

**RETIREE MEDICAL BENEFITS IN MERGERS AND ACQUISITIONS,
INCLUDING NEW TWISTS FROM HEALTH CARE REFORM**

ABA-JCEB

Employee Benefits in Mergers & Acquisitions

New York, NY

June 5, 2014

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Updated May 23, 2014

TABLE OF CONTENTS

	Page
I. Significance of Retiree Medical Plans in Mergers and Acquisitions	1
II. Overview of Retiree Medical Plans	3
A. Integration of Retiree Medical Plans with Medicare	4
B. Retiree Medical Prescription Drug Subsidy	5
1. Retiree Drug Subsidy After Health Reform.....	6
2. Retiree Health Benefit Prescription Drug Subsidy	6
3. Benefit Requirements.....	7
4. Records	8
5. Requirements for Retiree Medical Plan to Qualify for the Subsidy	9
6. Signed Sponsor Agreement.....	9
7. Processing of Application	10
8. Actuarial Information with the Application.....	10
9. Disclosures	11
10. Subsidy Calculation by Qualified Individual.....	11
11. Individuals Qualified for Subsidy	13
12. Subsidy Payments	13
13. Plan Design	14
14. Flexible Alternatives Permitted	14
15. Waivers	15
16. Employer/Union Steps to Obtain the Retiree Drug Subsidy.	16
17. Transitioning Retirees Eligible for the Subsidy to a VEBA Where The VEBA Is Assuming the Liability for Retiree Health Benefits	16
18. Other Steps to Consider Taking.....	17
19. Plans Covered	17
20. Subsidy Not Taxable to Plan Sponsor	17
21. Appeals	17
22. Change of Ownership	19
23. Effective Date	19
C. Accounting for Retiree Medical Benefits	20
D. FAS 132 – Disclosures.....	22
E. Financial Accounting and the Act’s Subsidy.....	24
1. FASB Staff Position No. FAS 106-2	24
F. Balance Sheet Liability Recognition Required for Post Retirement Benefit Plans.....	25
G. Impact of Accounting Standards on Merger and Acquisition Transaction.....	26
H. Health Reform Acts’ Early Retirement Reinsurance Program	27
I. Health Reform, the Retiree Only Plan Exemption and the Impact of Corporate Transactions	27
J. Methods of Funding Post-Retirement Medical Benefits	28
1. VEBAs in General	28
a. <i>Wells Fargo and Company v. Commissioner of Internal Revenue</i>	29

2.	Using a VEBA to Settle Retiree Medical Liabilities and move OPEB off the Company’s Balance Sheet.....	31
a.	General Motors Corp. and Ford Motor Company	31
b.	AK Steel.....	40
c.	Dana Corporation.....	42
d.	Goodyear.....	43
e.	Continental Tire	43
f.	Arvin Mentor	44
3.	Using a VEBA and a Captive Insurer to Limit the Financial Statement Impact of Retiree Medical Liabilities	44
K.	Cost of Retiree Medical Plans.....	45
L.	Nondiscrimination Rules for Medical Benefits	46
M.	Defined Contribution Post-Retirement Medical Benefits.....	47
N.	Shifting Retiree Medical Liabilities to a Captive Insurer	47
1.	Other Methods for Moving OPEB Off the Balance Sheet.....	47
III.	Potential Liabilities Arising Out of Post-Retirement Medical Benefit Plans	49
A.	Claims of Age Discrimination under the Age Discrimination in Employment Act (“ADEA”).....	49
1.	No claims of reverse age discrimination under the ADEA.....	52
B.	Amending or Terminating Post-Retirement Medical Benefits	53
1.	Railway Labor Act Collective Bargaining Agreements Differ From Those Under the National Labor Management Relations Act.....	54
2.	Sponsoring employer’s ability to amend retiree benefits	54
a.	First Circuit	55
b.	Second Circuit.....	56
c.	Third Circuit.....	58
d.	Fourth Circuit.....	59
e.	Fifth Circuit.....	59
f.	Sixth Circuit.....	60
g.	Seventh Circuit.....	67
h.	Eighth Circuit.....	72
i.	Ninth Circuit	75
j.	Tenth Circuit	76
k.	Eleventh Circuit	77
l.	Federal Circuit	78
3.	Misrepresentations give rise to liability and other limitations on the employer’s right to amend	78
a.	First Circuit	78
b.	Second Circuit.....	78
c.	Third Circuit.....	79
d.	Fourth Circuit.....	79
e.	Fifth Circuit.....	80
f.	Sixth Circuit	80
g.	Seventh Circuit.....	82
h.	Eighth Circuit.....	83
i.	Ninth Circuit	84

	j.	Tenth Circuit	84
	k.	Eleventh Circuit	84
	l.	Federal Circuit	84
	m.	U.S. Supreme Court	84
	4.	Standing is Key	84
	5.	Interplay between the sponsoring employer’s contractual right to terminate retiree medical benefits and the bankruptcy code.....	84
	a.	<i>In re N. Am. Royalties, Inc.</i>	85
	b.	<i>Nelson v. Stewart</i>	86
	6.	Merger Agreements with Benefit Mandates	86
	7.	Other Agreements with Benefit Mandates.....	88
	C.	Successor Liability under Collective Bargaining Agreements under the National Labor Relations Act and Other Contractually Based Claims.....	89
	1.	<i>Grimm v. Healthmont, Inc.</i>	89
	2.	<i>Bish v. Aquarion</i>	89
	3.	<i>LaForest v. Honeywell International Inc.</i>	90
	4.	<i>Cleveland Electric Illuminating Company v. Utility Workers Union of America, Local 270</i>	90
	5.	Contractual Liability	90
	D.	Executive Benefits	92
IV.		Role of Post-Retirement Medical Benefits in Negotiations Leading up to Merger and Acquisition Transaction	93
	A.	What a potential buyer should look for in conducting due diligence	94
	B.	Negotiations and structuring the transaction.....	95
	1.	Asset Sales	96
	2.	Stock Sales	96
	3.	Negotiation Considerations.....	97
	4.	Post Health Reform Acts Change Considerations	97
V.		Privacy, Security and Mergers and Acquisitions	97
	A.	During the Transition Period Prior to April 14, 2004.....	97
	B.	Privacy Liability Exposure	98
	1.	Civil Penalties	98
	2.	Criminal Penalties.....	99
	3.	Private Right of Action	99
	a.	Under ERISA	99
	b.	Preemption and State Causes of Action.....	99
	4.	Privacy and Due Diligence	105
	5.	Privacy and Plan Transition Issues	107
VI.		Conclusion	107
		APPENDIX A – Due Diligence Issues	109
		APPENDIX B – Issues to Address in Negotiations.....	113

Retiree Medical Benefits and HIPAA Privacy in Mergers and Acquisitions

I. Significance of Retiree Medical Plans in Mergers and Acquisitions

An important aspect of any merger or acquisition is the identification of the seller's employee benefits plans, and the unfunded liabilities that may arise from these plans. Retiree medical benefits plans are one type of welfare benefit plan that should be carefully analyzed as part of the due diligence and considered in the negotiation of the corporate merger or acquisition. Although such plans have decreased in popularity in recent years due to their high costs, they are still offered, usually in large corporations. It is estimated that 3.6 million early retirees between the ages of 55 and 64 and their spouses, and nearly 12 million retirees (age 65 or older) receive health coverage from a former employer or union.¹ For the age-65 or older retirees who are eligible for Medicare, employer-sponsored plans typically supplement benefits provided under Medicare and provide additional cost-sharing protections.² In testimony before the House Committee on Education and the Workforce, William J. Scanlon, Director of Health Care Services, GAO, testified that in fact in 2001, only about "one-third of large employers and less than 10% of small employers offer[ed] retiree health benefits."³ Between 1988 and 2006, the share of large employers offering retiree health benefits declined from 66% to 35%.⁴ The high cost of retiree health benefits in the automotive and steel industry have received press along with the attempts to reduce such costs and shift the related liabilities.

For purposes of this outline, any reference to a purchaser or buyer will be to a purchaser or buyer in a stock acquisition in which the liability is transferred with the entity, a joint venture in which the purchaser acquires the liability of the joint venture entity by virtue of investing and becoming a controlling shareholder or a partner with unlimited liability or an asset purchase in which the purchaser agrees to assume the liability and sponsorship for a retiree medical plan with respect to certain persons. The references to purchaser do not include the asset purchaser in which there is no assumption of liability for retiree medical plans, unless the buyer is a successor employer under the COBRA continuation coverage regulations⁵ or under a collective bargaining agreement as discussed below. The term purchaser only refers to situations in which a purchaser assumes the liability either by operation of law or expressly by contract, or in those situations discussed herein when a court finds a purchaser to be liable as a successor under a collective bargaining agreement or based on other reasons.

Retiree medical plans warrant special attention in merger and acquisition transactions because of the large liabilities they impose on their sponsoring corporations. The dramatic rise in health care costs, the aging population, early retirement all made more individuals eligible to participate in retiree plans, coupled with cutbacks in government sponsored health care coverage have all contributed to the sharp rise in costs associated with retiree medical plans. One study found that the total cost of providing retiree medical benefits increased approximately 10.3% between 2004

¹ "Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," page 1.

² *Id.*

³ 68 F.R. 41542, 41543 (2003).

⁴ "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits," December 2006, p. 1 (the "2006 Survey").

⁵ See Treasury Regulation § 54.4980B-9.

and 2005.⁶ A further concern to a prospective acquirer of a corporation sponsoring a retiree plan is the potential liability imposed by such plans, since many of the factors associated with retiree health costs are difficult to predict, e.g., longevity, co-morbidities, medical costs, medical advances, etc. Retiree medical plans require careful delineation of which entity is assuming the responsibility for which costs for which persons and how amounts currently held in funded reserves will be allocated between the parties, if at all, how those amounts will be calculated and how the reserves were calculated.

The extent of the liability assumed will depend upon how the transaction is structured and may depend on the terms of prior plan documents and collective bargaining agreements. If the transaction is structured as a stock purchase and the acquired entity sponsors or maintains a retiree medical plan, the acquiring entity will acquire the full liability or obligation of the entity whose stock it purchased. In such acquisitions, it is important to obtain all of the actuarial reports (for accounting purposes and for tax purposes and any others) and review these carefully with your own actuary to ascertain what assumptions were made and how they may impact the potential liability. The actuarial assumptions for calculating the tax deduction and for tax funding limitations for any VEBA trust need to be reviewed to determine if any risk exists with respect to the tax liabilities relative to the deduction taken for the VEBA funding.

The actuarial reports used for determining the expense and liability recognized on the company's financial statements should be reviewed to see how the assumptions may differ from the tax calculations and to determine the potential liability and how that number may vary based upon actual asset values and returns and actuarial assumption differences. If the International Financial Reporting Standards with the fair market valuation of assets and liabilities are adopted the liabilities shown for retiree medical may fluctuate more widely due to changes in asset values and market returns.

In any acquisition involving retiree medical benefits, negotiations should address which employees, former employees and retirees are transferring, who is liable for providing each group of employees, former employees or retirees medical benefits, what portion of reserves will be transferred to address the liability accrued for the individuals transferred, how that liability should be calculated, and what assumptions should be made in calculating the liability and the reserves to be transferred or any adjustment to the escrow or purchase price. Negotiations should also address the same factors for individuals who have retired if the obligation to provide such retirees' medical benefits will transfer to the purchaser. Negotiations should also address the potential liability for persons who are employed and will be transferred, but who have not yet satisfied the criteria for eligibility for retiree medical, as well as for which employees, former employees or retirees for whom the eligibility criteria are fully satisfied and for whom the obligation will be assumed. Negotiations and the agreements should carefully provide for any duration limits on any covenants or agreements regarding continuation of existing benefits or changes to benefits.

⁶ "Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," page 15.

This outline will not discuss all of the requirements of the Patient Protection and Affordable Care Act of 2010,⁷ the Health Care and Education Reconciliation Act of 2010,⁸ or the TRICARE Affirmation Act of 2010,⁹ (collectively the “Health Reform Acts” or “Health Reform”).

This outline will highlight certain aspects of the Health Reform Acts uniquely applicable to retiree medical plans. The outline will not discuss all of the requirements a group health plan must satisfy to be a qualified health plan under the Health Reform Acts because it is not clear if the exemption provided by section 9831(a)(2) of the Internal Revenue Code of 1986, as amended (the “Code”) or section 732(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) may still be available to exempt a retiree only medical plan from some of the Health Reform Acts’ requirements.¹⁰

If the Health Reform Acts fully apply to retiree medical plans, then the cost of these plans will increase further due to the unlimited annual and lifetime dollar benefit limits, new benefit mandates and reductions on cost sharing. While the short term limited reinsurance for early retiree programs provided by PPACA § 1102 provides some financial assistance, preliminary indications are that such reinsurance proceeds must be used to reduce the participants and beneficiary costs, thus there may not be any reduction in the plan sponsor’s costs and costs could increase due to administration of such a program with no way to offset the additional costs.

II. Overview of Retiree Medical Plans

A potential buyer of a company sponsoring a retiree medical benefits plan must understand how the plan is structured as well as the basic costs associated with maintaining such a plan. How the plan is structured can impact whether it is entitled to receive the Medicare prescription drug subsidy and if the tax structure complies with other legal requirements or presents additional risks. The potential buyer also needs to understand if the retiree medical plan is provided pursuant to a collective bargaining agreement and the terms of the current and prior agreements to determine what rates may exist related to making changes and what restrictions may exist in the collective bargaining agreements. To the extent of the plan’s provisions are negotiated or dictated by the collective bargaining agreement, its term, and when it terminates or becomes amendable. In a stock purchase, the buyer assumes the plan sponsored by the entity purchased in total for the employees and retirees of the entity purchased. While in asset purchases, the assumption of such obligations will only occur if the parties agree to transfer and assume such liabilities. However, some plans with related collective bargaining agreements result in the imposition of successor liability.

Retiree medical plans are generally structured so that the employer will provide medical benefits on a partially or fully subsidized basis to retirees who satisfied the plan’s requirements for eligibility. Typically, the benefits become available to the employee starting the date the employee retires, at either an early retirement or normal retirement date specified in the plan

⁷ P.L. 111-148.

⁸ P.L. 111-152.

⁹ P.L. 111-159.

¹⁰ See PPACA § 1563(a)(1) repealing 2721(a) of the Public Health Service Act (“PHSA”) and PPACA § 1563(e) adding Code § 9815(a)(2) and ERISA § 715(a)(2) which remove conflicts between PHSA provisions and ERISA and the Code provisions by having the PHSA provision override the ERISA and Code provisions. PPACA § 1563(a)(1) only repealed the exemption from the health plan standards for group health plans covering less than two current employees on the first day of the plan year for plans subject to the PHSA, but did not repeal the parallel exemptions in the Code or ERISA.

provided a minimum period of tenure is completed with the employer and continues either (1) until Medicare coverage begins, or (2) for the life of the retiree, and in some cases, for the life of the retiree's spouse. A study showed that 94% of the three hundred corporations surveyed offering retiree medical plans also provided coverage for the retiree's spouse, and that 84% of such plans also covered dependents other than the retiree's spouse.¹¹ In the 2006 Survey these numbers were the same.¹² Although most retiree medical plans cover both Medicare-eligible retirees, and retirees who are not yet eligible for Medicare, often the retiree medical plans provide different levels of benefits for the two classes of employees, since Medicare can be the primary payer of benefits for Medicare eligible individuals if certain conditions are met. However, as discussed in Section III(A), below, if the retiree medical plan offers a different level of benefits depending on an individual's eligibility for Medicare, the sponsoring employer must structure this coordination so that it does not present a risk for an age discrimination lawsuit under the Age Discrimination in Employment Act ("ADEA").¹³

A. Integration of Retiree Medical Plans with Medicare Before a covered individual reaches the age of sixty-five, thus becoming eligible for Medicare benefits, the benefits under the retiree medical plan will generally be the covered individual's primary source of healthcare coverage. Therefore, these benefits will be more extensive and expensive to the sponsoring employer than benefits that are only supplemental to Medicare. One of the reasons for increased costs in retiree medical benefits is that employees are retiring at earlier ages, meaning that their primary medical coverage comes from their employer's retiree medical plan for a longer period of time before they are eligible for Medicare. While Medicare's addition of some prescription drug benefits along with the subsidy for retiree medical drugs reduced some costs, some retirees continue their employment based coverage due to the gaps in Medicare coverage. After an individual becomes eligible for Medicare, the retiree medical benefits under the employer's plan will generally either be coordinated with the benefits available to the individual under Medicare, or will supplement Medicare benefits by covering expenses not covered by Medicare, but will not duplicate the Medicare coverage.

There are several ways that an employer's retiree medical plan can be coordinated with Medicare. Parties involved in a transaction should take note of the method of Medicare coordination adopted by the target's retiree medical plan, since the purchaser's monetary obligations will vary depending on the coordination method adopted. Furthermore, prior to the issuance of regulations by the U.S. Equal Employment Opportunity Commission ("EEOC") in final form¹⁴ there were potential issues under the Age Discrimination in Employment Act of 1967.¹⁵ These methods are only available for individuals who are no longer employed so they are no longer protected by the Medicare Secondary Payer provisions which require that a health plan not discriminate as to benefits for an employee or spouse who is covered by Medicare by virtue of age, disability or end stage

¹¹ "Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," page 2.

¹² 2006 Survey at p. 3.

¹³ 29 U.S.C. 1311 (2003).

¹⁴ 72 Fed. Reg. 72938 (December 26, 2007).

¹⁵ 29 U.S.C. 821 *et seq.*

renal disease.¹⁶ The following represent three common methods of Medicare coordination for retiree medical plans:

1. The first and most expensive method of Medicare coordination is to determine the amount of eligible benefits under the plan, excluding Medicare coverage. The benefits available under the plan are then combined with the benefits available under Medicare. If this combination of benefits exceeds 100% of the eligible charges, then the benefits under the plan are reduced accordingly. For example, if the Plan and Medicare paid \$120 for a \$100 service the Plan's benefit would be reduced so a total of \$100 would be paid.
2. The second method of Medicare coordination is to carve-out the benefits available under Medicare. Under this method, the amount of benefits available under the plan is determined excluding Medicare benefits. Medicare benefits are then subtracted from the total benefits, and the plan pays the difference in accordance with the cost-sharing provisions under the plan. If the benefits available under the plan are equal to, or less than, the benefits available under Medicare, then the plan does not have any monetary obligation after the Medicare payment. If the plan pays 80% for a service and Medicare paid \$80 of a \$100 bill, the plan would pay \$16 or 80% of the \$20 unpaid by Medicare.
3. Third, the employer's plan can serve as a supplement to Medicare, paying for eligible expenses that are not covered by Medicare, such as Medicare deductibles, coinsurance and non-covered items.

Even though retiree medical benefits that are supplemental to Medicare are less expensive for the employer to maintain than full retiree coverage, sponsors of such plans have seen their obligations increase over the past several years as Congress has reduced the benefits available under Medicare, Medicare has cut its payments, and the costs continue to rise. While the financial accounting rules require reporting of the potential liability for retiree medical benefits, the estimated liabilities remain estimates with the actual liability not fully known.

B. Retiree Medical Prescription Drug Subsidy. Retiree medical plans providing prescription drug coverage, if the plan's coverage meets Medicare's minimum standards to be creditable, may be eligible to obtain a subsidy for some of the costs from Medicare. In order to obtain the subsidy, the plan must keep certain records tracking its costs and the benefits it provides to Medicare covered individuals as well as satisfying annual notice requirements. This section provides an overview of the requirements for a retiree medical plan to obtain the subsidy. If the requirements are not satisfied, then the plan sponsor may be subject to recovery actions from the Center for Medicare and Medicaid Services.

The Medicare Prescription Drug Improvement and Modernization Act of 2003¹⁷ (the "Act") brought a number of changes that affect employer sponsored group health plans. There were changes to the Medicare Secondary Payer provisions, the enactment of the subsidy provision for the employer sponsored prescription drug benefits for certain

¹⁶ Code § 5000(b); and § 1862(b)(2) of the Social Security Act.

¹⁷ P. L. 108-173.

retirees who are Medicare eligible, and the enactment of certain tax incentives for health and retirement security, including health savings accounts. This outline will not address any changes brought about as the result of adding the new Medicare Advantage alternative for Medicare eligible individuals. To date, the Final Regulations issued on the Prescription Drug Subsidy for retiree prescription drug coverage have not addressed all of the issues under the Act. Reviewing the retiree medical plan's operations for compliance with the Medicare prescription drug subsidy requirements is important to determine if there is any potential exposure for losses due to noncompliance with the subsidy's requirements.

1. **Retiree Drug Subsidy After Health Reform.** The Patient Protection and Affordable Care Act of 2010¹⁸ ("PPACA") repealed the tax deduction for amounts the plan sponsor receives as the result of the Medicare Part D Retiree Subsidy and this changes the expense recognition on the financial statements. The elimination of the deduction equal to the amount of the retiree drug subsidy amounts received by the plan sponsor making this similar to the amounts never taken into income.¹⁹
2. **Retiree Health Benefit Prescription Drug Subsidy.** The Act added the prescription drug benefit for Medicare eligible individuals and added a new Medicare Advantage ("MA") managed care arrangement option under the Medicare program.

The legislative history indicated that Congress, while adding the Medicare prescription drug benefit did not want to cause individuals to lose retiree coverage. The legislative history noted that in 1988, 66% of the large employers provided retiree health benefits and by 2002 the number had decreased to just 34% of large employers providing retiree health benefits. Thus, in order to encourage the continuation of the retiree medical programs the Act provides for a subsidy payment to be made to sponsors of qualified retiree prescription drug plans so that the addition of the Medicare prescription drug benefit will not induce employers to drop retiree health coverage.²⁰ The Center for Medicare and Medicaid Services ("CMS") administers the retiree prescription drug coverage subsidy and Medicare prescription drug benefit.

Subsidies will be paid on behalf of individuals who are covered under a qualified employer sponsored retiree plan that are entitled to enroll in either a prescription drug plan (a plan available to Medicare beneficiaries offering prescription drug coverage alone, a "PDP") or a Medicare Advantage prescription drug plan but who have elected not to do so. The subsidy payment will be approximately 28% of the retiree plan related prescription drug costs calculated as provided under the statute and under guidance issued by the Secretary of Health and Human Services for costs that exceed \$250 but are not greater than \$5,000, with such amounts acting as the threshold and limitation being adjusted annually. The subsidy under the Act carries with it a number of other requirements. In order to obtain the

¹⁸ P.L. 111-148.

¹⁹ PPACA § 9012 effective for tax years beginning after December 31, 2012.

²⁰ Conference Agreement, Medicare Prescription Drug, Improvement and Modernization Act of 2003, Title I, Special Rules for Employer Sponsored Programs, page 53.

subsidy, the sponsor of the employer sponsored retiree health coverage must apply annually, at least 90 days prior to the first day of the plan year,²¹ unless a request for an extension has been filed and approved under procedures established by CMS. The application must include an attestation that the actuarial value of the prescription drug coverage under the plan is at least equal to the actuarial value of the standard prescription drug coverage.²² The actuarial value of the prescription drug coverage is measured over the coverage year which is the calendar year.²³ The determination of the actuarial equivalence of a benefit plan to the Medicare Part D coverage was not addressed in the proposed regulations, instead the preamble to the regulations considered several alternatives and requested comments. The preamble to the proposed regulations in a number of areas such as interest payments, actuarial equivalence, records and allocation of rebates, discounts, etc. and the allowable retiree costs contained more information than the actual proposed regulations. The first set of Final Regulations did not fully address the calculation of actuarial equivalence but the calculation is different for purposes of the notice and the subsidy. The calculation for the subsidy offsets retiree contributions so the subsidy is only available on the benefit provided by the employer's contributions.

