133 F.3d at 405.

[67] 29 U.S.C. § 1132(a)(3).

[68] *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356 (2006); *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Coan v. Kaufman*, 38 EBC 1609 (2d Cir. 2006); *Crosby v. Bowater Retirement Plan for Salaried Employees of Great Northern Paper, Inc.*, 33 EBC 1769 (6th Cir. 2004); *Callery v. United States Life Insurance Co.*, 34 EBC 1001 (10th Cir. 2004).

[69] *Adair v. Unisys Corp. (In re Unisys Corp. Retiree Med. Benefits Litig.)*, MDL No. 969, 2007 WL 2071876, 41 EBC 2609, 2007 U.S. Dist. LEXIS 51906 (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) ("*Unisys I*"). Given that the alleged "breach" consisted of the misrepresentation, not the termination of the plan, it is difficult to see how reinstatement of the plan would be an appropriate remedy to redress the breach. In other words, even if no breach of fiduciary duty had occurred, plaintiffs would still not have vested benefits. *See Tardif v. General Elec. Co.*, No. 4-98-cv-1374, 2000 WL 33376644, at *9 (D. Conn. Sept. 30, 2000) (rejecting breach of fiduciary duty claim seeking reinstatement of benefits because "even in the absence of the alleged misrepresentation, [plaintiff] would not have received the benefits. Thus, the breach itself could not have cause the 'loss' of benefits.").

statement was not "appropriate equitable relief" because it simply required the payment of money damages."[70]

While it is unclear whether this decision will be widely followed (an appeal was pending before the Third Circuit as of mid-2009), it creates competing incentives for both sides in retiree medical litigation. Defendants may be encouraged to vigorously litigate these cases since, under the *Unisys* court's holding, it may be less expensive to litigate for several years than to provide coverage for hundreds or thousands of retirees, if prospective reinstatement of coverage is the only available remedy. Plaintiffs, on the other hand, will have strong incentives to seek preliminary injunctions reinstating the coverage to avoid a permanent loss of coverage during the pendency of the litigation. The courts will also have to resolve a more basic question before the viability of breach of fiduciary duty misrepresentation claims becomes clear: whether reinstatement of coverage— retroactive or otherwise— is appropriate equitable relief, i.e., puts the retirees in the position they would have been in but for the misrepresentation. If the plan is unambiguously amendable or terminable, reinstatement would seemingly not remedy the breach since, absent the misrepresentation, the plaintiff would have been in exactly the same position as a participant in a terminable plan. The *Unisys* court apparently did not consider whether reinstatement of the plan would put the plaintiffs in the position they would have been in but for the breach.

Ultimately, the determination of the scope of "appropriate equitable relief" will have a dramatic impact on fiduciary misrepresentation claims in the context of retiree benefits litigation. If the relief typically sought is found by the courts not to be "appropriate equitable relief," these claims will be discouraged. On the other hand, if "appropriate equitable relief" is deemed to include retroactive reinstatement of, and monetary reimbursement for, lost coverage from the date of its termination or modification, or even prospective reinstatement from the date of judgment, fiduciary claims may proliferate.

Indeed, if the full panoply of relief is available, this rapidly evolving claim of breach of fiduciary duty may supplant the contractual analysis painstakingly developed by the courts, because affirmative misrepresentations or inadequate disclosures will "trump" governing plan documents that unambiguously refute any claim to vested benefits. Thus, breach of fiduciary claims are rife with danger for plan administrators and rich with promise for retirees who can prove the kind of affirmative misrepresentations necessary to get the attention of a federal judge.

Practice Tip: The uncertain direction in the development of future claims for breach of fiduciary duty underscores the need to ensure that a uniform message is delivered in the governing documents and all extrinsic communications. Thus, if the employer does not intend to vest retiree benefits it should ensure that benefit summaries, brochures, letters to employees and retirees, and nondocumentary communications are consistent with an explicit reservation of rights clause in the governing plan documents.

