

## **NO GOOD DEED GOES UNPUNISHED**

### **EMPLOYERS' ATTEMPTS TO MODIFY RETIREE HEALTH PLANS**

"But you promised!" is a refrain heard by parents of toddlers and teenagers. Like these parents, employers too are often puzzled as to when, how, and the extent to which they have made certain promises to employees. These implied promises can be expensive and disruptive when they involve employee benefits, particularly retiree medical benefits allegedly promised on a "permanent" basis to former employees and retirees. This article reviews recent cases discussing such implied promises and suggests ways employers can limit their scope.

#### Background

Employers first began to explore possibilities for altering retiree benefits in the 1980s, when a combination of factors converged to focus attention on the issue. First, the Financial Accounting Standards Board (FASB) issued Financial Accounting Statement 106 (FAS 106), which required corporations to reflect the value of future retiree medical liabilities on their financial statements. This in turn caused employers to evaluate seriously the scope and extent of their retiree health programs, and whether such programs could be sustained in the future. As health care costs rose dramatically, and employers

began to examine the demographics of their workforce, many recognized that if left unchecked, retiree medical obligations could soon surpass benefit program costs for active employees.

Many employers addressed rising health care costs by restricting or eliminating retiree medical benefits for future retirees. However, as retiree costs continued to grow, and as retirees began to constitute a larger and more expensive portion of total healthcare costs of all active and retired employees, employers have also attempted to manage health care costs of current retirees. This was particularly the case as employers began to introduce managed care programs for active employees.

#### Vesting Concepts

In sharp contrast to the laws governing qualified pension plans, there are generally no statutory rules requiring that participants in health plans have vested or nonforfeitable rights, although "qualification" requirements applicable to funding vehicles such as voluntary employees' beneficiary associations (VEBAs), Section 420 pension accounts, and cafeteria plans impose some limitations in that regard.

Moreover, with the exception of limited rules governing insured plans and certain aspects of multiple employer welfare arrangements (MEWAs), the Employee Retirement Income Security Act (ERISA) preempts any state law regulation of these benefits.

Initially, some courts attempted to advance a theory that retiree medical benefits vest as a common law right upon retirement, but this principle has generally not been adopted unless other significant factors are present. In Hansen v. White Farm Equip. Co., 5 Employee Benefits Cas.(BNA) ¶ 2130 (N.D. Ohio 1984), rev'd, 788 F.2d 1186 (6th Cir. 1986), the District Court held that "the modern view" was that an employer may not terminate the benefits of a retired employee as a matter of federal common law. This decision was reversed, but the Sixth Circuit was careful to preserve its view that although retiree status itself does not create full vesting, a presumption in favor of benefit continuation as long as the affected individual is a retiree should be inferred in an analysis of these issues. In part, these cases emphasized the relative economic powerlessness of retirees once they retired. Courts that adopt this approach often color their interpretation

of the facts of the case with the weight of this inference.

Other cases have continued to recognize that ERISA does not require automatic vesting of health and welfare plans, and seek more concrete proof of a promise to vest benefits. For example, in Sprague v. General Motors Corp., 133 F.3d 388, 400 (6<sup>th</sup> Cir. 1998), the Sixth Circuit, after observing that ERISA does not require vesting of welfare plans, stated that "an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest must be found in plan documents and must be stated in clear and express language."

Although ERISA does not require vesting of welfare benefits, it does require that employers state with some precision in their plan documents the scope of benefits to be provided under the plan. Every ERISA plan must specify a funding mechanism, allocate operational and administrative responsibilities, and state how payments are to be made to and from the plan. Courts and plaintiffs have emphasized these requirements and argued that where the plan documents are ambiguous, promises of lifetime benefits to retirees can be inferred. These "lifetime promises", particularly if written

but even if oral, can only be contradicted or amended if the plan document is properly drafted. As discussed below, courts continue to struggle with the issues of the scope of plan documents and whether the language contained in such documents is in fact ambiguous.

#### Reservation of Rights Clauses

Plan sponsors stand a better chance of being able to amend or modify their retiree medical benefits if the official plan documents and any supporting statements contain a clear "reservation of rights" clause that gives the sponsor the right, among others, to amend the plan. For example, courts have held that the express reservation of a health plan sponsor's right to amend or terminate the plan overrode certain ambiguous oral statements about the plan's permanence. In Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988), and Musto v. American Gen. Corp., 861 F.2d 897 (6th Cir. 1988), cert. denied, 490 U.S. 1020 (1989), the retirees challenged attempts to impose employee premium contributions, increases in deductibles, and certain changes in how the plan was coordinated with Medicare, maintaining that they were promised lifetime

benefits at no cost. The courts refused to allow oral promises to override the express reservation of rights language of the plan documents, absent a showing "tantamount to proof of fraud." See Moore, 856 F.2d at 492.