3. **Benefit Requirements.** The standard prescription drug coverage under the Medicare prescription drug benefit is the coverage against which the retiree health plan's coverage must be measured. The retiree prescription drug coverage must at least be equal to the standard prescription drug coverage (the Part D coverage under Medicare) that has a deductible that is equal in 2006 to \$250, in 2009 to \$295 and to \$305 in 2010 (which number will be adjusted for inflation). It must provide a co-insurance of 25% or an actuarially equivalent benefit to a benefit with 25% co-insurance for prescriptions after the deductible is satisfied and up to \$2,250 in 2006, \$2,700 in 2009 and \$2,780 in 2010. It may use tiers of co-payments as long as they meet the requirement that the value is the actuarial equivalent of the 25% co-insurance benefit. The coverage limit on the maximum prescription drug costs that will be considered as covered with the co-insurance is \$2,250 in 2006, \$2,700 in 2009 and \$2,780 in 2010. The plan must provide in the event an individual has Part D drug costs that equal or exceed the annual out-of-pocket threshold of \$3,600 in 2006, \$4,350 in 2009 and \$4,500 in 2010, that the co-payments or the cost sharing will be equal to the greater of a co-payment of \$2.00 for a generic drug or a preferred drug that is multiple source drug, and \$5.00 for any other drug or 5%.²⁴ There is no coverage once a participant reaches \$2,250 (or \$2,700 in 2009 or \$2,780 in 2010) and the participant must pay all prescription drug costs until the individual has paid \$3,600 in 2006 (\$4,350 in 2009 or \$4,500 in 2010) for the calendar year under the Medicare benefit. This is the donut hole in the coverage. The regulation also considers what applies to the True Out of Pocket maximum under Part D, the "TroOP." The TroOP is the amount the individual must actually pay before the Part D plan begins to pay for catastrophic coverage (when \$3,600 is incurred in 2006, when

²¹ 42 C.F.R. Part 423, § 423.884 (2005).

²² Section 1860D-22(a)(2) of the Social Security Act (the "SSA"); 42 C.F.R. Part 423, § 423.4 and 423.265(c)(3) (2005).

²³ SSA section 1860D-15(b)(4).

²⁴ SSA section 1860D-2(b).

\$4,350 is incurred in 2009 or \$4,500 in 2010). The final regulations clarify how HRAs, HSAs, MSAs, and FSAs are to be treated for calculation of TroOP. FSAs and HSAs and MSAs arrangements are “personal health savings vehicles” and are not considered to be part of any insurance payment thus the expenses paid by the HSA, FSA or MSA do apply toward the person’s satisfaction of the TroOP. HRAs are specifically excluded from the definition because HRAs do not involve a person setting aside and using their own funds to pay for the prescription drugs.²⁵

Plans can demonstrate actuarial equivalence to the Part D standard benefit by applying the net prong test to either their retiree medical plan as a whole on an aggregate basis, or to each benefit option as long as each option qualifies as creditable coverage provided each benefit option satisfies the gross value test for actuarial equivalence.²⁶ The options that meet the creditable coverage standard can be aggregated to pass the net prong of actuarial equivalence.²⁷ Thus, plan sponsors may want to design their plans by defining the different options and which should be aggregated as a plan because they will meet the actuarially equivalent standards and which are not intended to be creditable coverage for the retiree subsidy or are intended to only supplement the Part D benefit. Additional guidance on actuarial equivalence can be found on the HHS website.

4. **Records.** The retiree health plan is required to maintain records so that the Secretary of Health and Human Services may audit those records and conduct oversight, including reviewing all contracts, financial statements and records regarding the prescription drug plans, as such records are defined in section 1860D-2(d)(3) of the Social Security Act (“SSA”). The records would need to be sufficient to document the calculation of the subsidy. The regulations require retention of specific records for six years after the expiration of the plan year in which the costs were incurred for oversights and audits. The final regulations also give CMS and the Office of Inspector General the authority to extend the six year retention requirement in the event of an ongoing investigation, litigation or negotiation involving civil, administrative or criminal liability.²⁸ The records that must be retained are:

- a. Reports and working documents of the actuaries who wrote the attestation of actuarial equivalence of the benefits; and
- b. All documentation of costs incurred and other relevant information used in calculating the amount of the subsidy payment, including the underlying claims data and any other records specified by CMS.²⁹ The fact that the data is PHI belonging to the plan is addressed in the final regulations by requiring an agreement between the plan and plan’s sponsor to provide CMS the information.³⁰ The final regulations require

²⁵ 42 C.F.R. § 423.100 and 70 F.R. 4194, 4518 (2005).

²⁶ 42 C.F.R. § 423.884 (2005) and 70 F.R. 4194, 4521 (2005).

²⁷ 42 C.F.R. § 423.884 (2005) and 42 C.F.R. § 423.265 (2005).

²⁸ 42 C.F.R. Part 423, § 423.888(d) (2005).

²⁹ 42 C.F.R. Part 423, § 423.888(b) (2004) and 69 Fed. Reg. 46632, 46750 (2004).

³⁰ 42 C.F.R. § 423.884(b) (2005).

such agreement to provide for disclosure of the information to CMS so the plan sponsor can comply with the requirements to obtain the subsidy.³¹

5. **Requirements for Retiree Medical Plan to Qualify for the Subsidy.** In order for a retiree prescription drug plan to be a qualified retiree prescription drug plan only if all of the following requirements are met. First, the plan must have an actuarial attestation that meets certain requirements described below. Second, all Part D eligible individuals covered under the plan must be provided with the annual creditable coverage notice. Third, records must be maintained and made available for audit as described below.³² Fourth, the plan sponsor must have a written agreement with the health plan regarding disclosure of information to CMS and the plan must disclose to CMS on behalf of the sponsor the information that is necessary for the sponsor to comply with the Medicare prescription drug regulation.³³ Fifth, the plan sponsor must submit a signed application for the subsidy to CMS with the employer's tax identification number, the sponsor's name and address, an actuarial attestation that meets CMS's standards and any required supporting documents, a signed sponsor agreement, other CMS specified information, and either a list of all persons the plan sponsor believes are qualifying covered retirees under the plan sponsor's plan and who are not enrolled in Medicare Part D with each person's full name, health insurance claim number or Social Security number, date of birth, gender, relationship to retired employee, or the plan sponsor may enter into a voluntary data sharing agreement with CMS.³⁴

6. **Signed Sponsor Agreement.** The signed sponsor agreement must require the sponsor to agree to comply with the terms and conditions of eligibility for a subsidy under the regulations and CMS's guidance, acknowledge that the information is being provided to obtain Federal funds, and require that all subcontractors, including plan administrators acknowledge that the information is provided in connection with the subcontract to be used to obtain Federal funds.³⁵ This means that all contracts plan sponsors for retiree medical plans have with their plan's vendors needed to be amended for 2006 and subsequent years to provide for the vendor to comply with CMS regulations and guidance and to acknowledge the information is provided in connection with a contract/plan that is used to obtain Federal funds. The person signing the agreement must sign the completed application and certify that the information contained therein is true and accurate to the best of the sponsor's knowledge and belief. The application must be submitted no later than 90 days prior to the beginning of the plan year unless a request for extension was filed with and approved by CMS. The plan sponsor is also required to provide updates of the information on who is participating in the plan sponsor's retiree prescription drug benefit monthly.³⁶

³¹ 42 C.F.R. § 423.884(b) (2005).

³² 70 F.R. 4194, 4577 (2005); 42 C.F.R. § 423.884(a) (2005).

³³ 70 F.R. 4194, 4578 (2005); 42 C.F.R. § 423.884(b) (2005).

³⁴ 70 F.R. 4194, 4578 (2005); 42 C.F.R. § 423.884(c) (2005).

³⁵ 70 F.R. 4194, 4578 (2005); 42 C.F.R. § 423.884(c)(3) (2005).

³⁶ 42 C.F.R. § 423.884(c)(3) (2005).

7. **Processing of Application.** CMS matches the names and address of the retirees with the Medicare Beneficiary Database to determine which ones are eligible and not enrolled in Medicare Part D. CMS will provide the plan sponsor with information regarding which retirees are qualified covered retirees for whom the subsidy may be received.³⁷ The Medicare required data exchanges that became effective beginning in 2009 should assist with coordination if the plan sponsor agrees to include the information on retiree drug coverage in the exchange.³⁸

8. **Actuarial Information with the Application.** The application's actuarial attestation must meet a number of requirements and must provide that the actuarial value of the benefit under the plan is at least equal to the actuarial value of the standard prescription drug coverage under Medicare Part D. It must state:
 - a. The actuarial gross value of the plan's prescription drug benefit is at least equal to the actuarial gross value of the Medicare Part D standard benefit.
 - b. The actuarial net value of the plan's retiree prescription drug coverage is at least equal to the actuarial net value of the standard Part D benefit; and
 - c. The actuarial values must be determined using the actuarial methodology specified in the regulations. (The actuarial methodology will be specified in regulations.)

The attestation must be made by an actuary who is a member of the American Academy of Actuaries. The attestation must be signed by the actuaries and must state it is true and accurate to the best of the attester's knowledge. The attestation must state and acknowledge that the information is being provided to obtain Federal funds. The actuarial methodology used in the actuarial attestation must be based on generally accepted actuarial principles and CMS guidelines and the gross value of the plan's retiree prescription drug benefit must be determined using actual claims experience unless the plan sponsor's size or other factors do not have creditable data in which case those plans may use normative data specified by CMS.

The net value of the plan's coverage must be determined using the data from the gross value calculation and reducing it by the expected premiums paid by the Part D eligible individuals who are plan participants and their spouses and dependents. This will reduce the net costs of any retiree pay-all plans to zero. If the plan has a single premium for both medical and prescription drug coverage, the attestation must allocate the premium/contribution between the medical and prescription drug coverage using a method determined by the plan sponsor or its actuary.³⁹ Because the actuarial attestation must state that the retiree coverage is actuarially equal to or greater than the value of the standard Part D benefit, the actuary must calculate both the gross value of the standard Part D coverage and the net value of the standard Part D coverage using the plan's actual claims

³⁷ 42 C.F.R. § 423.884(c)(7) (2005).

³⁸ Medicare, Medicaid and SCHIP Extension Act of 2007, P.L. 110-173, § 111 ("MMSEA 111").

³⁹ 42 C.F.R. § 423.884(d) (2005).

experience and demographic data. The net value of the standard Part D benefit is reduced by monthly beneficiary premiums for a Part D Prescription Drug Plan or Medicare under 42 C.F.R. § 423.286 and an amount calculated as reflecting the impact the sponsor's supplemental coverage has on the defined Standard Part D benefit calculated using the initial coverage and cost sharing units for the standard Part D benefit in effect at the beginning of the plan year. The attestation must be submitted to CMS within 60 days after the Part D coverage limits are published.⁴⁰

If the plan offers more than one retiree benefit option, the actuarial attestation must be provided separately for each option. Thus, a plan which provides more than one option must clearly designate the separate options for which the sponsor will seek a subsidy. The actuarial attestation must be provided annually with each subsidy application and at least 90 days before any material change to the drug coverage impacting the actuarial value of the coverage is implemented.⁴¹

9. **Disclosures.** In order for the sponsor of the retiree health plan providing prescription drug coverage to obtain the subsidy, it must also disclose certain information regarding the prescription drug coverage. This disclosure must be made to the Secretary of Health and Human Services and to all of its retirees and their spouses and dependents eligible to participate in the plan who are Part D eligible individuals. The disclosure must indicate whether the coverage is creditable coverage for prescription drugs. If the coverage is not creditable coverage for Part D, the notice must state it is not creditable coverage, that there are limitations on when the individual may enroll in a Part D plan if the individual enrolls in that plan and not Part D, and that any enrollment in Part D at a later date would be subject to a late enrollment penalty.⁴² There is also creditable coverage for prescription drug coverage using rules similar to HIPAA's rules regarding breaks in coverage for enrollment in Part D.⁴³ This is the Medicare imposed late enrollment penalty.
10. **Subsidy Calculation by Qualified Individual.** The amount of the subsidy is calculated under the Act using a number of defined terms explained below. The subsidy payment is only for a qualifying covered retiree for a coverage year when such individual is enrolled in a retiree medical plan providing prescription drug coverage sponsored by the employer and not enrolled in a MA option, or under Part D of Medicare or under a commercial PDP.⁴⁴ The coverage year is the calendar year.⁴⁵

The subsidy is calculated as a portion of the "gross covered retiree plan related prescription drug costs" for a qualified retiree for the year to the extent it exceeds the cost threshold amount and does not exceed the cost limit, an amount equal to 28% of the allowable retiree costs attributed to such gross covered prescription

⁴⁰ 42 C.F.R. § 423.884(d) (2005).

⁴¹ *Id.*

⁴² SSA section 1860D-13(b)(6)(B); 42 C.F.R. § 423.56 and § 423.884(e) (2005).

⁴³ 42 C.F.R. Part 423, § 423.46 and 423.56 (2005).

⁴⁴ 42 C.F.R. § 423.882 (2005).

⁴⁵ 42 C.F.R. § 423.308 (2005).

drugs.⁴⁶ So for each individual you must determine their gross costs that exceed \$250 up to \$5,000 for the plan year ending in 2006 and \$295 and \$6,000 respectively in 2009 including co-payments. The “gross covered retiree plan related prescription drug costs” include amounts paid by both the retiree and the employer and non-administrative costs such as dispensing fees regardless of whether they are paid by the retiree or the plan.⁴⁷ Of this amount, only the amounts that are amounts actually paid for prescription drugs (net of discounts, charge backs and average percentage rebates) are qualifying costs on behalf of the covered retiree which may be “allowable retiree costs.” Special rules are provided for fiscal year plans which had years beginning in 2005 and ending in 2006.⁴⁸

The calculation begins with the portion of the gross covered retiree prescription drug costs. The gross covered retiree prescription drug costs during a coverage year are the costs incurred in the plan or by the retiree, but does not include any administrative costs, other than costs directly related to dispensing of the drugs during the year (e.g., a dispensing fee per prescription), and these costs include the amounts that are both paid by the retiree and by the plan. These gross costs then must be limited to the amounts that exceed the threshold amount of \$250 per person in the calendar year (\$295 in 2009) and do not exceed \$5,000 in 2006 and \$6,000 in 2009 per person for the calendar year. All of these amounts are calculated on an individual-by-individual basis and then aggregated for the plan.⁴⁹ Costs for reinsurance for alternative coverage must be limited so that only costs related to the standard Part D plan are considered.⁵⁰

The portion of total gross covered retiree plan-related prescription drug costs is only 28% of the “allowable retiree costs” which are the costs of actually providing the drugs net “of discounts, charge backs and average percentage rebates that the sponsor incurs on behalf of the qualified retiree that are attributable to the gross covered prescription costs over the cost threshold and less than the cost limit. This means the prescriptions would need to be traced by individuals, including amounts paid by the retiree, as well as the discounts; charge backs and average percentage rebates allocated on an individual basis to the qualifying retirees. There will also need to be a tracking of the amounts of dispensing fees, but not any administrative charges related to the prescription drugs for retirees. All costs paid by the plan for retirees under the plan must be traced or allocated in order to be able to calculate all of the components necessary to calculate the special subsidy.⁵¹ The formula appears to be:

.28 x allowable retiree costs attributable to such gross covered prescription drugs in excess of \$250 per qualified retiree (\$295 in 2009) and less than \$5,000 per qualified retiree (\$6,000 in 2009)

⁴⁶ SSA section 1860D-22(a)(3); 42 C.F.R. Part 423, § 423.85 (2005).

⁴⁷ 42 C.F.R. Part 423, § 423.886 (2005).

⁴⁸ 42 C.F.R. § 423.886(a)(2) (2005).

⁴⁹ *Id.* 42 C.F.R. § 423.308 (2005).

⁵⁰ 42 C.F.R. § 423.308 (2005).

⁵¹ SSA section 1860D-22(a)(3).

How the “allowable retiree costs” that are attributable to the portion of the gross retiree prescription drug costs in excess of \$250 per person (\$295 in 2009) and less than \$5,000 in 2006 and \$6,000 in 2009 per person involves tracing retiree prescription drug claims, rebates, co-payments and discounts or a formula using proportions or some other method.⁵²

11. **Individuals Qualified for Subsidy.** A qualified retiree is an individual who is a participant in the employer’s retiree prescription drug benefits who is eligible, but who is not enrolled in a prescription drug plan (a PDP under Medicare) or a Medicare Advantage drug plan or enrolled in Medicare Part D, but who is covered under a retiree prescription drug plan.⁵³ Each year 90 days before the beginning of the calendar year, the plan sponsor will need to submit an application for the subsidy listing, among other information, the full names of each qualifying covered retiree enrolled in each prescription drug plan (including, spouses and dependents, if Medicare eligible, and the Health Insurance Claim number (when available), date of birth, sex, social security number, and relationship to the retiree).⁵⁴ This information would then be processed by the Center for Medicare and Medicaid Services (“CMS”) through its data match program to determine which individuals are eligible based upon the Medicare Data Base and CMS then will notify the plan sponsor of the names and other identifying information of the qualified covered retirees.⁵⁵ Nothing in the retiree prescription drug subsidy regulations is intended to prohibit a Part D eligible individual who is covered under a qualified retiree prescription drug plan from also enrolling in a prescription drug plan or in a MA plan.⁵⁶

12. **Subsidy Payments.** The payments of the subsidies for the eligible individuals’ prescription drugs will be determined in one of several manners by the Secretary of Health and Human Services. SSA section 1860D-15(d) indicates that the payments will be made based on a method that is determined by the Secretary of Health and Human Services. The Secretary can establish a payment method by which interim payments may be made during a year based on the best estimate of the amount of subsidy that will be payable. Then, after obtaining all of the information there will be a reconciliation or accounting with either reimbursement to CMS or an additional subsidy payment. Payments may be made on a monthly, quarterly or annual basis as determined by CMS elected by the plan sponsor unless CMS decides the options must be restricted.⁵⁷ However, if a plan sponsor elects monthly or quarterly payments, it must submit information to CMS on the same basis.⁵⁸ If the annual basis is elected, then information must be submitted to CMS within 15 months after the end of the plan year. The information submitted for monthly or quarterly payments must include gross covered retiree plan prescription drug costs and an estimate of the extent allowable retiree costs will differ from the gross costs and the estimate must be

⁵² 42 C.F.R. Part 423, §§ 423.886, 423.882, and 423.301 to 343 (2005).

⁵³ SSA section 1860D-22(a)(4).

⁵⁴ 42 C.F.R. § 423.884(c) (2005).

⁵⁵ 42 C.F.R. Part 423, § 423.884(b)(7) (2005).

⁵⁶ 42 C.F.R. Part 423, § 423.894 (2005).

⁵⁷ 42 C.F.R. § 423.888(b) (2005).

⁵⁸ 42 C.F.R. § 423.888(b) (2005).

used to reduce periodic payments for the plan year until the final year end reconciliation.⁵⁹ Plans using the monthly or quarterly payment option also must submit an annual reconciliation within 15 months of the end of the plan year which will be used by CMS to adjust the plan's current quarterly or monthly payments.⁶⁰

Special rules exist for group plans that are insured to calculate payments that exclude administrative costs and risk changes.⁶¹ All payments are conditioned on the plan furnishing to the Secretary of the Health and Human Services in the form and manner that the Secretary prescribes the information required to carry out the section.⁶² Payments are conditioned on the plan providing CMS with the information necessary for CMS to administer the Part D program.⁶³ HHS's use of the information received by CMS for administering Part D is limited to payment calculation, payment oversight, and program integrity activities.⁶⁴

13. **Plan Design.** The Medicare Part D prescription drug subsidy for retirees covered by retiree health coverage retiree prescription drug coverage is not intended to be construed to preclude someone who is Part D eligible under Medicare and who is covered under an employment based retiree coverage from: (1) enrolling in a Medicare offered prescription drug program or in a Medicare Advantage prescription drug plan; (2) precluding any employment based retiree health coverage or any employer or any other person from paying all or any portion of any premium required for coverage under a Medicare offered prescription drug plan or a Medicare Advantage prescription drug plan for the individual; (3) or preventing any employment based retiree health care coverage from providing coverage that is either better than the standard prescription drug coverage described above to retirees who are covered under the qualified retiree prescription drug plan, or from providing any coverage that is supplemental to the benefits provided under the Medicare offered prescription drug plan, or a Medicare Advantage prescription drug plan.⁶⁵ This would also include benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in one of the Medicare prescription drug plans or the Medicare Advantage prescription drug plans. The Medicare Part D coverage is not intended to prevent any employer from having flexibility in benefit design and pharmacy access provisions without regard to the requirements for the basic prescription drug coverage as long as the coverage provided is at least actuarially equivalent.⁶⁶

14. **Flexible Alternatives Permitted.** The regulations also clarify that they do not prohibit either:

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² SSA sections 1860D-22(a)(5) and 1860D-15(d); 42 C.F.R. Part 423, §§ 423.888 and 423.301 through 343 (2005).

⁶³ 42 C.F.R. § 423.322(a) § 423.888(b) (2005).

⁶⁴ 42 C.F.R. § 423.322(b) (2005).

⁶⁵ 42 C.F.R. Part 423, § 423.894 (2005).

⁶⁶ SSA section 1860D-22(a)(6); 42 C.F.R. Part 423, § 423.894 (2005).

- a. A Part D eligible individual who is covered under employment-based retiree health coverage, including a qualified retiree prescription drug plan, from enrolling in Part D;
- b. A plan sponsor or any other person from paying all or any part of the monthly beneficiary premium for a Part D plan for a retiree or his spouse or dependents;
- c. A plan sponsor from providing coverage to Part D eligible individuals under employment-based retiree health coverage that is either supplemental to the benefits under a Part D plan or of a higher actuarial value than the actuarial value for a standard Part D plan; or
- d. A plan sponsor may provide for flexibility in the benefit design and pharmacy network for their qualified retiree prescription drug coverage without the requirements applicable to a Part D plan.

15. **Waivers.** The Medicare Advantage waiver provisions under section 1857(i) of the SSA also apply to prescription drug plans that are an employment based retiree health coverage in a similar manner to the way they apply to the Medicare Advantage plans, including authorizing the establishment of separate premiums amounts for enrollees in the prescription drug plan by reason of such coverage and limitations on enrollment to Part D eligible participants enrolled in the coverage.⁶⁷ This applies to retiree prescription drug plans that opt to be treated as Medicare Prescription Drug Plans under the Act in the same way a Medicare Advantage plan is an option to standard Medicare and chooses to be so reimbursed rather than seeking the subsidy. Section 1857(i) of the SSA provided originally for compatibility of Medicare + Choice programs with employer or union sponsored group health plans by facilitating offering Medicare + Choice plans under agreements between the employer or union and Medicare for the furnishing of benefits to the entity's employees, former employees or members or former members under the agreements in which the Secretary of Health and Human Services may waive or modify the requirements that either hinder the design of or offering of the, or the enrollment in the Medicare + Choice programs. The provision added permits the Secretary to waive requirements to similarly permit design of offering or enrollment in Medicare Advantage and the Medicare Prescription Drug Plan.⁶⁸

An employer sponsored group health plans that seek to be a prescription drug plan under the Act instead of just seeking the subsidy will be required to file for a waiver with CMS by February 18th of the preceding year.⁶⁹ Waivers permit employers to limit the offering of the prescription drug plan to just its retirees, avoid state licensing and solvency requirements, permit the employer to extend their coverage to all their retirees, not just those in a particular service area, and

⁶⁷ SSA section 1860D-22(b).

⁶⁸ SSA sections 1860D-22(b) and 1857(i) (42 U.S.C. § 1395 W-27).