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 have 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.[71] Thus, where an employer promises vested post-retirement medical coverage to employees in exchange for their agreement to retire early under a buyout program and the employees retire in reliance on the promise, the employer can be estopped to later deny that the post-retirement medical coverage is vested, even if the plan documents say it is not.[72] However, the presence of an unambiguous reservation of rights clause in the SPD may preclude any "reasonable" detrimental reliance on an interpretation that the SPD promised lifetime benefits.[73]

In recent years, claims for breach of fiduciary duty based on affirmative misrepresentation or affirmative disclosure have largely replaced promissory estoppel claims, although the latter still show up in the case law.[74] Although the law varies from circuit to circuit, to state a claim for promissory estoppel in the ERISA context, a

---

[70] *Adair*, 2007 U.S. Dist. LEXIS 51906, at *29-30.

[71] 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 (2d Cir. 1996).

[72] *Sprague v. General Motors Corp.*, 843 F. Supp. 266, 17 EBC 2457 (E.D. Mich. 1994); 857 F. Supp. 1182, 18 EBC 1747 (E.D. Mich. 1994).

[73] *Unisys I*, 58 F.3d at 907. *See also Alday v. Container Corp. of Am.*, 906 F.2d 660, 666 (11th Cir. 1990) (estoppel did not bar employer from modifying terms of retiree medical insurance plans despite participant's claim that employer induced him into believing that plan's terms would not change; plan unambiguously stated that employer reserved right to modify or terminate plan).

[74] The diminishing number of promissory estoppel suits may be due, in part, the Sixth Circuit's decision in *Sprague*, 133 F.3d 388, that promissory estoppel claims could not be asserted in a class action lawsuit because the plaintiffs' theories of recovery concerned many different representations made to many different people, so there was lack of commonality and typicality. *See also Jensen v. SIPCO, Inc.*, 38 F.3d 945, 18 EBC 2188 (8th Cir. 1994) (suggesting that ERISA equitable estoppel claim would not 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). However, the same rule has been applied to breach of fiduciary duty claims based on oral misrepresentations, yet those claims continue to be asserted with some frequency. *See* footnote 65, *supra*.

plaintiff generally must establish: (1) a material misrepresentation of fact; (2) reasonable and detrimental reliance on the misrepresentation, and (3) extraordinary circumstances justifying enforcement of the promise.[75] Most estoppel claims fail to clear this hurdle and are dismissed.[76]

Courts have also required that the "promise" forming the basis for a promissory estoppel claim reflect an interpretation of an ambiguous plan provision.[77] Although this requirement adds to the retirees' burden of proof, it is consistent with the contractual approach that requires a showing of ambiguity before extrinsic evidence will be considered. If the courts ultimately hold that viable remedies are available for breach of fiduciary duty misrepresentation claims, the expansion of these claims will likely render promissory estoppel claims obsolete because retirees generally bear a heavier burden in proving estoppel claims[78]

[75] *Nichols v. Alcatel USA, Inc.*, 532 F.3d 364, 44 EBC 1001 (5th Cir. 2008); *Combs v. Kentucky Wesleyan Coll.*, No. 05-139, 2008 WL 145253, 42 EBC 2322 (W.D. Ky. Jan. 11, 2008).

[76] *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, 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 WL 145253 (health plan was unambiguous and foreclosed estoppel claim).

[77] *Jones v. Am. Gen.*, 370 F.3d 1065, 32 EBC 2484 (11th Cir. 2004); *Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 33 EBC 1001 (7th Cir. 2004) (where documents are unambiguous, reliance on an oral promise is not reasonable); *Sprague*, 133 F.3d at 403 (holding that "[p]rinciples of estoppel...cannot be applied to vary the terms of unambiguous plan documents [but] can only be invoked in the context of ambiguous plan provisions"); *Fink v. Union Cent. Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996) (courts may apply the doctrine of estoppel in ERISA cases only to interpret ambiguous plan terms); *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1331 (9th Cir. 1996); 14 Fed. Appx. 210, *Band v. Paul Revere Life Ins. Co.*, 14 Fed. App'x. 210, 26 EBC 1929 (4th Cir. 2001) (holding that estoppel claim should have been rejected because informal amendments cannot alter the written terms of an established ERISA plan).