In Sprague v. General Motors Corp., 92 F.3d 1425 (6<sup>th</sup> Cir. 1996), reversed en banc, 133 F.3d 388 (1998), the District Court upheld a class of early retirees' challenge to a reduction in their benefits on the theory that GM's early retirement agreements promised to provide a certain level of coverage to employees who elected early retirement. These agreements were considered to be either separate plans or modifications to the existing plan that subsumed any reservation of rights clause in the original plan document. This decision, which was rendered after a trial on the facts, was initially affirmed by the Sixth Circuit, but later reversed en banc because "[n]one of GM's representations [to the early retirees] suggested that the plan was being modified...Far from modifying the terms of the welfare plan, it seems to us that this language [a reference to benefits applicable to early retirees] incorporated the plan's terms." *Id.* at 403. Thus, the documents' promises that benefits are

"lifetime benefits" did not contradict or make ambiguous the employer's clearly reserved right to amend or terminate the plan and to eliminate lifetime benefits. Rather, the employer's promise of lifetime benefits was a qualified promise "provided that the company chose not to terminate the plans...."

Although the principles of Sprague are often applied, a reservation of rights clause may not automatically trump a promise of lifetime benefits. In In re Unisys Corp. Retiree Med. Benefits "ERISA" Litig., 58 F.3d 896, 901 n.11 (3d Cir. 1995), the Third Circuit made it clear that each case must be considered fact-specific and the result would depend on the language the court was called upon to review. Moreover, if the reservation of rights clause has any hint of ambiguity, the courts may not automatically allow it to be applied. For example, in Alexander v. Primerica Holdings, 967 F.2d 90 (3d Cir. 1992), the communications to participants stated that the "employer necessarily reserves the right to amend [the plans]... in conformity with applicable legislation." The court found that the "in conformity" language thus limited the ability of the employer to make changes to the plan.

When retiree medical benefits are collectively bargained, the analysis is similar but not identical, with a focus on the collective bargaining agreement language and whether benefits were meant to survive the expiration or alteration of such agreements. In UAW v. Yard-Man, Inc., 716 F.2d 1476 (6th Cir. 1983), cert. denied, 465 U.S. 1007 (1984), the Sixth Circuit held that absent evidence to the contrary, it is assumed that retiree health benefits continue for the retiree's life. But not all courts have taken such a position. For example, in Turner v. Local Union No. 302, International Bhd. Teamsters, Chauffeurs, Warehousemen & Helpers of America, 604 F.2d 1219 (9th Cir. 1979), the court held that the employer could reduce health benefits after a review of the applicable collective bargaining agreement.

In many cases, the right to amend the plan is not as unambiguous as an employer might like, because it has only been recently that statements of risks and obligations contained in medical plan documents have been carefully scrutinized. Many were written by insurance companies and focus on the actual benefits offered with ERISA rights statements added as an

afterthought. When older documents do not contain an express reservation of rights clause, the issue has been whether an employer can use its power to amend the plan to add one before changing coverage. Such an addition was permitted in Pierce v. Security Trust Life Ins. Co., 979 F.2d 23 (4th Cir. 1992). But other courts have not been so lenient. See, e.g., Helwig v. Kelsey-Hayes Co., 93 F.3d 243 (6th Cir. 1996), cert. denied, 510 U.S. 1059 (1997), which held that a later SPD which included a reservation of rights clause could not be effective where the prior SPD stated that medical benefits “[would] be continued for the rest of your life without cost to you.” Id. at 248 (citation omitted). The court held even though the master plan document, which was an insurance policy, did in fact state that it could be terminated at any time by the employer or the insurer, the right to terminate referred to the contractual arrangement between the employer and the insurer, and did not affect plan participant rights.

Finally, even where reservation of rights clauses are contained in the documents, it is important that the employer have properly adopted the amendments. In Schoonejongen v.

Curtiss-Wright Corp., 143 F.3d 120 (3d Cir. 1998), the Third Circuit had to determine whether the employer exercised the proper corporate authority to adopt an amendment to its plan. After extensive review of state law and corporate bylaws, it was determined that the amendment procedure was proper, but the court noted in passing that the parties were in their fourteenth year of litigation over the terms of the medical program and the employer's authority to change those terms.