⁶⁹ CMS Part D Waiver Guidance for Employer/Union Retiree Coverage issued February 11, 2005 and additional update March 9, 2005.

to not comply with the Medicare Prescription Drug Plan enrollment requirements.⁷⁰

16. Employer/Union Steps to Obtain the Retiree Drug Subsidy.

- a. Submit an application to qualify for the retiree drug subsidy by September 30 each year; non-calendar plans must submit applications 90 days prior to the beginning of each plan year. The following information should be included in the application:
 - (1) An actuary's attestation that the plan meets the Act's actuarial equivalence standard.
 - (2) Certify that the creditable coverage status of the plan has or will be disclosed to participants and CMS.
- b. Electronically submit, and periodically update, enrollment information about retirees and dependents. Entering into a Voluntary Data Sharing Agreement with CMS simplifies this process. Information about the Voluntary Data Sharing Agreement is provided below and is available at: <http://www.cms.hhs.gov/>. Effective beginning in 2009, group health plans must participate in a data exchange with CMS.⁷¹
- c. Electronically submit aggregate data about drug costs incurred and reconcile costs at year-end. Plan sponsors can choose whether to submit data and receive payments monthly, quarterly or annually.
- d. The employer in its application for the subsidy must indicate the frequency at which it wants to receive interim payments which determines the frequency at which data must be submitted.

- 17. Transitioning Retirees Eligible for the Subsidy to a VEBA Where The VEBA Is Assuming the Liability for Retiree Health Benefits.** In recent years, several companies have negotiated with unions to transfer all or a portion of their retiree medical costs and liabilities to a VEBA trust, including prescription drug benefits. If such a transfer has occurred, there is a transfer of the plan sponsorship from the employer to the VEBA trustee or committee but there is not a change in ownership with respect to the retiree drug subsidy. In such situations, the plan sponsor may not get credit for the costs accumulated by the old plan sponsor for a period shorter than a twelve month period. The new VEBA trustee or committee must submit an application to participate in the drug subsidy under its own name and employer tax identification number.⁷²

⁷⁰ Medicare Prescription Drug Benefit: Solicitation for Application for New Employer/Union Direct Contract Prescription Drug Plan (PDP) Sponsors, issued January 27, 2006 (Revised February 2, 2006).

⁷¹ MMSEA 111.

⁷² "Transitioning RDS Retirees to a Group Health Plan That Uses a VEBA as a Funding Mechanism", Center for Medicare and Medicaid Services Retiree Drug Subsidy (RDS) Program Guidance, October 30, 2008. www.hhs.gov.

18. **Other Steps to Consider Taking.** In order to facilitate determining the eligibility of the participants and their dependents for the retiree drug subsidy (*i.e.*, verifying which are not also enrolled in Medicare Part D), the employer may enter into a Voluntary Data Sharing Agreement with CMS. A voluntary data sharing agreement can be obtained from the Center for Medicare & Medicaid Services, Voluntary Data Sharing Agreement Program, c/o Coordination of Benefits Contractor, P. O. Box 660, New York, NY 10274-0660 or by calling 1-800-999-1118.
19. **Plans Covered.** Group health plans that provide the employment based retiree health care coverage are groups that provide that health insurance or other coverage of health care and prescription drug costs for Part D eligible individuals under a group health plan based on their status as retired participants in the plan. Thus, the subsidy under the Act is not applicable to active employees who are Medicare entitled. The plan sponsor is always defined as in section 3(16)(b) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”)⁷³ and in the event it is a plan maintained jointly by one employer and an employee organization for the employer as the primary sponsor for financing, then the term means the employer. The group health plan includes both federal and state governmental plans, collectively bargained plans, church plans, as well as plans covered by the Employee Retirement Income Security Act of 1974, as amended.⁷⁴
20. **Subsidy Not Taxable to Plan Sponsor.** The subsidy payments for retiree prescription drug coverage are excluded from the gross income of the recipient and from inclusion alternative minimum taxable income for all tax years after enactment.⁷⁵
21. **Appeals.** While the Act did not provide for an appeals process for issues related to the calculation of the retiree medical plan subsidy and CMS does not believe there is a constitutional property interest in the retiree drug subsidy, CMS provided for an appeal procedure for the subsidy for certain issues.⁷⁶ The appeals procedures contemplate a rapid time frame for submission of the appeal by the plan sponsor (note, the claim for the subsidy is filed by the plan in order to utilize the privacy regulations permitted disclosure for “payment” as the basis for the disclosure while the appeal which must use this protected health information must be filed by the plan sponsor; the sponsor will have access to the data necessary to file the appeal using the permitted disclosure of “payment” under the privacy regulations provided the plan document is appropriately amended in compliance with the privacy regulations and the plan sponsor has the required agreement with the plan to provide information to CMS for the subsidy filing and appeal).⁷⁷

⁷³ 29 U.S.C. 1001, *et. seq.* 2006.

⁷⁴ SSA section 1860D-22(c) ; 42 C.F.R. Part 423, § 423.882 (2005).

⁷⁵ Act section 1202 amending Code section 56(g)(4)(B) and adding Code section 139A.

⁷⁶ 42 C.F.R. Part 423, § 423.890 (2005).

⁷⁷ 45 C.F.R. Part 164, § 164.504(f)(2)(iii)(A) (2003) and 42 C.F.R. § 423.884(c)(3) (2005).

The appeal process requires completion of several levels. The plan sponsor first must file a request for informal reconsideration for the following issues:

- a. the amount of the subsidy payment;
- b. the actuarial equivalence of the sponsor's retiree prescription drug plan;
- c. if an enrollee in a retiree prescription drug plan is a qualifying covered retiree; or
- d. any other similar determination (with the similarity determined by CMS) that affects eligibility for or the amount of a subsidy payment.⁷⁸

If a plan sponsor does not follow the regulation's requirements on requesting an informal written reconsideration, the initial determination regarding the retiree drug subsidy is final and binding.⁷⁹ The informal written reconsideration request must be filed in writing with CMS within 15 days of the date on the notice of adverse determination. The request must specify the findings or issues with which the sponsor disagrees and the reasons for the disagreement and any additional documentary evidence the plan sponsor wants CMS to consider. CMS will then review the subsidy determination and the evidence and findings on which it was based and any other written evidence submitted. CMS may inform the plan sponsor orally or through electronic mail of its determination and will only send a written determination if the sponsor requests it. (Note, the written determination is required to be submitted at the next appeal level.) This determination is final and binding unless a request for hearing is filed.⁸⁰

A request for hearing must be filed by the plan sponsor within 15 days of its receipt of the CMS reconsideration decision. The hearing request must include a copy of CMS's written reconsideration determination (if any), as well as the specific findings with which the plan sponsor disagrees and the reasons for the disagreements. CMS then provides written notice of the hearing date at least 10 days before the scheduled date for the hearing. A CMS hearing officer conducts the hearing, but will not receive testimony or accept any new evidence; thus, the plan sponsor must include all information in the first stage of the appeal in order for it to be used in the subsequent levels of appeal. The CMS hearing officer will review the record from its initial determination and the reconsideration only. If CMS did not issue a written determination on reconsideration, the hearing officer may request a written statement explaining its determination or CMS or its contractor may submit such an explanation on their own. The CMS hearing officer will decide the case and send a written determination explaining the decision to the plan sponsor. The CMS hearing officer determination is final and binding unless it is reversed by the Administrator pursuant to a review request filed within 15 days of receipt of the CMS hearing officer determination.⁸¹

⁷⁸ 42 C.F.R. Part 423, § 423.890 (2005).

⁷⁹ 42 C.F.R. Part 423, § 423.890(b)(2) (2005).

⁸⁰ 42 C.F.R. Part 423, § 423.890(a)(3) through (7) (2005).

⁸¹ 42 C.F.R. Part 423, § 423.890(b) and (c) (2005).

The third and final level of review is performed by the Administrator provided the requested review is received within 15 days of the plan sponsor's receipt of the CMS hearing officer's determination. The Administrator reviews the record before the Hearing Officer and decides whether to uphold, reverse or modify the decision. The Administrator's decision is final and binding, unless CMS decides to reopen the decision upon its own motion or upon the request of the plan sponsor.⁸² A decision can be reopened within one year of the notice of determination for any reason, within four years for good cause, or at any time if the underlying decision was obtained through fraud or similar fault.⁸³ A notice the determination is reopened is sent to the plan sponsor via mail. Good cause exists for reopening only if (1) new and material evidence that was not readily available at the time of the initial determination is furnished, (2) a clerical error in the compilation of payments was made, or (3) the evidence that was considered clearly shows on its face that an error was made. A change in legal interpretation or administration ruling is not good cause. A decision by CMS to not reopen an initial or reconsideration determination cannot be appealed.⁸⁴

22. **Change of Ownership.** If a partnership has a partner removed, added or substituted, unless the partners otherwise agree, they will have a change of ownership or "CHOW." If substantially all of the assets of a trade or business of a plan sponsor are sold to another party, this is also a CHOW. The merger of a plan sponsor's corporation into another corporation where the plan sponsor is not the surviving entity is also a CHOW. If the plan sponsor is the surviving entity there is no CHOW. If a plan sponsor has a CHOW, it must notify CMS of the CHOW at least 60 days before the anticipated effective date. If the CHOW results in a transfer of the liability for retiree prescription drugs costs, the existing sponsor agreement is automatically assigned to the new owner. The new owner is subject to all the applicable laws and the terms and conditions of the sponsor agreement.⁸⁵
23. **Effective Date.** There was not separate effective date for the section enacting the subsidy payment. However, the Medicare prescription drug benefit did not become effective until January 1, 2006, and since the subsidy is tied to the Medicare prescription drug benefit, there would have been no subsidy until the costs were incurred by the retiree plans instead of the Medicare program beginning January 1, 2006.⁸⁶ If the employer intends to apply for the subsidy, the employers must consider that they must establish agreements with their retiree plan and must review plan documents, plan designs and options so that effective communication with the retirees can be developed and the employer can determine who will enroll in its plan so it can file its application for its subsidy with CMS by September 30 for plans with a calendar year plan year, or at least 90 days prior to the beginning of the plan year for plans with a non-calendar year plan year.

⁸² 42 C.F.R. Part 423, § 423.890(c) and (d) (2005).

⁸³ *Id.* at § 423.890(d).

⁸⁴ 42 C.F.R. Part 423, § 423.890(d) (2005).

⁸⁵ 42 C.F.R. Part 423, § 423.892 (2005).

⁸⁶ Act section 101 enacting SSA section 1860D-1(a)(2) for the Medicare Part D effective date; special effective dates are provided at 42 C.F.R. Part 423, § 423.38 (2005).

- C. **Accounting for Retiree Medical Benefits.** A potential buyer of a company sponsoring a retiree medical benefit plan should understand the basic principles of accounting that govern the financial reporting for such a plan and the various ways in which actuaries estimate the costs for such benefits and the assumptions made in calculating the estimated liability.

The Statement of Financial Accounting Standards No. 106 (“FAS 106”)⁸⁷ requires the sponsor of the retiree medical plan to recognize expenses arising from the plan on its financial statements and recognizing the liability in footnotes to the financial statements. Prior to the implementation of FAS 106, employers were permitted to utilize cash-basis accounting for retiree benefits, not recognizing expenses arising from retiree medical plans until the employer actually paid the claim or premium, as provided for under the plan. Recognizing the large future liabilities imposed by retiree medical plans, the Financial Accounting Standards Board (“FASB”), the body responsible for establishing and improving standards of accounting and financial reporting, took the position that an employer’s failure to disclose liabilities related to retiree benefits plans, arising in part because of the practice of cash-basis accounting, misled potential investors, buyers and shareholders about the financial condition of the employer. Investors, buyers and shareholders were misled by the fact that the sponsor of the retiree medical plan had an obligation to pay for medical benefits for its future retirees, but the sponsor’s financial statements were not required, and thus did not recognize the obligation. Even if the retiree medical obligations were recognized as current liabilities on the sponsor’s financial statement prior to FAS 106, the current obligations recognized typically were not indicative of the scope of the future obligation, particularly if the company presently only had a handful of retirees covered under the plan.

To remedy this problem, FASB took the position that post-retirement welfare benefits were actually a form of deferred compensation, much like pension benefits under a defined benefit plan. Under that theory, an employee earns a portion of his or her post-retirement benefit each year that the individual works. Accordingly, FAS 106 requires employers to implement an accrual basis of accounting with respect to their retiree medical plans, under which employers must recognize the cost of providing retiree medical benefits not when the benefits are actually paid, but rather when the employee earns the right to the benefits. This required recognition of the accrual as an expense on the income statement, but did not require a balance sheet presentation of the full potential liability.

Generally, FAS 106 requires employers sponsoring retiree medical plans to do the following:

1. recognize the expense associated with making the change from cash-basis to accrual accounting. The Employer can recognize this amount immediately or amortize it over a period of time;
2. estimate the future costs of providing post-retirement benefits to its employees, and then recognize a portion of that amount as an expense on its annual financial statement. The employer must estimate the gross claims for each age at which an

⁸⁷ While FASB recodified all its pronouncements, we will refer to them with the familiar former references here for ease of understanding.

employee is expected to receive a benefits under the plan. This amount is then reduced by any cost-sharing provisions in the plan, like deductibles, co-payments and retiree contributions, and anticipated reimbursements by Medicare; or

3. treat the difference between the accrued expenses and actual payment as a liability on their balance sheet.

Future liabilities under the plan will be calculated actuarially using assumptions regarding whether employees will work to retirement age, the rate of inflation for medical benefits for the retiree's life, how long an individual will live after he or she retires, and how much Medicare benefits will be reduced in the future. The difficulty inherent in predicting the economic and political trends that will govern the rate of medical inflation, cost of new or improved medical technology and prescription drugs, and how much Medicare benefits will be decreased, makes it difficult to accurately determine the amount of liability imposed by retiree medical benefits. A potential acquirer of a company sponsoring a retiree medical plan must remain mindful of the difficulty inherent in predicting the future costs associated with such a plan and make appropriate adjustments in reserves required to be transferred in the purchase price, in escrowed amounts or the duration or scope of indemnifications.

FAS 106 does not require the employer to set aside cash to fund post-retirement obligations, so it does not affect the employer's actual cash-flow. However, FAS 106 does reduce the employer's net earnings since each year the employer recognizes a portion of the cost related to providing post-retirement benefits as an expense, rather than deferring the recognition until the claim is actually paid. The employer also recognizes an increase in its liability for the benefits if the employer does not fund a reserve to pay for such benefits.

Furthermore, because the sponsor is required to keep track of information regarding the demographics of their workforce, the cost of providing post-retirement benefits, and the projected rate of medical inflation, the administrative costs associated with maintaining a post-retirement benefit plan are necessarily increased by FAS 106. A potential acquirer of a company maintaining a post-retirement medical benefit plan should be mindful of the administrative costs associated with maintaining a plan when negotiating which party will be responsible for which liabilities under the plan. Part of the negotiations will include:

1. the amount of benefits accrued for active workers transferred and the liability related thereto;
2. the cost of benefits accrued for retirees transferred and the liabilities related thereto;
3. the amount of funding or reserves that may be transferred with respect to the active employees and retirees for when the liability will be transferred to the acquiring company; and
4. the actuarial methods and assumptions used to calculate each of the above.

Nevertheless, the required disclosures under FAS 106 will provide a potential acquirer of a company maintaining a retiree medical benefit plan with a more complete picture of the

potential liabilities arising from the post-retirement benefit plan that the acquirer will be subject to if he decides to assume the responsibility of sponsor of the plan. Specifically, FAS 106 requires employer's financial statements to include the following:

1. a complete description of the substantive post-retirement benefit plans maintained by the employer, including the cost-sharing provisions, and any modifications thereto, within the plan;
2. the employee groups covered by the plan;
3. the types of benefits available under the plan;
4. the funding of the plan;
5. the assets held by the plan; and
6. any significant non-benefit liabilities.

The employer's financial statement should also include information regarding:

1. the net cost of post-retirement benefits;
2. health care cost trend rates; and
3. the average of assumed discount rates used to measure the accumulated post-retirement benefit obligation.

FAS 106 requires employers to report liabilities arising from retiree benefits on financial statements regardless of whether the sponsor is required by law to continue the benefits, as long as it is reasonable to expect that benefits will continue to be provided to retirees. While FAS 106 requires disclosure of some of the basic information, additional investigation is required into the assumptions made and the methods used in the calculations of the liability by the actuaries to estimate the liability reflected in the range of potential calculations.

Financial Accounting Standards Board Statement 132, *Employers' Disclosures About Pensions and Other Post-Retirement Benefits* ("FAS 132") standardized the disclosure requirements for pensions and other post-retirement benefit plans to the extent practicable and required additional information on changes in the benefit obligations and the fair value of assets. On December 23, 2003, the FASB issued Revised FAS 132 which updated employers' disclosures about post-retirement benefit plans under FAS 106 and FAS 132. Revised FAS 132 does not change the accounting and disclosure requirements imposed by FAS 106 and FAS 132, it merely imposes additional disclosure obligations.

The accounting requirements adopted in FAS 106, as well as the new disclosure requirements promulgated in Revised FAS 132 are described below.

- D. FAS 132 – Disclosures.** Revised FAS 132 amends FAS 106 and updates FAS 132 by requiring sponsors of retiree medical plans to make additional disclosures regarding the assets, obligations, cash flow and costs associated with retiree medical plans and applies for public companies generally for disclosures in corporate fiscal years ending after

December 15, 2003. According to Revised FAS 132, information required to be disclosed about pension plans generally should not be combined with the information required to be disclosed about other post-retirement benefit plans, such as retiree medical plans. Revised FAS 132 generally became effective for fiscal years ending on or after December 15, 2003.

The following disclosures must be made by retiree medical plans under Revised FAS 132:

1. For each major category of plan assets, which shall include at a minimum equity securities, debt securities, real estate and all other assets, the percentage of the fair market value of all of the assets held as of the measurement date. FAS 132 encourages the disclosure of additional asset categories and additional information regarding specific assets in a category if the information would be useful in understanding the risks associated with each asset category.
2. A narrative description of investment policies and strategies, including target allocation percentages or ranges of percentages for each major category of plan assets presented on a weighted average basis as of the measurement date of the latest statement of financial position presented (if used), and other pertinent factors such as investment goals, risk management practices, allowable and prohibitive investment types including the use of derivatives, diversification and the relationship between plan assets and plan obligations. If a plan does not use a target allocation as part of its investment strategy, it is not required to create one in order to meet this disclosure requirement.
3. A narrative description of the basis used to determine the overall expected long-term rate of return on assets assumption, such as the general approach used, the extent to which the overall rate of assumption was based on historical returns and the extent to which adjustments were made to those historical returns and how those adjustments were determined.
4. A disclosure of the benefits expected to be paid in each of the next five fiscal years, and the aggregate for the succeeding five fiscal years. The expected benefits should be estimated based on the same assumptions used to measure the company's benefit obligation at the end of the year and should include estimated future employee service. This required disclosure is not effective until fiscal years ending on or after June 15, 2004.
5. A disclosure of the employer's best estimate, as soon as it is reasonably determinable, of contributions expected to be paid to the plan during the next fiscal year beginning on or after the date of the latest statement of financial position. Estimated contributions may be presented in the aggregate combining (1) contributions required by funding regulations or laws, (2) discretionary contributions, and (3) non-cash contributions. For retiree medical plans the amount required by this disclosure should be the amount equal to the amount of expected benefit payments less participant contributions.
6. A disclosure, on a weighted-average basis, of the following assumptions used in accounting for plans: assumed discount rates, expected long-term rates of return

on plan assets specifying in a table the assumptions used to determine the benefit obligation and the assumptions used to determine the net benefit cost.

7. A disclosure of the measurement dates used to determine the benefit measurements that make up at least the majority of the plan assets and benefit obligations.
8. The following disclosures must be made on interim financial statements that include a statement of income:
 - a. The amount of net periodic benefit cost recognized for each period in which a statement of income is presented, showing separately the service cost component, the interest cost component, and the expected return on plan assets for the period, the amortization of the unrecognized transition obligations or transition asset, the amount of recognized transition gains or losses, the amount of prior service recognized, and the amount of gain or loss recognized due to a settlement or curtailment.
 - b. The total amount of the employer's contribution paid, and expected to be paid during the current fiscal year, if this amount is different than the amounts previously disclosed.

E. Financial Accounting and the Act's Subsidy.

1. **FASB Staff Position No. FAS 106-2.** FASB Staff Position No. FAS 106-2 ("FSP 106-2") provides guidance on accounting for the effects of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the "MMA"). FSP 106-2 supersedes FSP 106-1, but considers the elections made by the plan sponsors in determining the appropriate accounting treatment and disclosures to be made. FSP 106-2 was posted on May 19, 2004, generally effective for annual periods beginning after June 15, 2004; however, for a non-public entity that sponsors one or more defined benefit post-retirement health care plans that provide prescription drug coverage, but of which no plan has more than 100 participants, then FSP 106-2 is effective for the fiscal years beginning after December 15, 2004, and earlier application is discouraged. FSP 106-2 only applies if the employer has concluded its defined benefit post-retirement health care plan covering prescription drugs is actuarially equivalent to the Medicare Part D benefit and the expected subsidy will offset or reduce the employer's share of the cost of the post-retirement prescription drug coverage. FSP 106-2 does not address situations where the subsidy may exceed the employer's share of the cost for multiemployer health plans.

FSP 106-2 requires the employer to initially account for the subsidy as an actuarial experience gain and to include it in measuring the costs of benefits attributable to current service as part of net periodic post-retirement benefit costs. Any changes in the expected subsidy from the regulations, legislation or changes in the underlying estimates of post-retirement drug costs or for reasons other than plan amendment the change in estimate is treated as an actuarial experience gain or loss.

FSP 106-2 requires certain disclosures in financial statements for interim and annual periods regarding the existence of the MMA, the fact that measures of the accumulated post-retirement benefit obligations (“APBO”) or net periodic post-retirement benefit costs do not reflect any amount associated with the subsidy because the employer is unable to conclude whether the benefits provided by the plan are actuarially equivalent to Medicare Part D under the Act. When the first interim or annual financial statements for the first period in which any employer includes the effect of the subsidy in measuring the net periodic post-retirement benefit costs, it shall disclose (1) the reduction in the APBO for the subsidy related to benefits attributable to past service, (2) the effect of the subsidy on the measurement of net periodic post-retirement benefit costs for the current period, and (3) any other disclosures required.

FSP 106-2 provides two alternatives for transition for a plan that was actuarially equivalent at the date the MMA was enacted and for which the Act was a significant event, FSP 106-2 can either be applied retroactively to the date of enactment of the MMA or prospective from the date of adoption.

Retroactive application requires remeasurement of the plan’s assets and APBO, including the effects of the subsidy as of the earlier of the plan’s measurement date that normally would have followed enactment of the MMA or the end of the employer’s interim or annual period that includes the date of the MMA’s enactment.

Prospective application requires remeasurement of the plan’s assets and APBO, including the effects of the subsidy, if applicable, and the other effects of the Act made as of the beginning of the period or adoption. The remeasurement of APBO is based on the plan provisions in place on the measurement date and shall incorporate current information on actuarial assumptions and discount rates.

If the employer did not elect to defer accounting for the MMA and if the employer’s previous accounting for the effects of the MMA differed from FSP 106-2, then adopting the MMA’s changes cumulative effect under FSP 106-2 will be a change in accounting principles. The change’s cumulative effect to the date the MMA was enacted must be shown in the financial statements. FSP 106-2 includes flowcharts to guide an employer through the analysis depending upon what positions it took with FSP 106-1 and in other areas.

- F. Balance Sheet Liability Recognition Required for Post Retirement Benefit Plans.** Statement of Financial Accounting Standards No. 158, Employers’ Accounting for Defined Benefit Pension and Other Postretirement Plans (“FASB 158”) amending FASB Statements No. 87, 88, 106 and 132R was issued on September 29, 2006, requiring employers to fully recognize the obligations associated with single-employer defined benefit pension, retiree health care and other postretirement plans in their financial statements as liabilities or assets and not just in notes to the financial statements. The delay in recognizing the changes in the obligations and assets that was previously permitted is no longer permitted so the financial statements will more accurately reflect the costs of providing such benefits. Forms 10-Q filed after September 30, 2006, were required to reflect the expected impact of FASB 158. Balance sheets of publicly traded companies must show the asset or liability recognized under FASB 158 on financial statements for fiscal years ending after December 15, 2006. Non-publicly traded

company financial statements must reflect the impact of FASB 158 for fiscal years ending after June 15, 2007.