[78] A good example of this approach appears in *Unisys I*, 58 F.3d 896, 19 EBC 1545 (3d Cir. 1995). There, the court held that retirees' claims of promissory estoppel based on extrinsic plan representations were not sustainable, because the retirees' reliance on extrinsic promises of vested benefits was unreasonable in the face of clear plan language permitting termination or modification of benefits. However, the court subsequently held that the same representations were actionable on a breach of fiduciary theory. *But see Estate of Becker v. Eastman Kodak Co.*, 120 F.3d 5, 21 EBC 1384 (2d Cir. 1997) (requiring the employee to show reasonable reliance on the alleged misrepresentation). *See also Jones*, 370 F.3d 1065 (affirming dismissal of promissory estoppel claims because the plaintiffs were unable to show that the misrepresentation involved interpretation of ambiguous plan provisions, something not required for fiduciary claims); *Vallone*, 375 F.3d 623 (where documents are unambiguous, reliance on an oral promise is not reasonable); *Sprague*, 133 F.3d at 403 (holding that "[p]rinciples of estoppel...cannot be applied to vary the terms of unambiguous plan documents [but] can only be invoked in the context of ambiguous plan provisions"); *Fink*, 94 F.3d at 492 (8th Cir. 1996) (courts may apply the doctrine of estoppel in ERISA cases only to interpret ambiguous plan terms); *Pisciotta*, 91 F.3d at 1331; *Band*, 14 Fed. App'x. 210 (4th Cir. 2001) (holding that estoppel claim should have been rejected because informal amendments cannot alter the written terms of an established ERISA plan).

Claims Based on Defective Amendment Clauses

Another issue arising in the context of modification or termination of unilaterally established post-retirement medical plans relates to ERISA § 402(b)(3), which provides that "[e]very employee benefit plan shall . . . provide a procedure for amending such plan, and for identifying persons who have the authority to amend the plan. . . ." The Third Circuit held that this statutory language invalidated the following amendment clause in Curtiss-Wright Corp.'s post-retirement medical plan:[79]

> The Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan.

The court found that the amendment clause, as well as a plan amendment terminating postretirement medical coverage for retirees, was invalid under ERISA § 402(b)(3) because the clause did not adequately specify a "procedure" for plan amendment or identify "the persons" who have the authority to amend the plan.[80]

The U.S. Supreme Court reversed the Third Circuit's decision, holding that the language of the amendment clause itself did not violate ERISA § 402(b)(3). However, the Supreme Court left open the possibility that the lower court still could nullify Curtiss-Wright's amendment if it determined that the amendment had been executed by persons who were not expressly or impliedly authorized to amend the plan:

> The answer will depend on a fact-intensive inquiry, under applicable corporate law principles, into what persons or committees within Curtiss-Wright possessed plan amendment authority, either by express delegation or impliedly, and whether those persons or committees actually approved the new plan provision contained in the revised SPD. . . If the new plan provision is found not to have been properly authorized when issued, the question would then arise whether any subsequent actions, such as the executive vice president's letters informing respondents of the termination, served to ratify the provision [after the fact].[81]

A subsequent appellate court decision applied this logic to find that a company had amended its retiree medical plan by including language in a merger agreement that provided for continuation of a certain level of retiree medical benefits. In *Haliburton v. Graves*[82], a merger agreement between Halliburton and Dresser Industries provided that Haliburton would maintain the retiree medical benefits provided to Dresser retirees and would modify the benefits only in a manner consis-

[79] *Schoonejongen v. Curtiss-Wright Corp.*, 18 F.3d 1034, 18 EBC 1225 (3d Cir. 1994), *rev'd on other grounds,* 514 U.S. 73, 18 EBC 2841(1995).

[80] *Id.*

[81] *Curtiss-Wright Corp.*, 514 U.S. at 84, 18 EBC at 2847.

[82] 463 F.3d 360 (5th Cir. 2006).

tent with changes made to the medical plans that covered Haliburton active employees. The merger agreement was enforceable only for a period of three years. Five years after the merger agreement became effective, Haliburton amended the Dresser retirees' benefits, reducing them to a level below the benefits provided to Haliburton's active employees. The retirees sued, and on appeal the court held that the merger agreement had amended the governing plan, despite the fact that the plan's amendment and termination clause required that any amendment be signed by the vice president of human resources. Relying on *Curtiss-Wright*, the appeals court found that Haliburton's board of directors and shareholders had amended the plan by approving the merger agreement and had authority under the plan to do so because any authority held by the vice president of human resources ultimately derived from the board and the shareholders. The court went onto find that, under corporate law, even if the amendment was defective for lack of approval by the vice president of human resources, the "amendment" had been ratified by Haliburton's compliance with the requirement that the retiree medical benefits be maintained.