#### Promissory Estoppel and Fiduciary Claims

Even if the plan documents and SPDs contain a reservation of rights clause, retirees employ other theories to maintain that their benefits cannot be changed. Retirees have used the promissory estoppel theory to argue that despite language in plan documents, if an employer promises post-retirement medical benefits in exchange for other consideration (e.g., early retirement, or voluntary termination), such benefits cannot be changed even if amendment is permitted under the plan documents. This theory may be useful to individuals, but at present the courts have been reluctant to permit its use in class actions, maintaining that the questions of reliance are

personal to individuals.<sup>1</sup>

Another theory that has enjoyed some success among plaintiffs, at least in egregious cases, is an argument that sponsors that modified their post-retirement medical plans breached their fiduciary duties in so doing. Varsity Corp. v. Howe, 516 U.S. 489 (1996), was the prime example of such a case. Here, the employer established a corporate subsidiary to which benefit liabilities were transferred. The court held that the employer induced older employees to transfer to the subsidiary by telling them that their employee benefits would remain unchanged, and that such an action was a fiduciary breach when the benefits in fact were to change.

In In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig., 242 F.3d 497 (3d Cir. 2001), the court reviewed a variety of claims made by retirees participating in a health plan. It agreed with the holdings of the district court that the retirees did not have a claim of breach of contract based on any "lifetime" language in the plan documents. The unambiguous reservation of rights clause also caused the court to dismiss the estoppel claim. However, the retirees also made a breach of

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fiduciary duty claim and demonstrated that in some cases company representatives may have counseled them that they had lifetime medical benefits without regard to the reservation of rights clause, so the Third Circuit remanded that issue for trial, noting that this allegation may have to be reviewed on an individual basis.

#### Illustration of These Principles

The recent case of Deboard v. Sunshine Mining & Refining Co., 208 F.3d 1228 (10<sup>th</sup> Cir. 2000) illustrates many of these concepts. The plaintiffs in that case were former employees of Woods Petroleum Corporation, which was merged into and became a subsidiary of Sunshine Mining in July of 1985. As part of the merger agreement, Sunshine agreed not to terminate Woods' employee welfare benefit plans for a period of ten years. In August of 1985, due to a downturn in the oil and gas industry, Sunshine's subsidiaries, including Woods, initiated a voluntary early retirement subsidy or "buyout program," that provided enhanced pension benefits for employees of a certain age and service level who opted to retire ("Rule of 70 retirees"). In response to questions from employees as to how

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their post-retirement health benefits would be handled under the buyout program, Woods issued a letter explaining the program. The letter, which began with "[f]or informational purposes only," advised employees of their "insurance entitlement" for which they would be eligible if they elected to retire under the Rule of 70. The letter stated that former employees and dependents would be eligible "to receive healthcare under our current group hospitalization plan. . .fully paid for by Woods Petroleum Corporation's expenses. . .until the time of your death." The letter went on to explain that during the retiree's life, he would submit claims to Woods' Personnel Department. Coverage for the retiree's spouse would continue for one year after the retiree's death, and at that point the spouse could convert to private coverage, 100% paid by the spouse, who would submit claims to the insurer, Mass Mutual. The letter further explained that once the retiree reached age 65, Medicare would provide primary coverage and the Woods program would be secondary.

In 1986, Woods circulated another memo outlining modifications to the health plan, including a requirement that

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all employees contribute \$20 a month if they selected family coverage. The requirement did not apply to current retirees, but the memo made it clear that it could apply to future retirees. A second early retirement buyout was offered in the fall of 1986; this one required the participants in that buyout to pay the \$20 per month family coverage, but they were told that the terms and conditions of the buyout were otherwise identical to the October 1985 buyout.

The plaintiffs in the case participated in either the 1985 or 1986 buyout. In 1995, ten years after the merger with Sunshine, Woods sent a letter to all participants in the retiree health program, indicating the it had maintained the program for the promised ten post-merger years, and would continue to provide for retiree coverage but at the retiree's expense.

Certain of the retirees protested the decision, arguing that they agreed to the early retirement program only because of the promise of lifetime coverage, and that the letter describing such coverage in 1985 constituted a new plan. The district court granted summary judgment to the retirees on the question of whether a separate "Rule of 70 Plan" existed, and

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after a trial on the facts, found that a fiduciary breach had occurred when the employer amended the plan. The court rejected similar claims for dental and life insurance coverage, maintaining that the 1985 correspondence was not explicit enough in that regard to create a plan.