FASB 158 does not change how the expense or income is reported on the entity's income statement. The asset or liability recognized under FASB 158 is offset by another entry in the financial statement as either a credit or debit respectively under the title of "accumulated other comprehensive income." This only applies to single employer plans and does not apply to multiemployer plans.

Recognition of this new liability may impact an entity's ability to meet its financial ratios and covenants in financing documents and failure to meet such ratios may impact the entity in a number of ways.

Under FASB 158, the funded status of each plan is determined by comparing the fair value of the plan's assets (*i.e.*, the assets that are segregated and restricted to pay plan benefits) and the benefit obligations. For pensions, FASB 158 refers to the pension obligation as the projected benefit obligation or "PBO." For other types of postretirement benefits, the obligation is referred to as the other postretirement benefit obligation or "OPEB."

FASB 158 includes provisions for previously disclosed but unrecognized gains and losses, prior service costs/credits, transition assets/obligations as a component of shareholder equity in accumulated other comprehensive income of "AOCI."

Balance sheet recognition of the actuarially calculated retirees' medical liability impacts a company's debt to equity and other finance ratios which impacts the company's ability to obtain financing and credit. The financial statement impact can also cause a company to have more difficulty in raising capital due to its increased liabilities. The retiree medical costs increase a company's costs and its ability to effectively compete with companies that do not have such legacy costs.

G. Impact of Accounting Standards on Merger and Acquisition Transaction. FAS 106 does not require the employer to set aside cash to fund post-retirement obligations, so it does not affect the employer's actual cash-flow. However, FAS 106 does have the effect of reducing the employer's net earnings since each year the employer recognizes a portion of the cost related to providing post-retirement benefits, rather than deferring the recognition until the claim is actually paid.

Furthermore, because the employer is required to keep track of information regarding the demographics of their workforce, the cost of providing post-retirement benefits, and the projected rate of medical inflation, the administrative costs associated with maintaining a post-retirement benefit plan are necessarily increased by FAS 106 and Revised FAS 132. A potential buyer should be mindful of these additional administrative costs when negotiating which party will be responsible for which liabilities under the plan.

In light of the accounting and disclosure requirements imposed by FAS 106 and Revised FAS 132, negotiations leading up to a merger and acquisition transaction should include discussions of:

1. the amount of benefits accrued for active workers transferred as a result of the transaction, and the liability related thereto;

2. the cost of benefits accrued for retirees transferred and the liabilities related thereto and which retirees, active or former employees for whom the liabilities related thereto are transferred;
3. the amount of funding or reserves that may be transferred with respect to the active employees and retirees for which the liability will be transferred to the buyer; and
4. the actuarial methods and assumptions used to calculate the liability and funding for each of the above.

H. Health Reform Acts' Early Retirement Reinsurance Program. The Early Retiree Reinsurance Program ("ERRP") was established as a temporary program to encourage employers providing early retirees age 55 to 64 (the "Early Retirees") with health coverage to continue to offer such coverage. It was funded with \$5,000,000,000 to reinsure qualified claims of the Early Retirees for claims incurred each year in excess of \$15,000 and up to \$90,000 per Early Retiree.⁸⁸ The program exhausted its funds quickly.⁸⁹ While ERRP's funds are exhausted it lives on as claims continue to be resolved through the administrative process for ERRP and because ERRP requires that the funds be used to lower costs for the plans receiving the ERRP funds.⁹⁰ Such use can be lowering premium contributions, copayments, deductibles or other out-of-pocket costs for the participants and the employee must maintain its contribution toward the retiree medical benefits. CMS has issued guidance on the "maintenance of contribution" requirements.⁹¹

An entity that acquires an employer with a retiree medical plan obligation, currently or at any time since 2010, in a manner in which it may be acquiring the funds such employer received from ERRP needs to know whether the ERRP reimbursements have been fully utilized in compliance with ERRP's requirements, and if not, how much remains from the ERRP reimbursements which is subject to the maintenance of contribution requirement. The acquiring entity should also obtain the historical records of the employer's contributions toward the coverage.

ERRP was not restricted to just retiree plans and some employers filed for ERRP reimbursements related to COBRA coverage provided to former employees. The Early Retiree age group so is any acquisition where the target has a health plan, the inquiry regarding whether ERRP reimbursements were obtained, fully used or remaining to be used must be made.

I. Health Reform, the Retiree Only Plan Exemption and the Impact of Corporate Transactions. When an entity acquires another entity and either entity has a retiree medical plan for which it has used the "retiree only" plan exemption to avoid application

⁸⁸ § 1102.

⁸⁹ 76 Fed. Reg. 77537 (December 13, 2011) Notice of ERRP ceasing to accept claims incurred as of December 31, 2011.

⁹⁰ PPACA § 1102(c)(4); 45 CFR § 149.200 (2010).

⁹¹ Center for Medicare and Medicaid Services "Guidance on Complying with the Maintenance of Contribution Requirement Associated with the Prohibition on Using Early Retiree Reinsurance Program Reimbursements as General Revenue" Revised February 27, 2013.

of Health Reform’s mandated changes regarding whom and what benefits are covered,⁹² the entities should carefully review whether either entity’s retirees are employed by the other entity because once the entities become part of the same controlled group, they may be treated as one employer. If two or more retirees of entity A are employed by entity B and entity A and B combine so that one of the combined entity’s retiree plans now covers two or more active employees on the first day of the plan year, the exemption may be lost as of the first day of the next following plan year.⁹³ There is no clarification regarding whether the controlled group rules will determine what constitutes the employer under the Public Health Service Act provisions, but if those rules are incorporated or brought in via the tax provisions interrelationship with the Public Health Service Act provisions of Health Reform, then the sudden loss of exemption could be very costly for the retiree only plan. While FAQ 111 addressed the retiree only plan exemption, it did not address the exemption considering its application in the context of mergers and acquisitions.⁹⁴

J. Methods of Funding Post-Retirement Medical Benefits. Following implementation FAS 106 many employers dropped their retiree medical benefit plans or froze the individuals eligible for retiree medical benefits. The recognition of the financial statement liability and expense created tension between FAS 106 and 158’s requirement that future liabilities be currently accounted for, and the fact that an employer’s ability to pre-fund benefits on a tax favored basis is limited by Section 419 and 419A of the Internal Revenue Code of 1986, as amended (the “Code”). Ideally, there would be a funding vehicle available to offset the balance sheet liability imposed by FAS 106 and 158, and allow sponsoring employers to pre-fund benefits much the same way that pension benefits are pre-funded.

Employers are restricted to a limited set of mechanisms to fund retiree medical benefit plans. Some of the more common methods for funding retiree medical benefits are through voluntary employees’ beneficiary associations (“VEBAs”) under section 501(c)(9) of the Code, Code section 401(h) accounts, and through HSOP’s. While this article does not explore in depth the various funding mechanisms, a potential acquirer will want to be mindful of how the seller’s plan is funded, and the tax liabilities that can arise out of the employer’s funding mechanism and the restrictions applicable to each funding mechanism.

In recent years employers and unions have negotiated settlements regarding retiree medical benefits that are funded by VEBAs to move the liability for some or all of the retiree medical benefits off the employer’s balance sheet. This is done by providing for funding of the VEBA and providing for the VEBA to be maintained by trustees independent of the employer. VEBAs are first described generally below and then the VEBAs used to move OPEB off the balance sheet are discussed.

1. VEBAs in General. One of the most common mechanisms for funding retiree medical benefits are VEBAs under section 501(c)(9) of the Code. VEBAs are trusts (or sometimes corporations) that are subject to the Code requirements that are only briefly touched on in this article, which if followed, enable the earnings on the trust to be exempt from federal income tax. VEBA trusts can be

⁹² PHSA § 2722, 42 U.S.C. § 300gg-21.

⁹³ *Id.*

⁹⁴ U.S. Department of Labor FAQs About the Affordable Care Act Implementation – Part III, October 12, 2010.

structured to fund the liability recognition required by FAS 106 so that the employer contributions for retiree benefits be sufficiently segregated to ensure that the assets will be used to offset the employer's liability for retiree health benefits contained on its financial statement. VEBA trusts are subject to the nondiscrimination requirements imposed by Code section 105(h) and discussed below. VEBAs are subject to the deduction limits imposed by section 419 and section 419A of the Code. Code section 505(b) provides additional nondiscrimination requirements if other nondiscrimination requirements are not applicable under the same chapter of the Code.⁹⁵ VEBA funding can also result in unrelated business income and the related tax on reserves accumulated later under Code sections 512 and 419 and 419A.

Failure to follow the Code's rules on VEBAs may subject the plan sponsor to tax liability resulting in the corporation's loss of the deduction for the employer's contribution to the fund and taxation of the earnings on the funds held in the VEBA trust and unrelated business income tax on excess additions. For example, the failure to follow Code rules regarding account limitations on the permitted amount of reserves in the trust may result in the employer losing the tax deduction for funding the reserve for post-retirement medical benefits. Additionally, if the retiree medical benefits in reserve exceed the limitations contained in Code section 419A(c)(2) and none of the limit exceptions apply (for example, the reserves are based on the cost of future retiree coverages amortized over less than their remaining working lives) the VEBA could be subject to tax on the excess under the unrelated business income tax provisions.

On February 13, 2003, the U.S. Tax Court issued its opinion on *Wells Fargo Company v. Commissioner*⁹⁶ changing the previous interpretation of what is deductible under Code sections 419 and 419A under *General Signal Corp. v. Commissioner*⁹⁷ and regarding the establishment of reserves for the funding of retiree benefits. In the *Wells Fargo* case, the tax court allowed an employer to deduct the entire present value of the post-retirement medical benefits funded for current retirees when they were funded in one year.

a. ***Wells Fargo and Company v. Commissioner of Internal Revenue***⁹⁸

The issue in this case revolved around the amount an employer may deduct for contributions made to a VEBA trust to provide post-retirement medical benefits to covered employees and their eligible dependents and for existing retirees whose benefits had not previously been funded. Specifically at issue was the computation of the account limit for the reserve necessary to fund post-retirement medical benefits for current retirees provided under Code section 419A(c)(2), the "additional reserve funded over the working lives of the covered employees and actuarially determined on a level basis (using assumptions that are reasonable in the aggregate) as necessary for post-retirement medical insurance benefits." The reserve funding for the existing retirees was the focus of the court.

⁹⁵ I.R.C. § 505(b)(3) (2003).

⁹⁶ 120 T.C. 5 (2003).

⁹⁷ 103 T.C. 216 (1994), aff'd 142 F.3d 546 (2d Cir. 1998).

⁹⁸ 120 T.C. 5 (2/13/03).

Wells Fargo funded a reserve actuarially calculated for all current retirees and fully funded the liability and deducted the full amount on establishment of the reserve. The tax court held that the employer's contributions to the post-retirement benefit trust did not exceed the account limit for reserve under section 419A(c)(2), and thus, the employer was entitled to a deduction of the entire contribution, amounting to approximately \$31 million, fully funding the actuarially calculated liability for the retirees assuming they had no further working life over which to fund the liabilities.

An actuary for the plan determined that the present value of future medical benefits was \$14 million for active employees, and \$28 million for retired employees. Then the actuary divided the \$14 million figure for active employees by the "average actuarial present value of future service" for active employees to produce a funding amount of \$2.9 million. Because the retired employees had no more working life, the actuary determined that the present value of future benefits for retired employees remained \$28 million funded over their remaining working lives of the retirees.

Accordingly, the employer made a contribution of \$31 million (\$28 million for retired employees and \$2.9 million for active employees) to a post-retirement medical trust and claimed a deduction for the entire contribution, as an addition to a "qualified asset account" pursuant to Code section 419A(b).

The tax court approved the actuary's computation of the contribution to the post-retirement medical trust and held that contribution did not exceed the account limit for reserve under Code section 419A(c)(2). The court interpreted the provision "reserve funded over the working lives of the covered employees" in section 419A(c)(2) to mean that assets necessary to satisfy the employer's liability for the individual retiree's medical benefits may be accumulated no more rapidly than over the working lives of the covered employees, such that the reserve with respect to an employee can be fully funded no earlier than at the retirement of the employee. Fully funding the reserve for retirees at, or after, retirement is permissible because the assets are accumulated less rapidly than over the working life of the employee.

With respect to the requirement of Code section 419A(c)(2), that the reserve funded over the lives of the covered employees be "actuarially determined on a level basis," the court held that the reserve, with respect to an employee, can not be fully funded earlier than the retirement of such employee. The actuary for Wells Fargo calculated the liabilities using the individual level premium cost method for calculating the liability for the retirees' reserve. Accordingly, the maximum amount of liability that may be satisfied by the reserve is the amount at the time, with respect to which the reserve is computed that, together with the future normal cost and interest, will be sufficient upon the retirement of each employee to pay future medical claims when they become due. The actuarial present value of the projected benefit for each employee should

be allocated on a level basis starting the later of the date that the reserve is created, or when the employee becomes a covered employee, and ending on the date when the employee is expected to retire. Therefore, with respect to employees that have already retired, there are no future years to which benefits may be allocated, so it is proper to allocate the entire present value of the projected benefit to the first year. The court distinguished the prior decision in *General Signal* because in that case the employer had funded amounts and tried to deduct them as a reserve but had not separated or treated the amounts as a reserve and had used them for payment of other benefits. Well Fargo, on the other hand established these amounts as a reserve calculated and set aside to fund the retirees benefits.

A potential buyer should seek legal counsel before merging VEBA trusts, or transferring the assets of one VEBA trust to another to ensure that the transaction will not result in (i) the disqualification of the VEBA as a tax-exempt entity under Code section 501(c)(9), (ii) a reversion to the employer resulting in an excise tax under Code section 4976, or (iii) the income earned on trust being treated as unrelated taxable business income under Code section 512. An employer contemplating the merger of two or more VEBA trusts, or the transfer of assets among VEBA trusts may want to obtain a private letter ruling from the Internal Revenue Service approving the transaction.⁹⁹

2. **Using a VEBA to Settle Retiree Medical Liabilities and move OPEB off the Company's Balance Sheet.** In recent years, several employers have tried to address the growing cost of retiree medical benefits by changing benefits unilaterally. Such changes are generally met with resistance from the relevant union. In several of the cases involving unilateral implementation of changes, the unions and employers have negotiated settlements that resulted in the establishment of a VEBA controlled by an independent fiduciary committee which assumes the responsibility for providing a portion or all of the retiree medical benefits. The union settlements frequently are found in court approved settlements for class actions or pursuant to requests for declaratory judgments filed related to the benefit changes. The VEBA's assumption of the responsibility for provision of the retiree medical is done with the intent of moving the liability for the retiree medical benefits assumed by the VEBA trust off of the employer's balance sheet.

- a. **General Motors Corp. and Ford Motor Company.**

- (i) **First Round**

- GM**

- General Motors Corp. ("GM") and Ford Motor Company ("Ford"), in an effort to contain growing retiree medical costs, proposed to have the retirees share in the cost of their health care

⁹⁹ For example, see PLR 200338023, PLR 200327063, and PLR 200327066.

in 2005. The International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (the “UAW”) claimed the retiree medical benefits were vested and filed an action seeking a declaratory judgment with a class of GM and Ford retirees. Through two similar agreements, the companies, the UAW and the classes proposed to settle the dispute. GM and Ford had negotiated with the UAW over retiree medical benefits since 1955, the retiree benefits were first provided without any company subsidy. In 1961, the companies assumed half the cost and by 1967 the full cost and the benefits covered continued to grow over the years. The majority of both companies’ costs for healthcare for active and retired employees goes toward retiree coverage. In 2005, \$1,525 of the cost of each GM car was for retiree medical coverage.

The UAW refused to discuss the possibility of modifying retiree health coverage in 2005 so GM responded that it would unilaterally reduce the retiree benefits. When no retiree initially filed suit, the UAW then agreed to negotiate on changes provided the company postpone any cuts until negotiations had concluded and that the company fully open its books and share its complete financial data with the UAW. Two retirees, Henry and Lauria, along with the UAW filed suit contesting the changes in October 2005. The settlement covered persons who were retirees as of November 11, 2005 and were otherwise eligible for the GM retiree medical plan for hourly employees. The UAW and GM entered into the first settlement agreement on retiree medical benefits in 2005 related to the UAW & Henry et al v. General Motors, case no. 05-73991 in which certain changes were made to retiree medical benefits for UAW members and which established The UAW and retirees had filed suit under ERISA and the Labor-Management Relations Act, 29 USC §§ 185, 1132 seeking a declaration that GM could not unilaterally change or terminate the retiree health benefits in the collective bargaining agreement.

The first settlement agreement replaced the then current premium-free, deductible-free retiree medical plan with a modified plan with modest monthly premiums and substantial benefits, or a catastrophic plan with no monthly premium, but higher deductibles, copayments and other cost sharing. The settlement preserved benefits for retirees with less than \$8,000 in annual pension income and who have an pension benefit rate of \$33.33 or less per month per year of credited service. The retirees who must pay the new costs will have a portion of those costs paid through a defined contribution VEBA (the “DC VEBA”). Under the first settlement agreement GM was to continue to provide retiree medical benefits to the UAW retirees, but the benefits GM provided were lower and the difference was to be made up partially by the DC VEBA, which GM was to fund. The GM retirees (other than those with less than \$8,000 in

annual pension income and who have an pension benefit rate of \$33.33 or less per month per year of credited service) were to be automatically enrolled in the Modified GM retiree plan when the first settlement was approved. The Modified GM plan reduced some of the very rich benefits and required retirees to pay a modest premium for coverage (\$50 for single and \$105 for family coverage per month), but the DC VEBA would reduce the amount the retirees would initially need to pay for the premiums to a lower amount.

The DC VEBA was to be administered by a committee independent of GM that would not include any representatives of GM. The DC VEBA was to be funded by cash contributions, profit sharing (based on the health care savings from the plan design changes), wage deferrals (employees were to forgo an average of \$1 per hour in deferrals of future wage increases and future cost-of-living allowance increases), stock appreciation (GM was to make a cash contribution to the DC VEBA based on the increase, if any, in the per share price of GM common stock over \$26.75 (the average price of GM common stock for the week ended October 14, 2005) (the increase was to be calculated with respect to the equivalent of 8,000,000 million shares of GM Common Stock, and one third of the value of the increase on the shares was to be added at three dates, the date of the court order approving the settlement, and the first and second anniversary of such date), and dividends (the dividends were to be contributed if GM raised its quarterly cash dividend above \$0.50 per share prior to September 14, 2011, then four quarters of the dividend increase were to be deposited). GM was required to maintain the benefits in the modified retiree plan at that level until December 31, 2011. A hearing was scheduled in March 2006 on the settlement.

A settlement was already framed when the declaratory action was filed. Retirees were given an opportunity to object to any aspect of the proposal at the hearing. Class representatives (through counsel) had reviewed the GM financial data for two months and hired their own consultant to analyze the data. The consultant reported that GM suffered significant financial strain and without cost sharing and other measures, GM's ability to continue to provide retiree health benefits in the future could be endangered. (This was from an opinion issued in August 2007, well before the economic downturn and bailouts in 2008 and 2009, including the government assistance to GM requiring GM to fund a portion of its contribution to the settlement VEBA in its own common stock without regard to any prohibited transaction issue it may cause.) Eleven days later GM and the class representatives agreed to a settlement. The district court approved the settlement covering existing retirees and dependents. Class members were notified of the settlement.

The Eastern District Court in Michigan entered an order approving the settlement on March 31, 2006 and ordered it to remain in effect at least until September 2011. The Sixth Circuit subsequently approved this settlement on August 7, 2007.¹⁰⁰

In GM's Form 8-K¹⁰¹ filing the settlement as a material agreement, it states that, "The reduction in health care expense, which will begin to be realized in the third quarter of 2006, will in the aggregate more than offset the required contributions to the DC VEBA and result in net cost savings of approximately \$13 billion over the Settlement Agreement's initial six-year term. . . Under the accounting treatment that GM believes is appropriate under U.S. Generally Accepted Accounting Principles, the obligation to make the contribution would be recognized in the period in which it becomes due and payable, so that the charge for the first quarter of 2006 would be \$1 billion pre-tax, even though none of the benefit of the agreement will be realized in that quarter. . . GM is currently in discussion with the Staff of the U.S. Securities and Exchange Commission and anticipates that the accounting treatment for the DC VEBA contributions will be resolved definitively before it files a Quarterly Report on Form 10-Q reporting the financial results for the first quarter of 2006."¹⁰²

The accounting treatment was resolved resulting in reductions in the OPEB obligation for retiree medical benefits being reduced by \$17 billion in the 3rd quarter of 2006¹⁰³. GM also indicated in the 3rd Quarter 10-Q that for the \$1 billion contribution to the DC VEBA, it anticipated that there would be a \$5 billion in reductions on an average running rate basis.¹⁰⁴ The average running rate is the average annual cost savings from the change into the foreseeable future when fully implemented.

A fairness hearing was held during which 1,250 retirees objected. The court took declarations from GM, the class and the UAW in favor of the settlement and then certified the class and approved the settlement.¹⁰⁵

The VEBA covers all the U.S. automakers (GM, Ford and Chrysler) but has subaccounts for each company and there is no

¹⁰⁰ *Automobile Aerospace and Agricultural Implement Workers of America v. General Motors Corp.*, 497 F. 3d 615, 41 EBC 1692 (6th Cir. 2007).

¹⁰¹ General Motors Form 8-K as filed with the U.S. Securities Exchange Commission (the "SEC"), filed on April 7, 2006, found at www.sec.gov/Archives/edgar/data/40730/000004073000022/attrition041306item.

¹⁰² *Id.*

¹⁰³ General Motors Corporation, Form 10-Q for the quarterly period ended September 30, 2006 as filed with the SEC, Note 12.

¹⁰⁴ *Id.* at Turnaround Plan.

¹⁰⁵ *Automobile Aerospace and Agricultural Implement Workers of America v. General Motors Corp.*, 497 F. 3d 615, 41 EBC 1692 (6th Cir. 2007).

financial cross subsidization. (Chrysler's information is not publicly available at this time.) GM was to contribute \$3 billion in cash to the VEBA through 2011 and at least \$30 million per year from 2006 through 2012 and additional payments based on increases in GM's stock price. Ford made similar promises. The UAW agreed to fund the VEBA by deferring negotiated wage and cost-of-living adjustments and contributing those to the VEBA, about \$2,000 per year from each active employee in the foregone wages would total \$4 billion of contributions to the trust for the next 20 years. There was some delay necessary to obtain approval of the SEC for the movement of the liability off GM's balance sheet and financial statements to the VEBA trust.¹⁰⁶

An independent committee administers the trust. The funds generated by the VEBA reduce the participant premium contributions (\$10 individual, \$21 family) and out-of-pocket maximums (\$250 individual, \$500 family). The plan coordinates coverage with Medicare so there is no duplication of coverage.¹⁰⁷

Although there is no termination date to the settlement agreement, the companies and the UAW have the right to each terminate the agreement any time after September 14, 2011.

The class representative hired consultants to analyze the settlement and the financial health of the entities. The Sixth Circuit found the class representative did not have a conflict of interest and represented the class vigorously.¹⁰⁸

While some of the class members who objected to the settlement pointed to the *Yard-Man* line of cases in the Sixth Circuit regarding the vesting of retiree benefits, GM and Ford invoked the *Sprague*¹⁰⁹ line of cases upholding the employer's reservation of the right to modify, amend or terminate the plans (*Sprague* was not addressing an employee covered by a collective bargaining agreement). The Sixth Circuit did not decide which line of cases applied or if they applied but looked solely to whether the parties are using settlement to resolve a legitimate legal and factual disagreement and upheld the settlement.¹¹⁰

¹⁰⁶ General Motors Corporation, Memorandum of Agreement dated October 29, 2005, filed on the Form 10-Q for the period ended March 31, 2006 with the SEC on April 13, 2007.