This is a sobering decision for practitioners in the area of mergers and acquisitions law, who often draft similar provisions into merger and acquisition agreements.

Practice Tip: Future retiree medical litigation may focus on whether the procedure used to amend retiree medical plans conforms to the requirements of the plans themselves or applicable corporate law, and whether the amendments were executed by authorized parties. If the answer to either of these questions is no, the courts might find the plan amendments unenforceable and retroactively restore any reduced or terminated benefits. Take special care in drafting benefits provisions of merger and acquisition agreements. It is typical to provide in these agreements that benefits will be continued for employees and retirees of the acquired company at levels comparable to the benefits provided to employees and retirees of the acquiring company. Unless specific sunset provisions and specific disclaimers of any intent to amend employee benefit plans are included, these provisions could, under certain circumstances, be deemed to have amended governing plan documents.[83]

Collectively Bargained Post-retirement Medical Benefits

Although changes and terminations of unilaterally established postretirement medical plans have occupied much of the attention of employee benefits professionals in recent years, collectively bargained benefits have been the subject of litigation since the 1960s.[84]

The basic framework for the contractual analysis applied in unilateral and collectively bargained benefits is the same. However, there are three subtle yet important differences between these types of cases that have contributed to a higher success rate for retirees in the collective bargaining cases.

First, under applicable labor law retirees are neither members of the bargaining unit (union) nor covered by labor laws requiring good-faith bargaining.[85] Therefore, unions have no obligation to represent retirees or negotiate on their behalf.[86] This presents the possibility that unions will bargain retiree benefits away 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.[87] 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 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 for a specified number of years, after which the agreements expire. Thus, the issue in these cases usually is 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 intent of the parties and takes into account the policies behind the labor laws, even when the contractual language at issue is unambiguous. These factors have led the courts to adopt different approaches to the determination of whether collectively bargained post-retirement medical benefits are vested. The first approach requires application of a vesting inference in the interpretation of the

---

[83] *See Franklin v. First Union*, 84 F. Supp. 2d 720, 23 EBC 2817 (E.D. Va. 2000); *Fram v. Equitable Assur. Soc.*, No. 93-0081, 1995 WL 579282 (N.D. Ill. 1995). *Compare Hutchins v. Champion Int'l Corp.*, 110 F.3d 1341 (8th Cir. 1997) (amendment denying disability benefits to incarcerated participants was validly adopted and thus enforceable)*with Smith v. National Credit Union Admin. Bd.*, 36 F.3d 1077, 18 EBC 2323 (11th Cir. 1994) (oral amendment and its subsequent formalization were invalid because the amendment had not been adopted properly according to plan requirements).

[84] *See Upholsterers' Int'l Union of N. Am. v. American Pad & Textile Co.*, 372 F.2d 427 (6th Cir. 1967).

[85] *Allied Chem. & Alkali Workers of Am. Local Union No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 1 EBC 1019 (1971).

[86] 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 did not represent the retirees unless each retiree separately consented to representation. Distinguishing *Rossetto*, the Seventh Circuit recently ordered an employer to arbitrate a grievance over unilateral changes to retiree benefits because, unlike in *Rossetto*, the arbitration clause was not 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, 44 EBC 2316 (7th Cir. 2008).

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

contract. The second approach applies normal principles of contract construction and is similar to the approach applied in cases involving unilaterally established plans. The third approach requires application of a no-vesting inference in the interpretation of a contract that is silent on the issue of vesting.

Third, many courts have held that LMRA § 301 provides for jury trials, which are not generally available under ERISA.[88] This is an important difference, since juries generally will be more sympathetic to the claims of retirees and more easily influenced by extrinsic evidence.