The circuit court agreed that a separate plan had been created, noting that employers can create more than one plan. The court said that this separate "Rule of 70" plan met the ERISA requirements for a plan - it had a written document (the letter) which identified the eligible participants and benefits, as well as setting forth the administrative structure and explaining who would process claims.

The court ignored the reservation of rights clause in the current medical plan, as well as the employer's argument that the reservation of rights clause was incorporated into the new plan in the same manner that medical benefits were incorporated. The court believed that the reservation of rights clause was not incorporated into the new plan because the old plan's SPD mentioned the right to terminate under the heading "The Insurer". Since the right to terminate was focused on the

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insurer, the court said, it could be read as dealing only with the right to terminate or change the insurer, not the plan itself.

The court also found that the parties' conduct - the fact that in 1986 the employer did not impose the new \$20 family coverage charge on current retirees -- indicated an intent to create vested insurance benefits. This differed from other cases in which courts had ruled that an employer's failure to exercise amendment rights does not waive those rights.

Finally, having lost the ability to charge for retiree benefits, the employer maintained that it had never promised a specific type or level of benefits. The court agreed that the more difficult issue was the type and level of health insurance contemplated by the new plan. The district court held that the Rule of 70 letters were ambiguous here. The circuit court found, however, that the intent manifested was to provide retirees with the same level of benefit coverage as Woods' current salaried employees, and that retiree coverage could change only if coverage were to change for active salaried employees. This provided benefits for retirees (because the

salaried employees health benefit plan had not been terminated), but avoided the result of protecting retiree medical benefits at a level greater than benefits that they would have enjoyed were they active employees.

### Conclusion

Employers changing their retiree medical benefits can face many challenges. Some employers are hampered by boilerplate SPDs and employee communications prepared long before companies became sensitive to the need to specify the scope of any retiree medical benefits. Representations undertaken in mergers and spinoffs, often prepared by corporate attorneys who are also not focused on these issues, can return to haunt the employer in the future. Even employers who take conservative measures such as "grandfathering" benefits for current retirees due to fairness concerns rather than contractual obligations, can find that such actions can be used

to infer that retiree benefits are vested.

Employers must live with their current programs and documents, but can take some steps to retain flexibility in the future. In addition to careful review of documents provided under all benefit plans or corporate severance programs, employers can and should review amendment procedures to ensure that any amendments at least pass procedural muster. Employers that grandfather certain groups of retirees with respect to benefit changes should consider telling those retirees that this action does not waive their right to make changes in the future. Communications (both written and oral) with retirees or potential retirees must be monitored.

Coordination of retiree medical changes with the administration of the active employees' medical plan also provides challenges. For example, various proposals over the years to "fix" Medicare illustrate how precarious the employer's coordination with Medicare can be, and how employers who merely agree to "supplement" Medicare may take on a larger responsibility than they had anticipated. These include proposals to allow Medicare beneficiaries to enroll in a variety

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of managed care plans and to participate in medical savings accounts; to increase the Medicare eligibility age to 67 or higher; to raise Medicare premiums and deductibles; and to reduce hospital and physician reimbursements. Employers should consider carefully how their active and retiree plans coordinate with Medicare and possible changes to that program and make this clear in employee communications.

Retiree health plans should also be designed to coordinate the benefits now voluntarily provided with those benefits required under the so-called COBRA "continued health coverage" requirements and should recognize that a company in reorganization under Chapter 11 of the Bankruptcy Code must continue to provide retiree health, disability and death benefits until a modification is agreed to by retirees or ordered by a court.<sup>2</sup>

Finally, companies that shift to a managed care environment must decrease expectations of participants that all medical services from all sources are equally available. Managed care only effects cost reductions if the medical services are closely monitored and controlled. This is a change

from many employees' expectations that the employer will provide for the most convenient and best available services when their health is at issue.

All of these measures will help employers to provide retiree health programs that meet reasonable expectations of retirees without unnecessarily restricting the employer with respect to future changes.

#### **ENDNOTES**

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<sup>1</sup> See e.g., Jensen v. SIPCO, Inc., 38 F.3d 45 (8<sup>th</sup> Cir. 1994), cert. denied, 514 U.S. 1050 (1995); Sprague v. General Motors Corp., 133 F.3d 388 (6<sup>th</sup> Cir.), cert. denied, 118 S. Ct. 2312 (1998).

<sup>2</sup> See Retiree Benefits Bankruptcy Protection Act of 1988, Pub. Law No. 100-334, 102 Stat. 610 (1988) (codified at 11 U.S.C. § 1114).