¹⁰⁷ *Id.*

¹⁰⁸ General Motors Corporation, Form 8-K, filed October 10, 2007 with the SEC, Exhibit Memorandum of Understanding.

¹⁰⁹ *Sprague v. General Motors Corp.*, 21 EBC 2267 (6th Cir. 1998).

¹¹⁰ *Automobile Aerospace and Agricultural Implement Workers of America v. General Motors Corp.*, 497 F. 3d 615, 41 EBC 1692 (6th Cir. 2007); Borzi, Phylis, "Retiree Health VEBAs: A New Twist On An Old Paradigm Implications for Retirees, Unions and Employers," March 2009, The Kaiser Family Foundation, pp. 13-15,

Ford

Ford followed a similar course of action and also settled with the UAW by establishing a similar VEBA. Ford's settlement VEBA was funded with \$30 million to be followed with contributions in 2009 and 2011 of \$35 million and \$40 million respectively.¹¹¹

(ii) Second Round

GM

In 2007, GM and the UAW again entered into a Memorandum of Understanding regarding retiree medical costs, a new labor agreement and a new healthcare agreement. The healthcare agreement again addressed retiree medical coverage and costs. In the 2007 agreement, the responsibility for retiree health care will permanently shift from GM to a new retiree plan funded by a new independent VEBA (the "New VEBA") for existing retirees and employees whose employment is subject to the terms of the collective bargaining agreement. Under the agreement the UAW may not negotiate to increase GM's funding of the VEBA or otherwise seek to obligate GM to provide any additional contributions to the New VEBA, make any other payments to provide retiree medical benefits or provide retiree medical benefits through any other means. Employees in the future may contribute the earnings they receive from wages, profit sharing, cost of living adjustments to wages ("COLA") or signing bonuses to the New VEBA. New hires after September 14, 2007 are not included in the New VEBA and will not be offered any defined benefit type of retiree health care. The New VEBA was to be funded assuming asset returns of 9% annually, with the risk borne by the New VEBA, ultimate health care trend rate of 5% annually (*i.e.*, healthcare inflation rate) (New VEBA bears this risk), incorporation of the 2005 retiree health settlement wage and COLA diversions and the use of standard actuarial assumptions. GM was to continue to make the \$1 billion DC VEBA payment from the 2005 agreement in 2011. The potential increase in the stock price profit sharing from the 2005 agreement was capped. The 2005 agreement's wage and COLA diversions were present valued and included in the funding for the New VEBA as a current contribution and the actual wage and COLA amounts are retained by the company.¹¹² Up to 20 payments of \$165 million per year were also required of GM if the cash flow projections show that the New VEBA will become

¹¹¹ Ford Motor Company, Form 10-Q filed on November 14, 2006 with the SEC for the quarter ended September 30, 2006, Note 14.

¹¹² General Motors Corporation, News Release dated October 10, 2007 filed with the SEC, available at <http://www.sec.gov/Archives/edgar/data/40730/000095012407005130/k19262exv10w2.htm>.

insolvent within 25 years.¹¹³ Initial New VEBA funding was to include a \$4.3715 billion convertible promissory note issued by GM.¹¹⁴

GM sought SEC concurrence with the accounting treatment under the negative plan amendment accounting treatment which reduces the liability to the present value of the future obligations as reduced by the plan amendment, with the change in the liability amortized over time. The negative plan amendment treatment arose due to the cap on GM's contributions and not due to the increased cost sharing or reduced benefits, but it requires mutual understanding with plan participants that benefits have been reduced and that all employer contributions will be included in the initial measurement of the capped obligation, including contingent payments. The other type of accounting treatment for a settlement on retiree medical plan obligations is plan settlement when the liability is entirely defeased and removed from the balance sheet and taken as a one-time net gain. The changes in GM's OPEB expense were to be realized beginning in 2010 and 2011 due to the accounting treatment.¹¹⁵ The agreement in 2007 was subject to the SEC's approval of the accounting treatment of the transfer of the liability to the VEBA as either a settlement¹¹⁶ or negative plan amendment¹¹⁷ accounting and final court approval.¹¹⁸

Accounting for the transfer of the retiree medical benefit obligation to a VEBA trust could be treated as either a settlement or as a negative plan amendment.¹¹⁹

¹¹³ General Motors Corporation, Form 8-K, filed October 10, 2007 with the SEC, Exhibit Memorandum of Understanding.

¹¹⁴ General Motors Corporation, News Release dated October 10, 2007 filed with the SEC, available at <http://www.sec.gov/Archives/edgar/data/40730/000095012407005130/k19262exv10w2.htm>.

¹¹⁵ General Motors Corporation, News Release dated October 10, 2007 filed with the SEC, available at <http://www.sec.gov/Archives/edgar/data/40730/000095012407005130/k19262exv10w2.htm>.

¹¹⁶ See FASB Statement 158 at pp. 158-8, 158-30; and FSP FAS 158-1, pp. 108-111 and 173-183.

¹¹⁷ See FASB Statement 158 at pp. 158-51; FSP FAS 158-1, pp. 74-78, 233-241.

¹¹⁸ General Motors Corporation, Form 8-K dated October 10, 2007, as filed with the SEC, Exhibit 10.1.

¹¹⁹ A plan settlement occurs when an obligation for post retirement benefit obligations for current retirees is transferred to an insurer through the purchase of insurance contracts. A settlement can result in recognition of income for the amount of the remaining "accumulated other comprehensive income" which is the account on the asset side of the balance sheet that is debited to offset the recognition of the accumulated post retirement benefit obligation liability account which reflects the projected liability for retiree medical benefits. (*I.e.*, the accumulated other comprehensive income amount is not really an asset of the company, it is just an offsetting entry to the recognition of the accumulated liability for retiree medical benefits. FASB Staff Position, FAS 158-1 pp. 108-111. Negative plan amendment treatment for the transfer to the VEBA is a different accounting treatment. A negative plan amendment accounting treatment applies when there is a plan amendment that decreases benefits. FASB Staff Position, FAS 158-1 pp. 74-76 and 233-242. When negative plan amendment treatment applies, the decrease in the accrued post retirement benefit liability is offset by reductions to amounts that are recognized in the accumulated other comprehensive income account by first reducing prior service cost, then reducing any transition costs and if there are still amounts to offset, by reducing prior service cost to a negative number. *Id.*

The DC VEBA was to be combined with the New VEBA after certain approvals were obtained.¹²⁰ The New VEBA was to have an independent trustee committee of 11 members and if GM determined from its discussions with the SEC staff that GM's proposed accounting treatment would not result if GM participated on the New VEBA's trustee committee, GM had the option to elect not to participate on such committee.¹²¹ The committee has the right to accelerate the other payments due if GM defaults on any payment and assess interest at 9% per annum.¹²²

The second GM Memorandum of Understanding dated September 26, 2007 continues to recognize that the parties do not agree regarding the vesting of any right to benefits and whether the employer has the unilateral right to amend, modify or terminate retiree medical benefits.¹²³ The GM 2007 Memorandum of Understanding was approved by the Eastern District of Michigan on July 31, 2008.¹²⁴

The GM Memorandum of Understanding requires that the funding for the first 20 years consider whether the funding is sufficient for providing 25 years of benefits. If the funding was not sufficient to provide 25 years of benefits at any time during the first 20 years, the agreement required a set contribution. It includes an acceleration of all payments due in the event GM defaults on any payment.¹²⁵ The second settlement requires GM to pay into the outside VEBA and transfer from its existing VEBA at least \$17.7 billion; however prior to approval of the second settlement GM faced an undiscounted \$27.1 billion obligation. The second settlement reduced GM's accrued other post employment benefit obligations for retiree medical by \$13.1 billion from the level measured at May 31, 2008.¹²⁶ The prohibited transaction exemption related to the second round settlement for GM was approved in 2009.¹²⁷

Ford

Ford's process followed a similar route and entered a settlement approved by the court regarding existing retirees and their

¹²⁰ General Motors Corporation, Form 8-K, filed October 10, 2007 with the SEC, Exhibit Memorandum of Understanding.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *International Union, United Autoworkers, Aerospace, and Agricultural Implementation Workers of America v. General Motor Corporation*, 2008 WL 2968408 (E.D. Mich.).

¹²⁵ *Id.*

¹²⁶ General Motors Corporation, Form 10-Q for the quarter ended September 30, 2008, as filed with the SEC, see Notes to the Financial Statements.

¹²⁷ PTE 2009-03.

dependents initially placing limits on the benefits and imposing premiums using a DC VEBA. Ford entered into a second memorandum of understanding with the UAW similar to the one described above for GM which transferred full liability for future retiree medical obligations for union employees and retirees to the new independent VEBA.¹²⁸

Ford then entered a settlement agreement with a Memorandum of Understanding – Post Retirement Medical Care dated November 3, 2007, and a Settlement Agreement dated March 28, 2008.¹²⁹ Ford's settlement was also subject to court approval and effective upon pre-clearance with the SEC of satisfactory accounting treatment for post retirement healthcare benefits. It was approved by the court on August 29, 2008 and became effective that date with a final implementation date of December 31, 2009. Ford agreed to provide the VEBA with \$2.73 billion in cash, a \$3 billion principal amount secured note with 9.5% interest per annum, a \$3.3 billion convertible note at 5.75% per annum and an obligation to make 15 annual installments of \$52.3 million beginning in April 2008. This reduced Ford's accumulated post retirement benefit obligations from \$19.4 billion to \$14.7 billion and recognized an actuarial gain of \$4.7 billion.¹³⁰

(iii) **Round 3**

Ford

Ford announced on March 11, 2009 it had negotiated a new agreement with UAW which provided an addendum to the VEBA. The addendum permits Ford to contribute up to \$6.5 billion of its funding obligation in company stock rather than cash. However, if Ford's stock price falls below \$1, the company gives up its ability to fund the VEBA obligation in company stock rather than cash. Previously, the contribution was to have been made solely in cash.¹³¹ Ford's 2009 Proxy requested approval of two resolutions permitting issuance of additional common stock to fund Ford's liability under the revised settlement and approving issuance of shares to an affiliate (the VEBA) to comply with the NYSE Manual. The 2009 Proxy also detailed the funding obligation by year and that the revised settlement was subject to obtaining a prohibited transaction exemption and court approval. The settlement was

¹²⁸ Ford Motor Company, Form 8-K filed on November 15, 2007 with the SEC, Memorandum of Understanding, dated September 26, 2007.

¹²⁹ Ford Motor Company, Form 8-K filed on April 7, 2008 with the SEC.

¹³⁰ Ford Motor Company, Form 10-Q filed on November 7, 2008 for the quarter ended September 30, 2008, pp. 20-23.

¹³¹ BNA Daily Labor Report, 44 DLR A-12-13, March 12, 2009.

subject to obtaining a prohibited transaction exemption for the transaction. A proposed exemption was filed and published.¹³² The final exemption was granted in 2010.¹³³

Chrysler

Chrysler followed Ford and GM in the first two rounds. On April 30, 2009 Chrysler filed for bankruptcy in the bankruptcy court of the Southern District of New York.¹³⁴ On June 10, 2009 Fiat purchased a portion of Chrysler and Chrysler exited bankruptcy. When Chrysler exited bankruptcy, fifty-five percent of Chrysler's stock was to be held by the UAW retiree medical VEBA.¹³⁵ Chrysler filed for another prohibited transaction in 2009 which was granted in 2010.¹³⁶

GM

General Motors filed for bankruptcy on June 1, 2009. While the salaried retirees have requested Bankruptcy Code protection under § 1114, the filings in the first few days of the GM bankruptcy reflected that a settlement had been reached with the UAW regarding the retiree medical benefits for its members. However, the initial filings did not include the exhibit which included the Memorandum of Understanding with the UAW.¹³⁷

The GM bankruptcy proposed to cut the liability to the UAW retiree medical VEBA from \$20 billion to \$9 billion in notes and preferred stock with a \$600 million annual dividend, resulting in the UAW VEBA owning 17.5% of the reorganized GM.¹³⁸

- b. **AK Steel**. In a separate settlement with a union, AK Steel established a VEBA to fund retiree medical obligations. The company's collective bargaining agreement expired on February 28, 2006 and the parties could not reach an agreement. The union voted to strike and the company locked the union out on March 1, 2006. On June 1, 2006, the company announced the termination of its retiree medical plan effective October 1, 2006 and implementation of a new plan with monthly premiums and

¹³² Fed. Reg. 30631, 30635 (January 26, 2009).

¹³³ 75 Fed. Reg. 14192 (March 24, 2010).

¹³⁴ <http://www.chryslerrestructuring.com>.

¹³⁵ "U.S. Trims Final Loan to Chrysler," Wall Street Journal, B-5, Saturday/Sunday June 13, 14, 2009; Chrysler exiting bankruptcy was proposed to be owned 55% by the UAW Retiree Medical VEBA."

¹³⁶ 75 Fed. Reg. 21668 (April 26, 2010).

¹³⁷ Debtors Motion Pursuant to 11 U.S.C. §§ 105, 363(b), (f), (k) and (m) and 365 and Fed. R. Bankr. P. 2002, 6004 and 6006 to (I) Approval of (A) the Sale Pursuant to the Master Sale and Purchase Agreement with Vehicle Acquisition Holdings, LLC, a U.S. Treasury-Sponsored Purchaser, Free and Clear of Liens, Claims, Encumbrances, and Other Interests; (B) the Assumption and Assignment of Certain Executory Contracts and Unexpired Leases, and (C) Other Relief; and (II) Schedule of Sale Approval Hearing, *In re: General Motors Corp.*, Case No. 09-50026(REG)(BRL) (Bank. S.D.N.Y. June 1, 2009).

¹³⁸ "GM in Final Lap to Chapter 11 As Bondholder Offer Sweetened," Wall Street Journal A-12, May 29, 2009.

reduced benefits. The company and retirees settled the lawsuit in October 2007 by creating a VEBA for the 4,600 retirees. The level of agreed contributions to the VEBA matched the projected liabilities for the promised benefits as calculated by actuarial consultants. There are five trustees, three from the retirees and two public trustees. The company is contributing \$663 million over four years with an initial payment of \$468 million. The actuarial projections are that the fund will fully fund benefits for 40-50 years.¹³⁹

The AK Steel Corp. was not in bankruptcy and was noted by the court to be financially strong, but the court found that did not defeat the settlement because it was better for the steel company to pay the funds now rather than hoping the company will continue to operate profitably for the next 40 to 50 years.¹⁴⁰ The court recognized the tumultuous nature of the steel industry and the fact that many companies in that industry had gone bankrupt; and if the company were on the verge of bankruptcy, it would not be in a position to fund the VEBA. The court noted how downturns in the industry had hurt many retirees in the past leaving them without any medical insurance (e.g., the LTV bankruptcy). The court considered how recently the company had “teetered on the brink of bankruptcy” and found that militated toward accepting the VEBA funding now to protect the retirees.¹⁴¹ The settlement required AK Steel Corp. to fund the VEBA initially with \$468.0 million in cash and to make three annual payments of \$65.0 million each for a total contribution of \$663.0 million. This covered \$1.0 billion of the Company’s \$2.0 billion OPEB liability for all retirees. It was accounted for as a negative plan amendment.¹⁴² There will also be a net annual reduction in periodic benefit costs associated with the settlement of \$30.0 million in addition to the lower interest costs related to the reduction in the OPEB liability.¹⁴³

On June 18, 2009, retirees of AK Steel Corp. who were once represented by the Butler Armco International Union filed suit alleging AK Steel Corp. violated federal labor laws by making unilateral modifications to their retiree medical benefits. This is a separate union from the union that entered into the settlement agreement with the VEBA.¹⁴⁴ The retirees allege there were promises of lifetime benefits back to 1947.

¹³⁹ Borzi, Phylis, “*Retiree Health VEBAs: A New Twist On An Old Paradigm Implications for Retirees, Unions and Employers*,” March 2009, The Kaiser Family Foundation, p. 16; *Bailey v. AK Steel Corp.*, 43 EBC 2593 (S.D. Ohio 2008).

¹⁴⁰ *Bailey v. AK Steel Corp.*, 44 EBC 2593, 2597 (S.D. Ohio 2008); Affirmed (6th Cir. No. 08-3166, unpublished April 7, 2008).

¹⁴¹ *Id.* at 2598.

¹⁴² AK Steel Holding Corporation, Form 10-Q filed with the SEC on May 5, 2008, for the quarter ended March 31, 2008.

¹⁴³ AK Steel Holding Corporation, Form 10-K filed with the SEC on February 24, 2009, for the year ended December 31, 2008.

¹⁴⁴ “*AK Steel Retirees File New Lawsuit Seeking Reinstatement of Medical Benefits*,” 36 BNA Pension Reporter 1571 (June 30, 2009).

- c. **Dana Corporation.** Dana Corporation (“Dana”) established VEBA’s for both union and non-union retirees. In bankruptcy Dana had filed motions to reject its collective bargaining agreements with the United Auto Workers (“UAW”) and the United Steel Workers (“USW”) and to modify their retiree benefits pursuant to Sections 1113 and 1114 of the Bankruptcy Code with respect to certain facilities. A hearing and trial was held on such motions. Dana’s OPEB as of December 31, 2006 was \$1 billion.¹⁴⁵ A settlement was negotiated with the UAW and USW that was approved as part of the plan of reorganization. The settlement eliminated \$220 million of annual legacy costs. The VEBA’s were created via settlement agreements with the two unions, the UAW and the USW while Dana was in bankruptcy and Dana obtained bankruptcy court approval to reject their collective bargaining agreements and to modify/terminate all three of its retiree medical plans. The settlement agreements required the establishment of two union VEBA’s. The settlement with the non-union retirees provided for the company to continue to pay for retiree medical benefits through July 1, 2007. The non-union VEBA immediately changed its benefit delivery structure. The Company maintained the union retiree benefits until the later of January 1, 2008 or the effective date of a plan of reorganization and after such date, the union retiree benefits will be provided by the VEBA formed in the settlements with the unions approved by the bankruptcy courts. The bankruptcy court approved the settlement on August 1, 2007.¹⁴⁶ The retiree committee (for non-union retirees) had the authority to create new health insurance and there was no requirement the benefits remain the same. The company made a one-time payment of \$78 million to the non-union VEBA and \$700 million in cash and \$80 million in company stock of the reorganized company to the union VEBA.

The settlement agreement with the two union groups allows modification of the benefits to keep the trust solvent. The union VEBA’s have a seven-member board with four public members who must be independent experts and three members appointed by the unions. The Company does not appoint any members.¹⁴⁷ An independent fiduciary controls the trust’s interest in the employer securities. The settlement indicates the company and the unions may negotiate an arrangement in which compensation that would otherwise go to active workers would be contributed to the VEBA.¹⁴⁸ There are two separate union VEBA’s, one for the UAW and one for the USW. The settlement agreement for the VEBA for the USW requires the company to contribute \$275.1 million in cash and \$31.3 million in stock in the reorganized company; however, if that amount of stock would cause the contribution of company stock to

¹⁴⁵ Order Pursuant to 11 U.S.C. §§ 1113 and 1114(e) and Federal Rule of Bankruptcy Procedure 9001, Approving Settlement Agreements with the United Steelworkers and United Autoworkers, and Pursuant to 11 U.S.C. §§ 105(a), 363(b), 364(c), 503 and 507, Authorizing the Debtors to Enter Into Plan Support Agreement, Investment Agreement and Related Agreements, *In re: Dana Corporation*, Case No. 06-10354 (BRL) (Bankr. S.D. N.Y. August 1, 2007).

¹⁴⁶ Borzi, Phylis, at p. 16.

¹⁴⁷ Borzi, Phylis, at p. 16.

¹⁴⁸ Borzi, Phylis, at pp. 12-13.

constitute a prohibited transaction then the value of the stock contribution is reduced to a level that will not constitute a prohibited transactions and the balance of the contribution is to be made in cash. The Company's maximum contribution is \$306.4 million.

The VEBA is governed by a Committee comprised of seven members, three appointed by the USW and four independent experts not affiliated with the Company or the union with expertise in health care, employee benefits, ERISA, asset management or similar qualifications. The independent trustees appoint their successors. The settlement agreement included a requirement that the Company continually provide the union with financial data (e.g., income and cash flow statements, materials costs, labor costs, SG&A expenses, budget information), quality, productivity, efficiency and safety reports with each facility's union representatives in a monthly meeting and it shall also be provided to the USW. The USW shall be able to request meetings with the Company's Comptroller no more frequently than quarterly to review the financial data. The Company shall also provide the USW with projected sales, costs and operating results along with the range of assumptions used in preparing the operating budgets, management reports/analysis submitted to corporate or divisional headquarters on the facility's performance for the last quarter and year end and identification of any unusual or non-recurring costs/write offs/income in the financial statements or projections, and capital expenditure and depreciation figures.¹⁴⁹

The Company also entered into a settlement agreement with the UAW. The UAW's agreement's terms mirror the terms of the USW agreement. Dana Corporation must pay \$428,900,000 in cash and deposit \$48,700,000 in value of common stock, with the same caveats as in the UAW settlement. The maximum payment required of Dana Corporation for the UAW VEBA is \$477,600,000. The UAW agreement included the same terms on sharing of financial information as did the USW agreement.¹⁵⁰

- d. **Goodyear.** Goodyear settled its retiree medical obligations using a VEBA trust that was funded with \$700 million cash and \$300 million of Goodyear stock. Additional amounts were paid to the VEBA for certain profit sharing and cost of living adjustments. The VEBA was administered by four independent trustees selected through an RFP process and three representatives of the United Steel Workers.¹⁵¹
- e. **Continental Tire.** The retirees of Continental Tire North America, Inc. ("CTNA") brought a class action contesting changes to the retiree medical plan. The class included those who were retired, spouses and

¹⁴⁹ Settlement Agreement Between Dana Corporation and United Steelworkers, part of the record of *In re Dana Corporation*, Case No. 06-10354 (BRL) (Bankr. S.D. N.Y. August 1, 2007).

¹⁵⁰ *Id.*

¹⁵¹ "Recent Developments in Collectively Bargained VEBAs," Diane M. Soubly, *Benefits Law Journal*, Vol. 22, No. 2, Summer 2009, p. 5.

surviving spouses of retirees. The retirees had been covered by a collective bargaining agreement between CTNA and the AFL-CIO union. In 2005 CTNA began negotiating further reductions in the retiree health benefits, a settlement was reached in 2006.¹⁵² In 2008, CTNA and the union negotiated an amendment to the VEBA trust agreement.¹⁵³ The independent trustees are paid \$12,000 annually plus \$1,500 per meeting up to \$18,000 per year. The VEBA's Committee was given the power to design the plan change benefits and provide different benefits to different groups.¹⁵⁴ Continental Corporation recognized an expense of 49.9 million Euros in 2007 related to the settlement. Continental Corporation is headquartered in Germany.

- f. **Arvin Mentor.** Beginning in 2003 Arvin Mentor ("AM") (formed after a merger of Rockwell International's spun-off automotive division and Arvin Industries) increased copays, deductibles and out-of-pocket maximums and shifting the costs of retiree medical benefits to retirees. In 2004, AM announced its intent to cancel retiree medical for Medicare eligible retirees effective as of January 1, 2006. Individual retirees and the United Steel Workers sued under Section 301 of the Labor-Management Relations Act to reinstate the benefits. During the litigation, the parties exchanged the relevant documents from 40 years of collective bargaining history. The court approved the establishment of a VEBA trust as the settlement. The VEBA was administered by an independent committee and an institutional trustee.¹⁵⁵

AM saw a reduction in accumulated post retirement benefit obligations (OPEB) of \$293 million which was amortized as a reduction in retiree medical obligations over the average remaining service period of 12 years.¹⁵⁶

3. **Using a VEBA and a Captive Insurer to Limit the Financial Statement Impact of Retiree Medical Liabilities.** Some companies have attempted to address their retiree medical financial statement liabilities through the use of captive insurers; however this use of an affiliate raises prohibited transaction issues.¹⁵⁷ Revenue Ruling 2014-15¹⁵⁸ provided a new twist by indicating that a reinsurer that reinsures only one entity is still treated as an insurance company

¹⁵² Continental, Annual Report 2008.