The "Status" Vesting Inference

In *UAW v. Yard-Man Inc.*,[89] the Sixth Circuit addressed what was, by then, a typical dispute over an employer's termination of post-retirement medical benefits following expiration of a collective bargaining agreement. After reviewing the relevant clauses of the collective bargaining agreement, the court held:[90]

> [W]hen the parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree. . . . Standing alone, this factor would be insufficient to find an intent to create interminable benefits. In the present case, however, this contextual factor buttresses the already sufficient evidence of such intent in the language of this agreement.

This crucial passage quickly became the basis for the "status" vesting inference applied by courts in the Sixth Circuit and, perhaps less forcefully, in a few other jurisdictions.[91] The effect of this inference has been to cause the courts to skew their interpretation of collective bargaining agreement expiration clauses in favor of vesting post-retirement medical benefits. Thus, in *Weimer v. Kurz-Kasch Inc.*[92] and *Policy v. Powell Pressed Steel Co.*,[93] the Sixth Circuit applied the vesting inference to reverse two lower court decisions that found that the collective bargaining agreements did not require continuation of post-retirement medical benefits after expiration. Instead of literally construing the terms of the collective bargaining agreements, the Sixth Circuit used the vesting inference to support a rather strained interpretation of the agreements, and found that the post-retirement medical coverage had vested under the contract.

Although the Sixth Circuit has subsequently denied that *Yard-Man* created a "presumption" that retiree medical benefits are vested,[94] employers who are sued over collectively bargained retiree medical obligations in the Sixth Circuit can expect to have the language of their collective bargaining agreements construed with an eye toward finding vested retiree benefits.

The Contract Construction Approach

A second approach to collectively bargained retiree medical benefits rejects the notion of a vesting inference and applies a straight contract analysis. A majority of circuits follow this approach, with some going a step further by requiring a "clear and express" statement providing vested retiree medical benefits.[95] For example, in *Anderson v. Alpha Portland Industries Inc.*,[96] the Eighth Circuit explicitly rejected the notion of a vesting inference for post-retirement medical benefits, stating, "[i]t is not at all inconsistent with labor policy to require plaintiffs to prove their case without the aid of gratuitous inferences."[97]

---

[88] *Stewart v. KHD Deutz of America Corp.*, 75 F.3d 1522, 1527 (11th Cir. 1996); *Senn v. United Dominion Indus.*, 951 F.2d 806, 813-14 (7th Cir. 1992); *Leannah v. Alliant Energy Corp.*, No. 07-169, 2008 WL 4830140, 45 EBC 2695 (E.D. Wis. Oct. 28, 2008); *Stamps v. Michigan 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 (6th Cir. 1996) (suit under LMRA § 301 alleging employer breached collective bargaining agreement when 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).

[89] 716 F.2d 1476, 4 EBC 2108 (6th Cir. 1983).

[90] *Id.* at 1482. *See also UAW v. BVR Liquidating Inc.*, 190 F.3d 768, 23 EBC 2152 (6th Cir. 1999); *Maurer v. Joy Techs. Inc.*, 212 F.3d 907, 24 EBC 1554 (6th Cir. 2000).

[91] *Noe v. PolyOne Corp.*, 520 F.3d 548, 43 EBC 1545 (6th Cir. 2008); *Keffer v. H.K. Porter Co.*, 872 F.2d 60, 10 EBC 2412 (4th Cir. 1989) (citing *Yard-Man* favorably but looking at language of agreement and past practice); *Steelworkers v. Connors Steel Co.*, 855 F.2d 1499, 10 EBC 1265 (11th Cir. 1988) (citing *Yard-Man* with approval). The U.S. Courts of Appeals for the First, Third, Fifth, and Eighth Circuits have explicitly rejected the *Yard-Man* inference. *See, e.g.*, *Senior v. NSTAR Elec. & Gas Corp.*, 499 F.3d 206, 216-17 (1st Cir. 2006); *UAW v. Skinner Engine Co.*, 188 F.3d 130, 140, 23 EBC 2022 (3d Cir. 1999) (collecting cases).

[92] 773 F.2d 669, 6 EBC 2258 (6th Cir. 1985).

[93] 770 F.2d 609, 6 EBC 2249 (6th Cir. 1985).

[94] *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571, 579-80 (6th Cir. 2006)) ("under *Yard-Man*, 'there is no legal presumption that benefits vest and the burden of proof rests on plaintiffs.' ") (internal citations omitted); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 19 EBC 2457 (6th Cir. 1996) ("[The vesting inference] does not shift the burden of proof to the employer, nor does it require specific anti-vesting language before a court can find that the parties did not intend benefits to vest. . . Rather, [the inference]. . . simply guides courts faced with the task of discerning the intent of the parties from vague or ambiguous [collective bargaining agreements].").

[95] Courts adopting the contract construction approach include the First, Second, Eighth, Ninth, and Eleventh Circuits. *See Senior v. NSTAR Elec. & Gas Corp.*, 499 F.3d 206 (1st Cir. 2006); *Am. Fed'n of Grain Millers v. Int'l Multifoods Corp.*, 116 F.3d 976 (2d Cir. 1997); *Anderson v. Alpha Portland Indus. Inc.*, 836 F.2d 1512, 9 EBC 1569 (8th Cir. 1988); *Bower v. Bunker Hill Co.*, 725 F.2d 1221, 5 EBC (9th Cir. 1984); *Stewart v. KHD Deutz of Am.*, 980 F.2d 698 (11th Cir. 1993). Circuits requiring "clear and express" vesting language are the Third, Fourth, and Fifth. *See UAW v. Skinner Eng. Co.*, 188 F.3d 130, 139 (3d Cir. 1999); *Gable v. Sweetheart Cup Co.*, 35 F.3d 851, 855 (4th Cir. 1994); *Wise v. El Paso Natural Gas Co.*, 986 F.2d 929, 937-38 (5th Cir. 1993).

[96] 836 F.2d 1512, 9 EBC 1569 (8th Cir. 1988).

[97] *See also Paperworkers Int'l Union v. Jefferson Smurfit Corp.*, 961 F.2d 1384, 15 EBC 1357 (8th Cir. 1992); *Paperworkers Int'l v. Champion Int'l Corp.*, 908 F.2d 1252, 12 EBC 2097 (5th Cir. 1990); *Turner v. Teamsters Local 302*, 604 F.2d 1219 (9th Cir. 1979); *Joyce v. Curtiss-Wright Corp.*, 171 F.3d 130, 22 EBC 2755 (2d Cir. 1999); *American Fed. Grain Millers v. Int'l Multifoods Corp.*, 116 F.3d 976 (2d Cir. 1997) (stating that a commitment to vest is not to be inferred lightly and that it must be found in the

Like the approach applied to unilaterally established plans, this approach seeks to determine whether the terms of the governing collective bargaining agreement address vesting, and whether the agreement's expiration clause is broad enough to cover post-retirement medical benefits. However, as noted by one court, the initial inquiry is not confined to the language of the agreement: "[I]n order to interpret such an agreement it is necessary to consider the scope of other related collective bargaining agreements, as well as practice, usage and custom pertaining to all such agreements."[98] For example, where an employer has continued coverage for retirees beyond the expiration of the collective bargaining agreement, this fact has been viewed as evidence of an intent to provide vested benefits.[99] Similarly, statements made by the parties during collective bargaining negotiations also have been cited as evidence of intent to vest post-retirement medical benefits.[100] Of course, employer-drafted summary plan descriptions and plan documents, usually not a part of the collective bargaining agreement itself, also can be considered evidence of an employer's intent to vest.[101] This contrasts with the interpretation of unilaterally established plans, where extrinsic evidence is considered only after an ambiguity is found in the governing language.

Alexander v. Primerica Holdings, Inc.[102] is a good example of a court drawing on extrinsic evidence to ascertain the parties' intent despite arguably unambiguous language. The district court found the contract language unambiguously repudiated the retirees' vesting claim but on appeal the Third Circuit, obviously influenced by the extrinsic evidence, reversed and instructed the lower court on remand to consider extrinsic affidavits and documents submitted by retirees, including an affidavit by the former chairman of the board that the company intended to promise lifetime benefits and did so to recruit and retain employees and to induce early retirement. The appellate court instructed the district court to review this evidence "in light of the duty of clarity that ERISA puts on a plan sponsor."[103]