¹⁵³ Stipulated Order Substitution of Second Amended Trust Agreement in *Pringle v. Continental Tire North America, Inc. Group Insurance Plan*, Northern District of Ohio, Western Division, Case No. 3:06-cv-02985, (September 4, 2008).

¹⁵⁴ *Id.*

¹⁵⁵ "Recent Developments in Collectively Bargained VEBAs," Diane M. Soubly, *Benefits Law Journal*, Vol. 22, No. 2, Summer 2009, p. 5; *Leonhardt v. Arvin Mentor, Inc.*, Case No. 04-CV-72845, E.D. Mich., Oct. 7, 2008; Order and Final Judgment Approving Class Action Settlement, Joint Motion (1) For Preliminary Approval of Class Action Settlement, (2) For Approval of Proposed Class Notice, and (3) To Set Fairness Hearing.

¹⁵⁶ Arvin Menton, Inc. Form 10-K for the fiscal year ended September 28, 2008.

¹⁵⁷ See Proposed Prohibited Transaction Exemption 2010-11 (4/2/2010) using a captive affiliate to reinsure retiree medical insurance.

¹⁵⁸ 2014-22 I.R.B. (5/27/2014).

for income tax purposes; thus it permits the reinsuring affiliate to accumulate reserves like an insurance company insuring multiple entities.

Employers have used VEBAs and 401(h) accounts to fund toward their retiree medical liabilities as well or at least to offset against the liability.

- K. Cost of Retiree Medical Plans.** The average total cost of retiree health benefits (including employer and retiree costs) for 2004 for the 300 private-sector employers participating in one study was \$69.6 million per employer, though the average cost varied significantly among the employer's surveyed.¹⁵⁹ Specifically, the average total cost (including employer and retiree costs) for employers with 20,000 or more employees was \$260.9 million, compared with \$28.2 million for employers with 10,000-19,999 employees; \$13.8 million for employers with 5,000-9,999 employees and \$4.7 million for employers with 1,000-4,999 employees.¹⁶⁰ This study indicated that size of the employer sponsoring the retiree medical plan is the greatest indicator of the potential liability imposed by the plan. However, other factors affecting the cost of retiree medical benefits include the demographics of the retiree group, differences in plan design and in utilization of medical services, the type of health plans offered (e.g., HMO, PPO), and the geographic concentrations of retirees.¹⁶¹

The rising costs associated with providing retiree medical benefits, along with rules promulgated by the FASB requiring employers to account for retiree medical obligations on an accrual basis (rather than on a pay-as-you-go basis), have prompted many employers who sponsor retiree medical plans to place caps on their future financial obligations to provide retiree medical benefits. One study indicated that 63% of the 300 private-sector employers surveyed report having a cap on the employer's contributions for retiree health coverage.¹⁶² When employers place a cap on their financial obligations to provide retiree medical benefits, the retirees will begin to pick up a greater portion of the cost as their medical costs rise above the level of the cap. Employer's have several different options available for structuring financial caps. The employer may opt for a cap on the total cost (e.g., the company will not spend more in total for retiree medical than twice what was spent in a given year). Alternatively, the employer may structure the cap so that it applies to the individual participants (e.g., the employer subsidy for post-65 retiree medical costs will not exceed \$2,000 per person). The cap may also include a service-related aspect, or the cap may be indexed to rise as future costs rise.

It is important to note that caps cannot be imposed on benefits to which retirees can claim they have a vested interest. For example, if a collective bargaining agreement provides that individuals who retire while the agreement is in place will be entitled to certain benefits for life in the Sixth Circuit, the sponsor may not be able to impose a cap on those benefits for the retirees covered by the collective bargaining agreement without first negotiating the cap with the union. (However, there is the question of whether the union represents the retiree) Another alternative is to pursue a declaratory action regarding the ability to amend the retiree benefits, see III. below for a discussion of cases regarding

¹⁵⁹ "Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," page 16.

¹⁶⁰ *Id.*, at page 15.

¹⁶¹ *Id.*

¹⁶² *Id.*, at page 17.

changing retiree benefits, including one where an employer sought a declaratory action regarding its ability to alter the retiree benefits of an acquired entity and hired counsel to represent the class of retirees.

Some employers are considering a defined contribution approach to retiree medical benefits, similar to a health reimbursement account.

- L. Nondiscrimination Rules for Medical Benefits.** If medical plan provides benefits though a self-funded arrangement, such as VEBA or Code section 401(h) account, then the plan must satisfy the nondiscrimination requirements of Code section 105(h) in order for benefits to be excludable from the participant's income. Code section 105(h) provides that medical plan cannot discriminate, either in eligibility to participate, or with respect to benefits provided under the plan, in favor of highly compensated individuals. However, there is no guidance on how one determines a plan is discriminatory. Highly compensated individuals are defined as an individual who is either (i) one of the five highest paid officers, (ii) a shareholder who owns more than ten percent in value of the stock of the employer, or (iii) among the highest paid twenty-five percent of all employees, other than employees who are statutorily excluded.¹⁶³ If the plan does not satisfy the nondiscrimination requirement, and therefore the underlying funding mechanism does not meet the nondiscrimination requirements, a penalty will be imposed on the retiree that is equal to the amount of any discriminatory post-retirement medical benefit provided to any highly compensated individual.¹⁶⁴ Code section 105(h) provides that medical plan cannot discriminate, either in eligibility to participate or with respect to benefits provided under the plan, in favor of highly compensated individuals. Code section 505 also includes a prohibition on discrimination for welfare benefits funded through a VEBA that are not subject to any other nondiscrimination rules under the same chapter of the Code.¹⁶⁵

Furthermore, self-insured medical plans that cover retiree benefits are subject to an additional rule that retiree benefits will not be considered discriminatory if type or dollar limitations on benefits provided to retirees who were highly compensated individuals are the same as those for all other retired participants.¹⁶⁶

Potential stock purchasers must be aware of the nondiscrimination requirement and may want to seek advice before assuming a plan that seems to run afoul of such requirements. Particularly, the potential stock purchasers will want to be aware of any plan that provides different benefits to former highly compensated employees. A potential stock purchaser should also inquire whether retired highly compensated employees are receiving any medical benefits not described in the plan, such as pursuant to their employment contracts or otherwise. Potential buyers in a stock purchase should review all contracts with executives to ascertain what, if any, special retiree medical benefits may exist and then must further inquire into the funding, if any, for such benefits and compliance with Section 409A of the Code.

¹⁶³ I.R.C. § 105(h)(5) (2003).

¹⁶⁴ Treas. Reg. § 1.105-11(e) (1981).

¹⁶⁵ The same chapter of the Code includes section 1 through and including section 1400L.

¹⁶⁶ Treas. Reg. § 1.105-11(c)(3)(iii) (2002).

All collective bargaining unit agreements must also be reviewed to determine the extent of any promised, post-retirement medical benefits and the funding of such benefits to ascertain the extent of potential liabilities. If the employee is involved with any multi-employer plans, the obligation of the employer pursuant to such contracts must be reviewed. Some multiemployer plans purport to contractually impose withdrawal liability for ceasing to participate in the welfare plan.

- M. Defined Contribution Post-Retirement Medical Benefits.** Some employers are shifting or converting their post-retirement medical benefits to either notional accounts with a set amount credited per retiree or per dependent per year upon which the individual may draw to pay medical expenses. These operate similar to health reimbursement accounts.¹⁶⁷ Another technique used on an individual basis are health savings accounts (“HSA”).¹⁶⁸ HSAs work best for younger workers who are healthy and have time to accumulate sums.

Defined contribution arrangements limit the employer’s liability, but unless amounts accumulate over the worker’s life, the defined contribution plan can be depleted quickly with a catastrophic illness or injury.

N. Shifting Retiree Medical Liabilities to a Captive Insurer.

- 1. Other Methods for Moving OPEB Off the Balance Sheet.** Often employers have sought to insure their obligation to provide benefits to remove the liability from their financial statements. This was done through an offshore captive insurer by Columbia Energy Corp. in PTE 2000-48 for long-term disability benefit.¹⁶⁹ Columbia Energy Corp. created a wholly-owned subsidiary, Columbia Insurance Corp. Ltd. to act as its captive insurer and it was based in Bermuda. Columbia Energy did the offshore captive insurer technique to insure its long-term disability plan. The plan’s benefits were enhanced and it was insured by Employers Insurance of Wausau but such insurer would not reinsure 100% of the risk with the offshore insurer.

Archer Daniels Midland used a captive insurer to insure its life insurance plan. Archer Daniels Midland obtained approval of its captive insurer transaction in PTE 2003-07.¹⁷⁰ A third PTE for a similar transaction was approved in PTE 2004-12 to Svenska Cellulosa Akiebolaget (SCA).¹⁷¹ Since such time more than a dozen employers have obtained approval of similar transactions through the expedited prohibited transaction approval process or “Ex-Pro.”¹⁷² One of the requirements for the prohibited transaction exemptions was that the participants received enhanced benefits. Enhancing retiree medical benefits will increase costs and the related liabilities; thus the captive reinsurer strategy may not decrease costs or liabilities. If the captive insurer prohibited transaction

¹⁶⁷ Rev. Rul. 2002-41, 2002-2 CB 75 and Notice 2002-45, 2002-2 CD 93.

¹⁶⁸ Code § 223.

¹⁶⁹ 65 Fed. Reg. 60452 (October 11, 2000).

¹⁷⁰ 68 Fed. Reg. 23764 (May 5, 2003).

¹⁷¹ 69 Fed. Reg. 40969 (July 7, 2004).

¹⁷² PTEs 03-32E, 04-17E, 05-22E, 06-11E, 06-14E, 07-01E, 07-02E, 07-04E, 08-04E, 08-07E, 08-08E, 08-16E, 08-17E, 08-18E, 08-22E, and 09-01E.

exemption is not approved, the company can be left with enhanced retiree medical benefit expenses, if it did not condition the enhancements upon receipt of the prohibited transaction exemption, if those enhancements were negotiated with a collective bargaining unit.

In order to obtain a prohibited transaction for the use of a captive insurer to insure the life or disability benefits, the company requesting the exemption had to demonstrate the following items:

- 1) The insurer is a) a party in interest with respect to the plan; b) is licensed to sell insurance or conduct reinsurance obligations; c) has a certificate of authority; d) has recently undergone an exam by an independent CPA or the insurance commissioner of the state; e) and is licensed to conduct reinsurance transactions by a state whose law requires an annual actuarial review of reserves;
- 2) The plan pays no more than adequate consideration for the contracts;
- 3) No commissions are paid by the plan with respect to the direct sale of the insurance contracts or the related reinsurance contracts;
- 4) In the initial year of the contract, there is an immediate and objectively determinable benefit to the participants and beneficiaries in the form of increased benefits;
- 5) In subsequent years, the premium should be based on a formula comparable to that of other insurers and should be reasonable;
- 6) The plan only contracts with insurers with a rating of A or better. The reinsurance arrangement will be indemnity insurance only; and
- 7) The plan sponsor retains an independent fiduciary for the plan to ensure these requirements are met.

The expedited prohibited transaction exemptions require a notice be provided to the participants in the plan explaining the transaction and the conditions on the exemption and providing the participants an opportunity to comment on the proposed exemption. The benefit requirements and reinsurance program are to be implemented within 30 days of the exemption's approval.

Coca-Cola requested an expedited prohibited transaction exemption (an "Ex-Pro") to use a captive insurer to fund its retiree health benefits. In April, the U.S. Department of Labor denied Coca-Cola's request for an Ex-Pro because it did not believe there was enough support for why the request was substantially similar to the other prohibited transaction exemptions granted for captive insurers for life and disability benefits. The Department refused fast track processing and

required Coca-Cola to provide more information on how it would use the captive insurer program to enhance benefits.¹⁷³

III. Potential Liabilities Arising Out of Post-Retirement Medical Benefit Plans

Employee welfare benefit plans, like retiree medical plans are not subject to ERISA's mandatory vesting and anti-cutback provisions, which are applicable to employee retirement benefit plans, thus these plans normally, do not have vesting or accrued benefit concepts. Retiree medical benefits have resulted in significant litigation. A careful review of the litigation in the various Circuits in which a company may be exposed for a suit based on retiree medical benefits. Review ERISA's provisions regarding courts having jurisdiction to review claims for benefits and related claims as well as the venue provisions to determine which jurisdictions should be reviewed to ascertain the related risks. Actions can also be brought under labor laws such as the Labor and Management Relations Act ("LMRA") or Railway Labor Act ("RLA"). Thus, evaluating litigation risk is another potential cost or liability related to retiree medical plans.

The causes of action available to potential plaintiffs for benefits under a retiree medical benefits plan under ERISA are generally limited to federal causes of action including age discrimination under the ADEA, breach of agreements, failure to comply with the plan, actions for benefits and other actions recognized under ERISA, Railway Labor Act or LMRA, claiming that the modification or termination of benefits breaches an agreement between the sponsoring employer and the employees, breach of fiduciary duty claim under section 404 and section 502(a)(3)(B) of ERISA (such as in *Varity Corp. v. Howe*,¹⁷⁴ and with respect to former union employees, breach of contract claims for labor agreements under section 301 of the LMRA or under the Railway Labor Act.

- A. **Claims of Age Discrimination under the Age Discrimination in Employment Act ("ADEA")**. The ADEA, which generally prohibits age discrimination, has been interpreted to impose limitations on an employer's ability to modify or terminate retiree medical benefits on the basis of an individual's eligibility for Medicare eligibility. In *Erie County Retirees Association v. County of Erie, PA*, ("Erie") the Third Circuit found that since Medicare eligibility was a direct proxy for age, Medicare eligibility could not be used as a criteria for modifying or terminating retiree benefits.¹⁷⁵ Specifically, the court found that the employer violated the ADEA since it did not give employees who were eligible for Medicare benefits the same benefit options that were available to employees who were not eligible for Medicare benefits. The parties subsequently settled out of court following the Third Circuit's decision.

After the *Erie* case was decided, the EEOC withdrew a section of the EEOC Compliance Manual Chapter on "Employee Benefits" relating to retiree health benefits¹⁷⁶ saying that it wished to study further the relationship between certain employer practices regarding

¹⁷³ "Retiree Benefit Funding Challenges Elevate Interest in Benefit 'Captives'," BNA Pension and Benefit Reporter, 36 BPR 1320, June 2, 2009.

¹⁷⁴ 516 U.S. 489 (1996).

¹⁷⁵ 220 F.3d 193 (3d Cir. 2000).

¹⁷⁶ Specifically, the EEOC withdrew Section IV(B) of the EEOC Compliance Manual Chapter on "Employee Benefits" and deleted the example regarding retiree health benefits in Section II (B) of the Compliance Manual Chapter. The text of the deleted Example read "Employer B provides health insurance for its retirees but eliminates that coverage once the retirees become eligible for old-age benefits under Medicare. Because eligibility for these Medicare benefits is tied to age, Employer B's plan treats retirees differently on the basis of age."

the provision of retiree health benefits and the ADEA. Partly in response to the Erie decision and the uncertainty it invited, the EEOC issued proposed regulations regarding ADEA and retiree health benefits in 2003.¹⁷⁷ The proposed regulations provided relief solely to retiree health plans and contained an exemption to the ADEA which would authorize the practice of altering, reducing or eliminating employer-sponsored retiree medical benefits when retirees become eligible for Medicare or state sponsored retiree health benefits programs.¹⁷⁸ The proposed regulations recognized the declining availability of retiree health benefits noting that the number of employers with 500 or more employees who offer retiree coverage decreased 17% between 1993 and 2001 for both pre and post Medicare eligible retirees.¹⁷⁹ Under the proposed regulation, a retiree health plan may alter, reduce or eliminate retiree health care coverage when the participant is eligible for Medicare health benefits or health benefits under a comparable State health plan.¹⁸⁰ The proposed regulations did not apply to any other benefits. This exemption made it clear that the ADEA permits employers to freely coordinate the provision of retiree health benefits with Medicare eligibility. The exemption also applied to dependent and spousal health benefits that are included as part of the health benefits provided to retired participants. The exemption covered newly-created as well as existing retiree health plans.

There was some thought that Congress would also respond to the Erie decision through legislation. Although the Medicare *Prescription Drug Improvement and Modernization Act of 2003*¹⁸¹ did not include any provisions revising the *Erie* decision, the accompanying conference report did address the decision.¹⁸² Specifically, the conference report states that upon reviewing the legislative history of the ADEA, the Congressional conference committee determined that the legislative history underlying the ADEA “clearly articulates the intent of Congress that employers should not be prevented from providing voluntary benefits to retirees only until they become eligible to participate in the Medicare program.”¹⁸³

The AARP filed for a temporary restraining order and a preliminary injunction barring the EEOC from issuing final regulations regarding ADEA and retiree health benefits in February 2005.¹⁸⁴ The District Court issued its opinion on the motions for summary judgment on March 30, 2005. The court, not surprisingly, followed the 3rd Circuit’s decision in *Erie County*.¹⁸⁵ The District Court found, applying *Erie County*, that Congress intended the ADEA to apply to the exact same behavior that the EEOC’s challenged exemption would exempt and, bound by the *Erie County* precedent, granted AARP’s motion for summary judgment and denied the EEOC’s motion to dismiss.¹⁸⁶ In May of 2005, the EEOC appealed the case to the Third Circuit U.S. Court of Appeals.

¹⁷⁷ 68 F.R. 41542 (2003).

¹⁷⁸ 68 F.R. 41542 (July 14, 2003).

¹⁷⁹ 68 F.R. 41542, 41544 (2003).

¹⁸⁰ Prop. Reg. § 1625.32.

¹⁸¹ P.L. 108-173.

¹⁸² H.R. Conf. Rep. No. 108-391, at 365 (2003).

¹⁸³ *Id.*

¹⁸⁴ *AARP v. Equal Employment Opportunity Commission*, (E.D. Pa, filed February 22, 2005).

¹⁸⁵ *Erie County Retiree Ass’n v. County of Erie*, 220 F.3d 193 (3d Cir. 2000)

¹⁸⁶ *AARP v. Equal Employment Opportunity Commission*, 383 F. Supp. 2d 705 (E.D. Pa, March 30, 2005).

However, the story doesn't end there. In June of 2005, the Supreme Court issued an opinion dealing with the impact of judicial precedence in light of conflicting regulatory guidance that ultimately caused the District Court to vacate its decision in *AARP v. EEOC*. The Supreme Court decision dealt with whether the decision of a court binds the decision of a lower court when a federal regulatory agency has issued a conflicting interpretation. In *National Cable and Telecommunications Association v. Brand X Internet Services*, the Supreme Court held that "only judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaced a conflicting agency construction."¹⁸⁷ In light of this decision, the EEOC requested a motion to reconsider, and the District Court vacated its March 2005 decision.¹⁸⁸ In September, 2005, the District Court, applying the Supreme Court's holding in the *Brand X* case, found that it was not bound by the Third Circuit's holding in *Erie County*. The District Court said that, since the Third Circuit's opinion in *Erie County* did not say that it was the only permissible interpretation of the ADEA, the opinion did not foreclose a later contrary interpretation by the EEOC.¹⁸⁹ Although the court vacated its March 2005 holding in *AARP v. EEOC*, the injunction on the final EEOC regulations remained in effect for a period, pending the EEOC's appeal of the March order. The AARP appealed the District Court's September holding vacating the March opinion. The Third Circuit on appeal upheld the District Court's holding in June, 2007.¹⁹⁰ AARP requested the U.S. Supreme Court issue an order to stay the Third Circuit's decision, but that request was denied on November 20, 2007.¹⁹¹ AARP requested an *en banc* review at the Third Circuit, but that request was denied on August 25, 2007. The Third Circuit then confirmed its decision and lifted the injunction in August 2007.¹⁹² AARP also filed a writ of certiorari with the U.S. Supreme Court asking the Supreme Court to review the Third Circuit's decision on November 20, 2007.¹⁹³

Following all of the litigation with the AARP, the EEOC issued the long awaited final regulations on coordination of retiree medical benefits with Medicare on December 26, 2007.¹⁹⁴ The regulation creates a narrow exemption to ADEA's prohibition on discrimination based upon age solely for retiree medical benefits. The regulation was effective on December 26, 2007. The final regulation is not intended to provide any inference regarding how ADEA might apply to non health benefits.¹⁹⁵ The regulation also stated "It is the Commissioner's position, however, that all of the anti-discrimination statutes also protect former employees when they are subjected to discrimination arising from the former employment relationship."¹⁹⁶ The exemption permits plans providing health benefits to retired participants that alter, reduce or eliminate health benefits when the participant is eligible for Medicare or a comparable State health benefit plan whether or not the participant actually enrolls in Medicare or a comparable State health plan.¹⁹⁷

¹⁸⁷ *National Cable and Telecommunications Association v. Brand X Internet Services*, 125 S. Ct. 2688, 545 U.S. 967 (June 27, 2005).

¹⁸⁸ *AARP, et al v. Equal Employment Opportunity Commission*, 390 F. Supp. 2d 437 (E.D. Pa, September 27, 2005).

¹⁸⁹ *Id.*

¹⁹⁰ *AARP v. EEOC*, 489 F.3d 558 (3rd Cir. 2007).

¹⁹¹ 72 Fed. Reg. 72938; 72941 (December 26, 2007).

¹⁹² Case Nos. 05-4594 (August 31, 2007).

¹⁹³ *Cert. den'd*, 128 S. Ct. 1733 (March 24, 2008).

¹⁹⁴ 72 Fed. Reg. 72938 (December 26, 2007).

¹⁹⁵ *Id.* At 72840.

¹⁹⁶ *Id.*

¹⁹⁷ 29 C.F.R. § 1625.32(b).

No other aspects of ADEA coverage or employee benefits other than retiree health coverage coordination with Medicare or a comparable State health plan are covered by this exemption.¹⁹⁸

In *Gutchen v. Board of Governors of the University of Rhode Island*, the Rhode Island District Court found that a Plan did not violate the ADEA even though the amount of the benefit stipend available to retirees depended on Medicare eligibility, which is inextricably tied to age.¹⁹⁹ The employer in this case offered an early retirement incentive program that included two options. Under the first option, the plan would pay the allotted stipend amount to the insurance company, and under the second option, the plan would pay the allotted stipend amount directly to the retiree. The amount of the stipend was determined based on whether the retiree was eligible for Medicare. For retirees aged 58-64, the allotted stipend was \$5,000. For retirees aged 65-72, the allotted stipend was \$2,000. The amount of the reduction on the stipend for retirees eligible for Medicare was determined based on social security tables estimating the amount by which the out-of-pocket costs for retirees are decreased once the retiree becomes eligible for Medicare. The court found that because the overall benefits for retirees eligible for Medicare and those that are not eligible for Medicare were equal, the costs amount by the employer to the two groups did not have to be equal under the ADEA. Furthermore, because the Medicare-eligible retirees did not allege that their benefits were inferior to the retirees who were not yet eligible for Medicare, the court found that it did not need to apply the analysis adopted by the court in Erie County.

In addition to these issues, the impact of the U.S. Supreme Court's decision in *Smith v. Jackson, Mississippi*, approving disparate impact cases under the ADEA and acknowledging the exception of "reasonable factors other than age" in such cases is yet to be determined.²⁰⁰ This decision will impact how retiree medical benefits are designed, and with respect to other benefit plans, will change the issues that must be considered and documented when benefit changes are contemplated.