The "No Vesting" Inference

The rule of contract construction adopted by the U. S. Court of Appeals for the Seventh Circuit counters the Sixth Circuit's "vesting inference" with a "no vesting" inference when the collective bargaining agreement is silent on the question of vesting.[104] In such cases, the rule requires the court to infer that the parties intended all benefits to expire upon expiration of the collective bargaining agreement if the agreement is silent on the duration of retiree medical benefits.[105] If the agreement is not silent but is ambiguous, extrinsic evidence is allowed to determine whether the employer intended to vest the benefits.[106]

In *Bidlack v. Wheelabrator Corp.*,[107] retirees claimed that Wheelabrator could not discontinue retiree medical benefits because the collective bargaining agreement conferred lifetime rights to the benefits, which therefore survived the CBA. Rejecting *Yard-Man*, the court held that employee expectations of continued benefits do not justify a presumption or inference that the benefits were vested; instead, courts should protect the "limitation of liabilities that is implicit in the negotiation of a written contract having a definite expiration date."[108] Inferences based on factors outside of the CBA, the court reasoned, would "deprive the parties of the protection of a written document."[109] The court therefore adopted a presumption that retiree medical benefits do not vest under collective bargaining agreements that are in effect for a specified term; and retirees can rebut this presumption only by pointing to language unambiguously vesting benefits, or by demonstrating that the contract is ambiguous—that is, that a "yawning void" exists in the contract which must be filled through extrinsic evidence.[110] Thus, in the Seventh Circuit the fact that a collective bargaining agreement is in effect for a specified term gives rise to a presumption that benefits provided under the agreement expire at the end of the term.

Predictably, differing approaches to collectively bargained retiree benefits have spawned forum-shopping by both retirees and employers, which is facilitated by ERISA's liberal jurisdiction and venue provisions.[111]

---

express language of plan documents).

[98] *Trull v. Dayco Products, LLC*, 178 Fed.Appx. 247, 250 (4th Cir. 2006).

[99] *United Paperworkers v. Champion Int'l*, 908 F.2d 1252, 12 EBC 2097 (5th Cir. 1990); *Schalk v. Teledyne Inc.*, 751 F. Supp. 1261, 13 EBC 1167 (W.D. Mich. 1990), *aff'd*, 848 F.2d 1290 (6th Cir. 1991).

[100] *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 14 EBC 1632 (6th Cir. 1991).

[101] *Bower v. Bunker Hill Co.*, 725 F.2d 1221, 5 EBC 1180 (9th Cir. 1984); *see also Stewart v. K H D Deutz of Am. Corp.*, 980 F.2d 698, 16 EBC 1452 (11th Cir. 1993).

[102] 967 F.2d 90, 15 EBC 1881 (3d Cir. 1992).

[103] *Id.* at 96.

[104] *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 16 EBC 2217 (7th Cir.), *cert. denied*, 510 U.S. 909 (1993).

[105] *Id.* at 608.

[106] *Id.*; *Murphy v. Keystone Steel & Wire Co.*, 61 F.3d 560 (7th Cir. 1995); *Rosetto v. Pabst Brewing Co.*, 217 F.3d 539, 543, 24 EBC 2089 (7th Cir. 2000).

[107] 993 F.2d 603, 16 EBC 2217 (7th Cir. 1993).

[108] *Id.* at 608.

[109] *Id.* at 607.

[110] *Id.* at 608.

[111] *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 U.S. Dist. LEXIS 12869 (S.D. Iowa Feb. 11, 2009); *Newell Operating Co., Inc. v. UAW*, No. 06-cv-50010 (N.D. Ill. 2007); *In Re John Amendt*, No. 05-2458, 2006 U.S. App. LEXIS 3944 (3d Cir. Jan. 18, 2006); *ACF Indus. LLC v. Chapman*, No. 4:03-CV-1765, 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.

Venue transfer motions regularly follow and the outcome of these motions is often dispositive of the merits if the case lands in either the Sixth or Seventh Circuits.[112]

Standing of Unions to Represent Retirees in LMRA Actions

The Seventh Circuit has also limited the ability of unions to challenge modification of retiree welfare benefits. In *Rossetto v. Pabst Brewing Co.*,[113] the court held that the union lacked standing to represent retirees in a challenge to the termination of their retiree medical benefits because there was no consent by the retirees or the employer to the union's representation of the retirees. The Seventh Circuit subsequently explained that the consent requirement allowed a union to represent any consenting retirees was sufficiently broad to cover a dispute over retiree benefits.[114] The Sixth Circuit, joined by the Ninth, again disagrees with its neighbor, holding that "where a union and company bargain over retiree benefits and include the benefits in a contract, the union has standing to represent the retirees in any dispute concerning those benefits."[115]

In summary, the cases involving collectively bargained post-retirement medical benefits reflect additional complexities in the basic contractual analysis, first in the form of differing rules of contract construction applied in different circuits, and second in the additional factual considerations associated with interpreting a bilaterally bargained contractual agreement. These complexities can combine to create different outcomes in different jurisdictions on substantially identical facts. It also should be noted that claims of promissory estoppel and breach of ERISA fiduciary duty similar to those outlined in the discussion of claims involving unilaterally established plans can be asserted in the context of collectively bargained plans.[116]

Future Retirees and the National Labor Relations Board

Under the NLRA, retirees are generally not considered members of the bargaining unit and their benefits cannot be bargained away by unions seeking greater remuneration for their constituencies (*i.e.*, active employees). Thus, their retiree medical benefits usually depend (as discussed above) on the language of the collective bargaining agreement as interpreted by the courts. On the other hand, the NLRB has held that an employer is not free to unilaterally modify future benefits for active employees, even where the plan contains a reservation of rights clause, unless the union has bargained over the reservation clause.[117]

In *Mississippi Power Co. v. NLRB*,[118] the employer unilaterally adopted a medical insurance plan that contained clear reservation of rights language. The employer subsequently announced changes to the terms of the medical coverage that would affect current employees who retired in the future and the employees filed an unfair labor practice, contending that the employer's unilateral action violated the NLRA because the employer had failed to bargain to impasse over the changes. Citing Supreme Court precedent, the Eleventh Circuit reaffirmed the principle that "the retirement benefits of a company's current retirees are not mandatory bargaining subjects but that future retirement benefits of active workers are . . . a well-established statutory subject of bargaining."[119] However, the court went on to hold that the union had waived its right to bargain over changes to the medical plan and upheld the company's unilateral modification of the future retirees' medical benefits.

This rule has the odd effect of elevating the rights of active employees to future post-retirement medical benefits above the rights of current retirees to the continuation of benefits they already have become entitled to receive.

Practice Tip: An employer that wants to exercise a reservation of rights clause to terminate coverage for active employees should make a record of negotiations over language in the collective bargaining agreement that acknowledges the employer's right to unilaterally change the benefits and incorporates any plan documents containing the reservation of rights clause.

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

[112] An example of "dueling" venue motions is *Newell Operating Co., Inc. v. UAW*, where 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. 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. *Newell Operating Co., Inc. v. UAW*, No. 06-cv-50010 (N.D. Ill. Mar. 27, 2007), *aff'd* 532 F.3d 583, 44 EBC 1307 (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, 207 WL 2025780 (W.D. Mich. July 9, 2007).

[113] 128 F.3d 538, 21 EBC 2053 (7th Cir. 1997),.

[114] *Exelon Generation Co. v. Elec. Workers IBEW Local 15*, 540 F.3d 640, 647, 44 EBC 2316 (7th Cir. 2008).

[115] *United Steel Workers of America v. Cooper Tire & Rubber Co.*, 474 F.3d 271, 282 (6th Cir. 2007) (internal citations omitted).

[116] *See, e.g., Armistead v. Vernitron Corp.*, 944 F.2d 1287, 14 EBC 1632 (6th Cir. 1991).

[117] *See Midwest Power Sys.*, 323 NLRB 404 (1997); *Georgia Power Co. and Int'l Bhd. of Elec. Workers, Local 84, AFL-CIO*, 325 NLRB 420 (1998), *aff'd*, *Georgia Power Co. v. NLRB*, 176 F.3d 494 (11th Cir. 1999) (table).

[118] 284 F.3d 605, 26 EBC 1498 (5th Cir. 2002).

[119] *Id.* at 614 (emphasis in original) (citing *Allied Chem. & Alkali Workers of Am. v. Pittsburgh Plate Glass*, 404 U.S. 157, 180 (1971)).

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 do not 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.