1. **No claims of reverse age discrimination under the ADEA.** In *Cline v. General Dynamics*, the Sixth Circuit found that the ADEA provides a cause of action for discriminating against younger workers in the protected class, but the U.S. Supreme Court did not agree.²⁰¹ In other words in the Sixth Circuit's opinion, the ADEA does not just protect against discrimination in favor of older workers with respect to younger workers; there can be a claim of reverse age discrimination so long as the claimant falls within the class of individuals protected by the ADEA (e.g., individuals over the age of forty). In this case a collective bargaining agreement initially provided for full health benefits upon retirement for all employees with thirty years of service. A subsequent collective bargaining agreement said that only employees aged fifty or older on the effective date of the new collective bargaining agreement were entitled to full health benefits upon retirement. The plaintiffs claimed that the new collective bargaining agreement adversely affected workers between the ages of forty and forty-nine. Although the Sixth Circuit found a cause of action for reverse age

¹⁹⁸ 29 C.F.R. § 1625.32(c).

¹⁹⁹ 148 F.Supp.2d 151 (D.R.I., 2001).

²⁰⁰ *Smith v. Jackson, Miss.*, 544 U.S. 228 (2005).

²⁰¹ 2002 Fed. App. 0242P (6th Cir. 2002), cert. granted April 21, 2003, No. 02-1080.

discrimination, so long as the plaintiffs fell within the purview of the ADEA's protected class, the U.S. Supreme Court reversed the Sixth Circuit's decision and found no violation of ADEA.²⁰² Relying on the text, structure, purpose and history of the ADEA, along with the ADEA's relationship to other federal statutes, the Supreme Court found that the ADEA was not intended to stop an employer from favoring an older employee over a younger one.²⁰³

Relying on the Supreme Court's decision in *General Dynamics Land Systems, Inc. v. Cline, et al.*, a District Court in the Eastern District of Michigan dismissed a plaintiffs' reverse age discrimination claim under the ADEA, and found that the plaintiffs state law reverse age discrimination claim under Michigan's Elliot-Larsen Civil Rights Act was preempted.²⁰⁴

B. Amending or Terminating Post-Retirement Medical Benefits. Employers who maintain a post-retirement medical benefit plan may assert that such a plan does not represent an actual liability to the sponsor, or potential acquirer, since the plan, which is not subject to the mandatory vesting or anti-cutback provisions of ERISA, can by its terms be amended or terminated at any time. While non-collective bargaining employees have generally not been protected from loss or changes to their retiree benefits, when a plan or summary plan description has included a reservation of the right to amend, modify or terminate the plan.²⁰⁵ Collectively bargained plans have found somewhat greater protections in the courts. In the collectively bargained context, all communications regarding retiree benefits and union contracts should be reviewed to ascertain the representations and contract provisions that may preclude terminating or making changes to the retiree benefits. A careful review of all collective bargaining agreements, plan documents and summaries provided to employees as well as an evaluation of the potential Circuits in which litigation might be brought and the types of case is important to understanding the total risks and liabilities related to a retiree medical plan.

The sponsoring employer's ability to terminate or amend a retiree medical benefit plan in a non-collectively bargained context will generally turn on whether the employer has explicitly reserved the right to terminate or modify the plan in the plan document, the summary plan description (*i.e.*, is there a reservation of right clause?). Courts will generally uphold the sponsor's right to amend, modify or terminate the plan if such right has been reserved and communicated (e.g., through the SPD) to plan participants. However, a reservation of right clause does not provide a clear escape when it involves a plan that is maintained pursuant to a collective bargaining agreement which requires review of the collective bargaining agreement and other documents, consideration of whom the amendment impacts, and in which Circuits the parties reside.

Because of the large liabilities retiree medical benefit plans impose on sponsoring employers, the potential acquirer in a stock purchase or in any acquisition in which the purchaser agrees to assume the retiree liabilities by purchasers will want to ensure that if it takes on the responsibilities associated with sponsoring the plan, it will be able to amend, modify or terminate the plan, should it become too costly to maintain (e.g., by

²⁰² *General Dynamics Land Systems, Inc. v. Dennis Cline, et al.*, 540 U.S. 581 (February 24, 2004).

²⁰³ *Id.*, at 610.

²⁰⁴ *Williams, et al. v. DTE Energy Company*, 36 EBC 2069 (E.D. Mich., August 30, 2005).

²⁰⁵ *Sprague v. General Motors Corp.*, 133 F.3d 386, 21 EBC 2267 (6th Cir. 1998).

increasing participant deductibles, rates of coinsurance or co-payments or limiting lifetime maximum benefits). However, collective bargaining agreements, other plan documents, and applicable authorities must be carefully reviewed prior to making any change in the retiree benefits because a change will usually require negotiation with the union unless the collective bargaining agreement has terminated. Employers sponsoring such plans should also review the respective documents and evaluate their potential risks when deciding upon a strategy to address the legacy costs of retiree medical benefits.

1. **Railway Labor Act Collective Bargaining Agreements Differ From Those Under the National Labor Management Relations Act.** In considering retiree medical promises in union contracts, it is important to determine if the collective bargaining agreement is one that is subject to the Railway Labor Act, enacted in 1926.²⁰⁶ Agreements under the Railway Labor Act differ from other collective bargaining agreements because they do not have contract termination dates but are continuing agreements subject to a request by either party under Section 6 to amend or change the agreement. A Section 6 notice indicates a party wants to make a change and triggers the duty to bargain and opens negotiations.²⁰⁷ The Railway Labor Act applies to “carriers” which includes any express company, sleeping-car company, carrier by railroad and any company which is directly or indirectly owned or controlled by or under common control with a railroad or airline which operates any equipment or facilities or performs any service (other than trucking service) in connection with the transportation, receipt, delivery, elevation, transfer or transit, refrigeration or icing, storage and handling of property transported by the carrier.²⁰⁸

While some collective bargaining agreements expire and the expiration is used by some courts to end certain retiree medical benefits, there is a debate regarding the collective bargaining agreements under the Railway Labor Act. Railway Labor Act contracts were historically drafted as continuous documents without expiration dates. When parties reached an agreement they simply agreed not to reopen the agreement for a definite period. Some airline contracts have historically looked more like National Labor-Management Relations Act agreements with a duration clause with an expiration date, and an amendable date. It is not clear based on the case law whether the contract continues in effect beyond the stated expiration date.²⁰⁹

2. **Sponsoring employer’s ability to amend retiree benefits.** Most courts have found that so long as the employer has expressly reserved a right to amend or terminate the retiree medical benefit plan in the plan document, summary plan description, and other representations made to the employees regarding retiree medical benefits, the employees will not be vested in such benefits, and the employer will be able to amend or terminate the plan at will. Through the years numerous cases have reviewed an employer’s right to amend, modify or terminate retiree medical benefits. Generally, in a non-collectively bargained scenario most courts have upheld the employer’s reservation of rights clause. In

²⁰⁶ Extended to air carriers in 1936. 45 U.S.C. § 181.

²⁰⁷ 45 U.S.C. § 156.

²⁰⁸ 45 U.S.C. § 151.

²⁰⁹ *EEOC v. United Airlines*, 755 F.2d 94 (7th Cir. 1985).

situations involving a collectively bargained plan, the ability to change the retiree medical benefits varies by the facts and the relevant Circuit. The cases described below represent some of the more recent Circuit Court decisions dealing with retiree medical benefits.

a. First Circuit.

(i) Collectively Bargained

Senior v. NSTAR Electric and Gas Corp. The First Circuit Court of Appeals found that an employer created by a merger with Com/Energy and BEC Energy did not violate ERISA or section 301 of the Labor Management Relations Act by ending Com/Energy's practice of reimbursing certain retirees' Medicare Part B premium payment and terminating its retiree dental benefits.²¹⁰ The First Circuit found the claim for benefits based on the LMRA created no presumption regarding vesting. The court found that the language in the early retiree program promising lifetime dental benefits did not create a vested right to the dental benefits. The employer's obligation to provide such benefits was interpreted in light of the collective bargaining agreement, the early retirement programs, both of which were ambiguous and the related dental plan documents which included a reservation of right to amend clause. The court found that the employer did not negotiate to give up its right to amend the plan and that the early retirement program was governed by the terms of the plan document.

*United Steelworkers v. Textron.*²¹¹ The First Circuit upheld an injunction ordering the employer to pay the pre-sale retirees' health and life insurance premiums pending a trial on the merits of the disputed labor contract. The successor employer had assumed the liability for the retiree life and health benefits and then ceased making payments once it went out of business. The union argued the contract language "shall pay for retiree life and that medical benefits shall be provided" generated the requirement those benefits be provided for life.

(ii) Non-Collectively Bargained.

*Balestracci v. Nstar Electric and Gas Corp.*²¹² The First Circuit upheld a reservation of right clause permitting plan changes in a retiree medical and dental plan.

²¹⁰ *Senior v. NSTAR Electric and Gas Corp.*, 449 F.3d 206 (1st Cir. 2006), aff'g 372 F. Supp. 2d 159 (D. Mass., 2005).

²¹¹ 9 EBC 2204.

²¹² 449 F.3d 224 (Case No. 05-1894) (1st Cir. 2006).

*Larocca v. Borden, Inc.*²¹³ The First Circuit denied retirees request for a refund of retiree medical premiums because the relief requested was not appropriate equitable relief under ERISA.

b. Second Circuit.

(i) Collectively Bargained.

*Joyce v. Curtiss-Wright Corporation.*²¹⁴ The Second Circuit found that, “In particular, the SPD’s reservation of rights clause explicitly mentions that the company ‘reserves the right to end or amend’ the health insurance coverage it offered. The SAR informed the retirees that Curtiss-Wright ‘shall’ terminate benefits if the CBA lapses ‘for any reason.’” Although we have not joined those circuits that have adopted the position that “a general amendment provision in a welfare benefits plan is of itself sufficient to unambiguously negate any inference that the employer intends for employee welfare benefits to vest contractually,” *Spacek v. Maritime Ass’n*, 134 F.3d 283, 293 (5th Cir. 1998) (citing cases in the Third, Fourth, Eighth, Tenth and Eleventh Circuits), we believe that the SPD’s reservation of rights clause, when combined with the termination language of the SAR, precludes any viable claim that the SPD served to vest the retiree’s benefits.”

AFL-CIO v. International Multifoods Corporation. In *AFL-CIO v. International Multifoods Corporation*²¹⁵ the Court found the reservation of rights clause coupled the fact it followed its procedures for amending the plan defeated any claim for vested benefits.

Bouboulis v. Transportation Workers Union of America. Similarly in *Bouboulis v. Transportation Workers Union of America*,²¹⁶ a separate letter containing a promise of lifetime benefits was not sufficient to constitute a plan amendment.

(ii) Non-Collectively Bargained.

Abbruscato v. Empire Blue Cross and Blue Shield. In *Abbruscato v. Empire Blue Cross and Blue Shield*,²¹⁷ the Second Circuit found a reservation of right to amend an early retirement program clause, but such clause did not mention the benefits under the early retirement program and this rendered the

²¹³ 27 EBC 1262 (1st Cir. 2002).

²¹⁴ 171 F.3d 130 (2d Cir. 1999).

²¹⁵ 274 F.3d 90, 116 F.3d 1976 (2d Cir. 1997).

²¹⁶ 2006 U.S. App. LEXIS 6120 (2d Cir. 2006).

²¹⁷ 274 F.3d 90, 27 EBC 1139 (2d Cir. 2001).

reservation of right clause ambiguous with respect to whether the underlying benefits could be changed. The Second Circuit remanded the case for further proceedings regarding whether the retiree life insurance benefit that was offered under the early retirement program could be changed. In another case where an SPD promising lifetime retiree medical benefits did not include a reservation of the right to amend, modify or terminate the benefits, the retiree's claim could not be dismissed on a motion for summary judgment.²¹⁸ Thus, a clear reservation of right clause for the benefits is important.

(iii) **District Court within Second Circuit – Non-Collectively Bargained.**

Adams v. Tetley USA Inc. A U.S. District Court in Connecticut granted the defendants' motion for summary judgment finding that the plaintiffs' breach of contract, breach of fiduciary duty and promissory estoppel claims all must fail.²¹⁹ Although early versions of the plan document and summary plan description at issue did not contain a clause reserving the employer's right to amend or terminate the retiree medical program, the court found that the employee's breach of contract claim must fail since those early documents did not contain any language that could be interpreted as promising lifetime benefits. In dicta, the court noted that if a plan fiduciary deliberately fostered a misleading belief that beneficiaries were entitled to lifetime coverage, or failed to provide beneficiaries with a plan document or summary plan description so that the beneficiaries could read the reservation of rights language, or otherwise prevented beneficiaries from verifying the details of the plan, there may be a basis for a breach of fiduciary duty claim. However, the court found that the plaintiffs' understanding that the company had promised them lifetime benefits was based on a misapprehension that "retirement benefits" or "continued benefits" equated to "lifetime benefits," and so, the court found that the breach of fiduciary duty claim could not stand. Finally, the court found that because there was never a promise of lifetime benefits, the promissory estoppel claim also failed.

(iv) **Bankruptcy Court within Second Circuit – Collectively Bargained.**

*In re AMR Corporation.*²²⁰ In rendering a decision on the motions for summary judgment in litigation seeking to terminate the company's obligation to provide retiree medical benefits in bankruptcy, the court found that the case must proceed to trial to

²¹⁸ *Kunkel v. Empire Blue Cross and Blue Shield*, 27 EBC 1129 (2d Cir. 2001).

²¹⁹ *Adams v. Tetley USA Inc.*, 363 F. Supp. 2d 94 (D.C. Conn., 2005).

²²⁰ Case No. 11-15463(SHL) (Bank. S.D. N.Y. April 2014).

determine whether the retiree benefits vested, because the language of the CBAs were reasonably susceptible to interpretation as a promise to vest benefits and lack language categorically reserving the company the right to terminate their contributions to the retiree benefits. Reliance on *CIGNA Corp. v. Amara*,²²¹ to claim the plan controls over the summary plan descriptions and over the CBAs failed to consider that *Amara* did not consider the existence of CBAs in the vesting question and failed to consider Second Circuit authorities looking to the CBAs on vesting questions because CBAs are not solely in the control of the employer. Not all of the CBAs were abrogated under § 1113 and § 1113 proceedings do not abrogate retiree medical plan benefits promises because those are addressed only under § 1114. The CBAs must be considered. However the Railway Labor Act does not guarantee that retiree benefits must continue regardless of whether those benefits vested. References to a lifetime maximum on one group's benefits was not the same as a promise of lifetime benefits and other agreements settling grievances promised no changes to the benefits for flight attendants. A promise that retiree health coverage will commence after the employee retires was found to be a promise of vested benefits also. Promises to non-union early retirees with a ROR clause did not survive because there was no language to vest these employees.

c. **Third Circuit.**

(i) **Collectively Bargained.**

*United Auto Workers Local No. 1697 v. Skinner Engine Co.*²²²
The Third Circuit found that silence as to the duration of retiree benefits did not make the benefits lifetime benefits. The collective bargaining agreements all had terms and termination dates. The court explicitly rejected the Sixth Circuit's *Yard-Man*²²³ analysis and would not infer an intent to vest and provide benefits for lifetime without change. The Plan and SPD contained a reservation of right to amend clause.

*In re Visteon Corp.*²²⁴ Visteon was permitted to terminate its retiree medical benefits under 11 USC § 1114 bankruptcy proceedings. Visteon changed instead of terminating its retiree medical benefits and the Third Circuit found that if the bankruptcy court permitted them to terminate the retiree medical benefits, it could also modify such benefits.

²²¹ 131 S.Ct. 1866 (2011).

²²² 23 EBC 2022 (3d Cir. 1999).

²²³ *International Union, UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983).

²²⁴ 612 F.3d 210 (3rd Cir. 2010).

(ii) **Non-Collectively Bargained.**

*Adams v. Freedom Forge Corp.*²²⁵ The Third Circuit upheld the District Court's grant of a preliminary injunction enjoining the Company from charging two retirees a premium for retiree medical coverage, but denied the injunction for 134 retirees who were not able to show irreparable harm. A company representative had told them their benefits were to be free for their lifetime as part of a voluntary job elimination program. The SPD did not include a reservation of right to amend clause.

d. **Fourth Circuit.**

(i) **Collectively Bargained.**

Ketter v. H.K. Porter Co., Inc. In a LMRA collective bargaining agreement case,²²⁶ the collective bargaining agreement entered into by the employer acquired by H.K. Porter Co., Inc. specified a separate duration clause for retiree medical benefits from the rest of the agreement so that the agreement continued beyond its normal expiration date for retiree medical benefits. The separate duration clause for retiree medical was upheld.²²⁷

*Dewhurst v. Steelworkers.*²²⁸ The retirees lost their motion for an injunction to prevent the reduction of their retiree benefits.

e. **Fifth Circuit**

(i) **Collectively Bargained.**

*Evans v. Sterling Chemicals.*²²⁹ Following an acquisition, the successor entity filed for bankruptcy and abrogated the CBAs which included the promised retiree medical benefits. It did not file under § 1114 to abrogate its responsibilities with respect to the retiree medical plan. The asset purchase agreement required Sterling to maintain the retiree medical benefits on terms no less favorable than they provided to its other employees. They reduced the retiree medical benefits and the retirees sued. The Fifth Circuit found that the asset purchase agreement was not abrogated in the bankruptcy and the abrogation of the CBA did not eliminate the obligations under the retiree medical plan without going through the § 1114 process. Thus, Sterling Chemicals was bound to provide the retiree medical benefits.

²²⁵ 204 F.3d 475, 24 EBC 1696 (3d Cir. 2000).

²²⁶ This is a case under a collective bargaining agreement under the Labor Management Relations Act of 1947, 29 U.S.C. § 185.

²²⁷ *Ketter v. H.K. Porter Co., Inc.*, 10 EBC 2412 (4th Cir. 1989).

²²⁸ 649 F.3d 287 (4th Cir. 2011).

²²⁹ 660 F.3d 862 (5th Cir. 2011).

United Paperworkers International Union v. Champion International Corp. In *United Paperworkers International Union v. Champion International Corp.*,²³⁰ the Fifth Circuit examined a collective bargaining agreement regarding whether the promise of retiree medical benefits was to be without change in payment of the amount of the Medicare Part B premium for such coverage. The company now was owned by a successor entity. The court considered whether the Sixth Circuit's factors in the *Yard-Man*²³¹ decision existed and determined they were not all met and remanded the case for further analysis in light of the extrinsic evidence to determine the intent of the collective bargaining agreement.

(ii) **Non-Collectively Bargained and Collectively Bargained.**

Nichols v. Alcatel USA, Inc. In *Nichols v. Alcatel USA, Inc.*²³² a former salaried employee sought a preliminary injunction to stop her former employer from eliminating her retiree medical benefits. The Fifth Circuit found the employee had a reservation of right to amend, modify and terminate provisions in the plan, the plan did not vest the employees in their retiree health benefits and the plan was not a pension plan. Union employees also sued in this cause. The Court found the contractual obligations under the collective bargaining agreement ceased when the contract terminated and that there was no evidence that the contractual benefits for the union retirees vested, but that the retiree benefits were only effective during the term of the collective bargaining agreement.

f. **Sixth Circuit.**

(i) **Collectively Bargained.**

The Sixth Circuit has a long string of cases analyzing the language in collective bargaining agreements for promises for “lifetime” or “while you are paid a pension” and finding such language to bind employers to provide lifetime retiree medical benefits without change.²³³ The Sixth Circuit has found “vested” or “status” benefits to exist even though the summary plan description contained a reservation of right to amend, modify and terminate the plan.

²³⁰ 12 EBC 2097 (5th Cir. 1990).

²³¹ *International Union, UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983).

²³² 44 EBC 1001 (5th Cir. 2008).

²³³ See *International Union, UAW v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983); *Yolton v. El Paso Tennessee Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006), *cert. denied* ____ U.S. ____ (U.S. Nov. 6, 2006) (No. 06-201); *McCoy v. Meridian Automotive Systems, Inc.*, 33 EBC 2825 (6th Cir. 2004).

*Steelworkers v. Kelsey-Hayes Company*²³⁴ In *Kelsey-Hayes*, the Sixth Circuit found that Kelsey-Hayes unilateral change of the retiree medical plan from a defined benefit health plan to a defined contribution retiree health reimbursement account violated the collective bargaining agreement. The CBA promised that upon retirement the plaintiffs were entitled to continuation of the same coverage they had as employees.

*Tackett v. M&G Polymers USA, LLC*²³⁵ Collective bargaining unit members sued the most recent owner of their plant decided to shift the increased retiree costs to the retirees. The retirees sued under ERISA 502(a)(1)(B) and (a)(3) to enforce the plan to request reinstatement of their lifetime contribution-free retiree medical benefits. The District Court ordered that the retirees be reinstated to the post-2007 versions of their plans. The retiree benefits were tied to the pension benefits, the CBA referred to the Company paying the full company contribution for retiree medical and the placement of the language regarding the retirees paying the balance of the premium indicated an intent to vest the retiree medical benefits. While the court found that the lifetime retiree benefits were vested, it also found that they could not be free of any retiree contribution because the CBU and the company had agreed the retirees would make contributions toward retiree medical benefits. The U.S. Supreme Court has agreed to review one of the issues raised in the appeal of this case.²³⁶ The U.S. Supreme Court is reviewing whether courts construing collective bargaining agreements in LMRA cases should presume silence concerning the duration of retiree medical benefits means the parties intended those benefits to vest for life.

*Tackett v. M&G Polymers, USA, LLC*²³⁷ In *Tackett*, the company announced it would start to require retirees to share the cost of their health benefits. While the District Court held there was no vested right to benefits without a company contribution and there was no violation of the collective bargaining agreement, it also held it lacked jurisdiction over the LMRA claim. On appeal the Sixth Circuit found there was jurisdiction and then looked at the collective bargaining agreement's language and found it provided that employees who retired during the life of the CBA, who were receiving a pension and who satisfied the age plus service equals at least 95 points criteria, "will receive a full Company contribution towards the cost of [health] benefits." The CBA also provided that employees were required "to pay the balance of the health-care

²³⁴ Case No. 13-1717, 2014 BL 111194, 199 LRM 3146, 57 EBC 2745 (6th Cir. 2014).

²³⁵ 733 F.3d 589 (6th Cir. 2013).

²³⁶ *M&G Polymers USA LLC v. Tackett U.S.*, No. 13-1010 cert. granted 5/5/14.

²³⁷ 46 EBC 1901 (6th Cir. 2009).

contribution, as estimated by the Company annually in advance, for benefits.” The Court found this language to entitle retirees with 95 points to receive the total amount of the company’s potential contribution toward the cost of benefits. The Sixth Circuit read the “total amount of the Company’s contribution” to mean the total cost of the benefits because the union would not have entered into a CBA with no specified contribution. The Sixth Circuit found the linking of entitlement to health benefits to receipt of pension benefits as supporting vesting of the retiree health benefits upon retirement.

*Bender v. Newell Window Furnishings, Inc.*²³⁸ The Sixth Circuit found that an employer unilaterally increasing the employees’ premiums and co-pays in the retiree medical plan violated the LMRA and ERISA and breached the CBAs. The defendant was a successor employer and liable for the violations.

*Schreiber v. Philips Display Components Company.*²³⁹ SPD language did not contain language that could be construed as providing lifetime benefits. Lifetime benefits had been repeatedly rejected in CBA negotiations. The Sixth Circuit held there was no promise of lifetime benefits.

*VanPamel v. TRW Vehicle Safety Systems, Inc.*²⁴⁰ The retirees brought their claim for reducing retiree medical benefits as a claim for a violation of the LMRA and seeking to compel arbitration of the dispute. TRW eliminated retiree prescription drug coverage and replaced it with a health reimbursement account, an alleged violation of the CBA. The motion to compel arbitration was granted. The retirees cannot argue for their benefits under the CBA and also argue they are not subject to the CBA’s arbitration of disputes requirement because they are retirees and some courts have held the CBU does not represent retirees.

*Curtis v. Alcoa, Inc.*²⁴¹ CBUs negotiated with Alcoa and agreed to a deferred cap on retiree medical benefits with additional costs shifting to the retirees. Retirees sued alleging violations of the LMRA and ERISA regarding the cap agreements were illegal because their retiree benefits were vested. Retirees were eligible to lifetime retiree health benefits that were capped.

*Shy v. Navistar International Corporation,*²⁴² In *Shy*, Navistar unilaterally substituted Medicare Part D coverage in place of

²³⁸ 681 F.3d 253 (6th Cir. 2012).

²³⁹ 503 Fed. Appx. 385 (6th Cir. 2012).

²⁴⁰ 723 F.3d 664 (6th Cir. 2013).

²⁴¹ 525 Fed. Appx. 371 (6th Cir. 2013).

²⁴² 701 F.3d 523 (6th Cir. 2012).

retiree medical plan coverage of prescription drugs. The court ruled the prescription drug coverage was separate and distinct from the medical coverage. The District Court did not abuse its discretion in refusing to hold an evidentiary hearing and ordering reinstatement of the retiree prescription drug benefit.

Mauver v. Joy Technologies, Inc. In *Mauver v. Joy Technologies, Inc.*,²⁴³ the Sixth Circuit held the union was precluded from arguing that retirement benefits had vested because it failed to file a grievance when the employer distributed an SPD containing an explicit reservation of right clause permitting the employer to terminate coverage.²⁴⁴

Winnett v. Caterpillar, Inc. In *Winnett v. Caterpillar, Inc.*,²⁴⁵ the Sixth Circuit found in a collectively bargained plan that the protections for retiree medical coverage under the collective bargaining agreement only protected those who had actually retired, and those who were eligible to retire, but who had not retired were not protected or vested in their retiree medical coverage. The case was again considered in 2013.²⁴⁶ When no new CBA was agreed to, the union struck and the company made change to retiree medical benefits. The second case looked at a different group of employees and then the surviving spouses of retirees.²⁴⁷

Reese v. CNH America, LLC. In *Reese v. CNH America, LLC*,²⁴⁸ the Sixth Circuit provided a slight dent in its long line of cases on collectively bargained retire medical cases by finding that even though a collective bargaining agreement provided for lifetime medical benefits, the retirees could be subject to reasonable changes in these health care benefits as long as the changes were reasonable in light of changes in health care and roughly consistent with the kinds of benefits provided to current employees.²⁴⁹ It did not prevent the employer from changing the benefits or payments for the retiree medical plan. It did not preclude the employer from making changes to the contents of such plan. In this case the plan language that required the plan to provide benefits for the lifetime of the retirees was language indicating that eligibility for the pension plan made the individual eligible for the retiree medical plan and that employees that retire under the pension plan for hourly

²⁴³ 212 F.3d 907 (6th Cir. 2000).

²⁴⁴ *Id.* at 913, 919.

²⁴⁵ 45 EBC 2512 (6th Cir. 2009); the case was reconsidered at 609 F.3d 404 (6th Cir. 2010) for different sub class of retirees which were barred by the statute of limitations.

²⁴⁶ 510 Fed. Appx. 417 (6th Cir. 2013).

²⁴⁷ *Id.*

²⁴⁸ 574 F.3d 315 (6th Cir. 2009).

²⁴⁹ 514 F.3d 315, at 326 (6th Cir. 2009).

employees after July 1, 1994 and their surviving spouses were eligible to receive health care benefits. This language does not clearly state a participant has lifetime retiree medical benefits, but it provides an example of how some courts are finding interesting constructions of what otherwise would have been considered an eligibility clause to create a basis for finding a promise of a lifetime of vested retiree medical coverage. In *Reese*²⁵⁰ the Sixth Circuit found that binding a company to provide benefits in the same way for the lifetime of the retirees is not feasible, but that binding the company to provide some benefits for a lifetime is feasible. *See also CNH America LLC v. UAW*, 645 F.3d 785 (6th Cir. 2011).

Noe v. PolyOne Corp. In *Noe v. PolyOne Corp.*,²⁵¹ where a collective bargaining agreement tied retiree health benefits to eligibility for a pension and did not clearly limit the duration of the benefits, the collectively bargained retiree medical benefits were vested and could not be changed.

Cole v. Arvin Meritor, Inc. Similarly in *Cole v. Arvin Meritor, Inc.*,²⁵² an automobile parts manufacturer was required to reinstate retiree health benefits for retired members of its collective bargaining unit because the retired members of its agreement stated that health insurance “shall be continued thereafter” after an employee retires was enough to indicate the retirees were provided lifetime benefits.

*Yolton v. El Paso Tennessee Pipeline Co.*²⁵³ In *Yolton v. El Paso Tennessee Pipeline Co.* the district court found that the successor to the former parent company of Case, Tenneco which became El Paso Tennessee Pipeline Co. (“El Paso”) in 1996 is responsible for paying the cost of health care premiums for one group of former employees who were promised lifetime coverage under a collective bargaining agreement before it was extended. When the collective bargaining unit agreement was extended in 1993 from 1993 to 1995, there was an attempt to cap payouts per retiree in a separate letter between a Senior Vice President of Case and the UAW Secretary/Treasurer. The retirees had been represented by United Auto Workers in 1971, 1975 and 1990 contracts which promised lifetime benefits. The court did not determine whether or not Case Equipment Corp. which became Case Corporation which was later known as Case, LLP (collectively “Case”), which was the entity created to receive assets sold by El Paso’s asset sale was obligated to the

²⁵⁰ *Reese v. CNH America LLC*, 694 F.3d 681 (6th Cir. 2012).

²⁵¹ 43 EBC 1545 (6th Cir. 2008).

²⁵² 45 EBC 1969 (6th Cir. 2008).

²⁵³ 435 F.3d 571 (6th Cir. 2006), *aff’d* 2003 U.S. Dist. LEXIS 24539 (E.D. Mich. 2003), *cert. denied* ____ U.S. ____ (U.S. Nov. 6, 2006) (No. 06-201).

fund coverage under the injunction. The injunction was issued to prevent irreparable harm to the retirees by requiring El Paso to pay the \$501 per month premium for a retiree until the disputed issues are resolved. The 6th Circuit affirmed the district court's decisions. The U.S. Supreme Court denied the petition for certiorari, appealing the 6th Circuit's decision. Similarly, an injunction was issued against the entity that had acquired several plants with UAW contracts promising retiree benefits for as long as you receive a pension to require maintenance of the retiree medical plan benefits without reductions. Yoltan followed the precedent set by *UAW v. Yard-Man, Inc.*²⁵⁴ The Sixth Circuit in *Yard-Man* considered whether the collectively bargained retiree medical benefits survived the expiration of the collective bargaining agreement, that is did the retiree medical benefits vest. Whether the benefits vested depended on the intent of the parties and the first place to look is the language of the CBA.

McCoy v. Meridian Automotive Systems, Inc. In *McCoy v. Meridian Automotive Systems, Inc.* the Sixth Circuit affirmed the issuance of a temporary restraining order requiring Meridian to continue providing the UAW workers with retiree medical benefits for life until the dispute was resolved. Meridian had purchased the plant out of bankruptcy and integrated the UAW agreements. The SPDs caveated all provisions reserving the right to terminate or amend the plan with references to the collective bargaining agreements and the limitations on such rights in the agreements.

*Wood v. Detroit Diesel Corp.*²⁵⁵ In *Wood v. Detroit Diesel Corp.* an injunction precludes the company from increasing retirees' premiums due to provisions in prior collective bargaining agreements promising lifetime benefits. The Sixth Circuit in reviewing the collective bargaining agreement stated it is the plaintiff's burden to prove that the retiree medical benefits vested and overturned the District Court's presumption that the retiree's right to health care benefits were vested. Even with this error, the Sixth Circuit then reviewed the requested injunction de novo and determined that the collective bargaining agreement language did not show an intent to vest fully-funded lifetime healthcare coverage. The Sixth Circuit found the collective bargaining agreement and other extrinsic materials inconclusive except with respect to the promise of lifetime benefits for pre-1993 retirees for life. However, the named plaintiffs did not show irreparable imminent harm, but the Sixth Circuit still affirmed the District Court's grant of injunction as relief because of Detroit Diesel's historic commitment to paying the retirees' health benefits as evidenced in a cap agreement with the UAW

²⁵⁴ 716 F.2d 1476 (6th Cir. 1983).

²⁵⁵ 213 Fed. Appx. 463; 35 EBC 2649 unpub'd. (6th Cir. 2007); No. 05-74106 (E.D. Mich. 2005).

which capped liability for retiree medical as a lifetime commitment. The Sixth Circuit heard the appeal of this case again in 2010.²⁵⁶ The dispute centered around the cap agreements entered into to limit the financial statement liabilities related to retiree medical benefits. The court found that the Company was entitled to summary judgment because the only coherent reading of the cap agreements established the retirees are entitled to lifetime capped healthcare benefits.

Schreiber v. Phillips Display Components Co. In *Schreiber v. Phillips Display Components Co.*,²⁵⁷ the Sixth Circuit found ambiguity in the collectively bargained plan and remanded the case to the District Court to review the summary plan description, plan and extrinsic evidence and then determine if the hourly plaintiffs claim can proceed. After remand, the District Court found there was no intent to vest the retiree medical benefits, that the plaintiffs were not employees of the defendants when they retired and were not entitled to retiree medical benefits. The plaintiff's ERISA claim was both unsubstantiated and time barred.²⁵⁸

Moore v. Menasha Corporation,²⁵⁹ Retired members of a CBU brought suit alleging violations of ERISA and the LMRA when the company increased the amount they and their spouses had to pay for their retiree medical insurance premiums. CBA made no distinction between employees and retirees. The ROR clause in the SPDs did not save the employer from the language in the CBAs.

(ii) Collectively Bargained with a ROR in the CBA.

*Witmer v. Acument Global Technologies, Inc.*²⁶⁰ A collective bargaining agreement that reserved the employer's right to amend, modify or terminate retiree benefits prevented a group of retirees suit claiming violation of ERISA and the LMRA from succeeding. The ROR clause was clearly tied to the pension and retiree medical benefits.

(iii) Non-Collectively Bargained.

Sprague v. General Motors Corp. In *Sprague v. General Motors Corp.*²⁶¹ in a noncollectively bargained situation the plan's reservation of rights clause precluded a claim to lifetime retiree

²⁵⁶ *Wood v. Detroit Diesel Company*, 607 F.3d 427 (6th Cir. 2010).

²⁵⁷ 680 F.3d 355 (6th Cir. 2009).

²⁵⁸ *Schreiber v. Philips Display Components Company*, 503 Fed. Appx. 385 (6th Cir. 2012).

²⁵⁹ 690 F.3d 444 (6th Cir. 2012).

²⁶⁰ 694 F.3d 774 (6th Cir. 2012).

²⁶¹ 21 EBC 2267 (6th Cir. 1998).

medical benefits by non-collectively bargained employees of General Motors Corporation (“GM”). Many retirees who had exited employment through early retirement programs had been told that they would receive lifetime retiree medical benefits as part of that exit, but at the same time were provided with summary plan descriptions containing GM’s reservation of right to amend, modify or terminate the retiree medical benefits. The district court’s grant of summary judgment finding that the plan documents preserved GM’s rights to change or terminate the benefit was upheld.

g. Seventh Circuit.

(i) Non-Collectively Bargained.

*Bland v. Fiatallis N. Am. Inc.*²⁶² In *Bland*, the Seventh Circuit was faced with plan documents providing for benefits continuing while the “you and your spouse are living” with no reservation of rights clause. The Seventh Circuit decided the case was not proper for a motion for summary judgment and remanded the case to the Northern District of Illinois to determine if this “lifetime” language in several of the plan documents is at least ambiguous as to whether some or all of the retiree benefits are vested. The Seventh Circuit found that if any retiree benefits were vested, then additional determinations must be made with respect to which benefits are vested or whether the 2001 modifications including higher employee costs and adding a reservation of rights clause effectively cut off the retirees’ rights.

*Sullivan v. CUNA Mutual Insurance Society.*²⁶³ Executives sued for continuation of their retiree medical benefits because they were not given the option of using their sick leave balances in cash toward their retiree medical premiums. The employer’s plan had a ROR clause and it was permitted to change the retiree medical plan.

(ii) Collectively Bargained.

Independent Lift Truck Builders Union v. NACCO Materials Handling Group, Inc. In *Independent Lift Truck Builders Union v. NACCO Materials Handling Group, Inc.*,²⁶⁴ the Seventh Circuit remanded an appeal of an arbitration order for the District Court to determine if the collective bargaining agreement was intended to apply to retirees, the claims for current employees were clearly covered by the agreement. There

²⁶² 401 F.3d 779 (7th Cir. 2005).

²⁶³ 649 F.3d 553 (7th Cir. 2011).

²⁶⁴ 23 EBC 2625 (7th Cir. 2000).

is a question of whether retirees are represented by a union after they retire and if the union can represent them.

Temme v. Bemis Company, Inc.²⁶⁵ Changes were made to the deductible and copayments in the retiree medical plan by the successor to the employer. The District Court found there was no promise of lifetime benefits to retirees. The Seventh Circuit found there was an agreement to provide lifetime benefits and remanded the case for further proceedings.

Exelon Generator Co. v. Electrical Workers, IBEW Local 15. In Exelon Generator Co. v. Electrical Workers, IBEW Local 15,²⁶⁶ the Court found that the union could arbitrate on behalf of the retirees, without obtaining their consent. The union had the right to arbitrate on behalf of active and retired employees regarding retiree medical benefits.

International Union of United Automobile, Aerospace and Agricultural Implement Workers of America, U.A.W. and its Local 803, et al. v. Rockford Powertrain, Inc.²⁶⁷ The Seventh Circuit upheld the District Court's grant of the employer's motion for summary judgment when the retirees claimed lifetime medical benefits and the collective bargaining agreement did not discuss the terms of post-retirement welfare benefits and the summary plan description included a statement that "although the company expects and intends to continue the plan indefinitely, it reserves the right to modify, amend, suspend or terminate the plan at any time." Reading the document in its entirety, the Seventh Circuit found that the benefits were to continue subject to the plan sponsor's ability to change them at will. Thus, the termination of benefits was upheld.

Cherry v. Auburn Gear, Inc.²⁶⁸ Borg Warner sold its Auburn facility to Auburn Gear, Inc. The collective bargaining agreement provided for lifetime benefits for the insurance agreement, et al. and each portion was negotiated separately. The collective bargaining agreement also limited the lifetime benefits to the duration of the collective bargaining agreement. The insurance agreement's terms were amended a number of times since the acquisition in November 1982. The collective bargaining agreement was renegotiated a number of times beginning in 1983 and always limited the promise of benefits to the duration of the collective bargaining insurance agreement. The Seventh Circuit found that "lifetime" benefits only extended so long as the collectively bargained insurance agreement was in

²⁶⁵ 622 F.3d 730 (7th Cir. 2010).

²⁶⁶ 44 EBC 2316 (7th Cir. 2008).

²⁶⁷ 350 F.3d 698 (7th Cir. 2003).

²⁶⁸ 441 F.3d 476 (7th Cir. 2006).

effect and the retiree's claim was denied on a motion for summary judgment.

*Barnett v. Ameren Corp.*²⁶⁹ In *Barnett*, Ameren Corp. was formed after Central Illinois Public Service (“CIPS”) and Union Electric (“UE”) merged. Most of the plaintiffs had retired prior to the 1997 merger. Ameren took the position that the obligation to provide retiree medical benefits continued only as long as the collective bargaining agreement was in force. In 2003, Ameren decided that beginning in 2009 retirees would be required to pay 25% of their premiums and 50% of their dependent premiums and the retirees filed this action. The explicit language in the agreement regarded the “term of the agreement” and “life of the labor agreement” as the duration was explicit and defeated any reference to “vested” or “vesting.”

The Seventh Circuit found there was no ambiguity in the document promising retiree medical benefits which reserved to the Company the right to amend the benefits under a collective bargaining agreement and only discussed the continuation for the life of the Labor Agreement. The court further found there was an express limit on the duration of the promise in the collective bargaining agreement and once there was no ambiguity, this defendant's motion for summary judgment was properly granted. Ameren had inherited the retiree medical promise of the two utilities that merged to become Ameren Corporation.

*Newell Operating Co. v. International Union of United Automobile, Aerospace and Agricultural Implement Workers of America.*²⁷⁰ In a unique twist, the employer brought suit seeking a declaratory judgment against the union and its retirees that it had a right to amend its retiree health plan to charge retirees premiums while the union had sued in a different court alleging the company had violated the collective bargaining agreement by amending the retiree health plan. The Company filed in Illinois within the Seventh Circuit and the union had filed in Michigan within the Sixth Circuit. The Seventh Circuit characterized the employer's action as an attempt to bring the action within ERISA by “advantageous and creative pleadings.” Jurisdiction under 502(a)(3) requires appropriate equitable relief to be provided for a violation of ERISA or to enforce the terms of a plan and the employer did not seek either. The court stated, “The appellants have attempted to usurp the jurisdictional choice of the UAW and the retirees by filing an anticipatory suit for declaratory relief under ERISA § 502(a)(3) before they could be sued in Michigan; however, without a need to enforce the Plan or ERISA, appellants' effort is for naught. The appellants' suit for

²⁶⁹ 436 F.3d 830, 36 EBC 2639 (7th Cir. 2006).

²⁷⁰ 532 F.3d 583 (7th Cir. 2008).

declaratory and injunctive relief under ERISA § 502(c)(3) against the UAW and retirees was unnecessary, and the district court properly concluded that jurisdiction did not exist under the statute.”

The appellants also sought a declaration that the court had jurisdiction under § 301 of the Labor and Management Relations Act and that the plan amendment was not a violation of the collective bargaining agreement. The court indicated it is usually wary of a declaratory judgment action that is “aimed solely at wresting the choice of forum from the natural plaintiff” and dismissed the case since the natural plaintiffs’ claims were more sensibly brought in the action in Michigan.

Zielinski v. Pabst Brewing Co.²⁷¹ Pabst was a successor to Schlitz and changed the prescription drug benefits under the collectively bargained shutdown agreement Schlitz had entered into by increasing drug copays and placing an annual cap on prescription drug benefits. The retirees sought an injunction under ERISA and the National Labor-Management Relations Act. The Seventh Circuit noted the shutdown agreement did not have any termination date and used the words “shall continue” so the court said it would not interpolate a termination date. The Seventh Circuit then recognized that it would not be sensible to interpret the shut down agreement as locking in benefit copayments at the 1971 rates because it was not “reasonably commensurate” and holding Pabst to the literal terms of the ancient plans would give retirees an “insanely generous plan.” The Seventh Circuit then recognized that the shut down agreement contained gaps and the court then proceeded to indicate the gap should be filled if “reasonable commensurability” is ascertainable. Since there was little evidence of what was covered by the 1971 benefit plan, the court decided the plaintiff class was entitled to the benefits “specified in the agreement, but adjusted to the extent possible without wild conjectures – for changes to which the parties to the agreement would have agreed had they focused at the outset on the duration of the commitment made by the employers.” The court then remanded the case to the District Court to determine what this might mean.

Pabst Brewing Co. v. Corrao. In Pabst Brewing Co. v. Corrao,²⁷² the court found that the employer did not violate section 301 of the LMRA by terminating its retiree medical plan when the collective bargaining agreement expired. Even though the collective bargaining agreement provided lifetime benefits,

²⁷¹ 38 EBC 2418 (7th Cir. 2006).

²⁷² 22 EBC 1981, 161 F.3d 434 (7th Cir. 1998).

those benefits did not vest and contract only provided for the life of the agreement.

Orth v. Wisconsin State Employees Union Council 24. In *Orth v. Wisconsin State Employees Union Council 24*,²⁷³ the Seventh Circuit found that because the collective bargaining agreement specified the employer would pay 90% of the premium for retirees, the employer's unilateral change to the amount they would pay was a violation of the agreement.

(iii) **District Court within the Seventh Circuit – Non-Collectively Bargained.**

*Jefferson v. R.R. Donnelley and Sons Co.*²⁷⁴ The employer told employees at a meeting that all employees who retired as of a certain date would be entitled to free retiree medical benefits for life. This promise was also expressed in written memorandums distributed to the employees. The court found that the retirees' claim, alleging that their former employer breached its ERISA fiduciary duty by misrepresenting that retiree medical benefits would be free for the lifetime of the retirees, was time-barred under ERISA section 413. Their claim under the "fraud and concealment" provision of ERISA section 413 was insufficient since the retirees' complaint did not allege steps taken by the employer involving "trick or contrivance" to keep its intent to change the retiree medical benefits secret. In order for the "fraud and concealment" provision to be applicable, the plaintiff must allege more than the original wrong, the plaintiff must show that the fiduciaries took steps to keep their actions secret or "cover their tracks." The employer's failure to disclose its intention to change retiree medical benefits is not enough to trigger the fraud and concealment provision.

However, the court found that the retirees' second claim for breach of fiduciary duty was not time-barred, since it was sufficient to bring in the fraud and concealment provision. The second claim alleged that, contrary to disclosure obligations under ERISA, the employer failed to provide plaintiffs with notice of enhanced pension benefits until three years after the plan was amended to adopt the enhanced benefits.

While the claim for "fraud and concealment" with respect to retiree medical benefits was not strong enough to survive in this case, it seems likely that were the claim for breach of fiduciary duty not time-barred it would have been actionable. Therefore, this case indicates the importance in examining all representations made by the seller to employees regarding retiree

²⁷³ 45 EBC 1303 (7th Cir. 2008).

²⁷⁴ 26 EBC 2207 (D.C. N. Ill. 2001).

medical benefits. In other words, the plan document, summary plan description and other written representations are not the only things that may give rise to a cause of action for benefits or for breach of fiduciary duty; oral representations or promises may be actionable as well.²⁷⁵ Nevertheless, as long as the sponsoring employer reserves the right to terminate or amend benefits in its written documents, courts will generally find that any claim or oral promises for benefits is precluded under the general principals of contract law, unless the sponsoring employer knowingly provides misleading information. Therefore, a potential stock purchaser will want to obtain a representation from the seller in the purchase agreement that the seller has fully disclosed all matters related to the retiree medical benefits to the employees and that it has not misled the employees about the retiree medical benefits they are, may be, or will be, entitled to receive.

(iv) **District Court – Collectively Bargained.**

*Bialoszyński v. Milwaukee Forge.*²⁷⁶ The retirees sued as a class when Milwaukee Forge reduced retiree benefits. The defendants' motion for summary judgment failed because the plan's incorporation of the health plan's provision by reference referred to a document that did not exist because none of the health benefit descriptions had the name that was incorporated by reference. Furthermore, the collective bargaining agreements were clear that retiree and early retiree benefits continued until eligibility for Medicare and did not include a reservation of right to amend. None of the insurance documents that included the reservation of rights clause were incorporated in the collective bargaining agreement or were part of the plan.

h. **Eighth Circuit.**

(i) **Non-Collectively Bargained.**

*Stearns v. NCR Corporation, et. al.*²⁷⁷ In this case, the Eighth Circuit court of appeals found that the sponsoring employer did not commit a breach of contract when it reduced retiree medical benefits that had been promised as part of an early retirement incentive program. The retirees signed a separate contract promising them more favorable health benefits than were available under the employer's existing retiree medical care plan in exchange for their promise to release the employer from any and all claims related to their employment, or termination of

²⁷⁵ See also *Varity Corp. v. Howe*, 516 U.S. 489 (1996) regarding how misrepresentations regarding retiree medical benefits can be actionable.

²⁷⁶ 2006 U.S. Dist. LEXIS 10018 (E.D. Wis. 2006).

²⁷⁷ 297 F.3d 706 (8th Cir. 2002).

employment. The court said that the contract was actually part of the overall retiree medical benefit plan, which included a reservation of rights clause allowing the employer to terminate or amend the retiree medical benefit plan. The contract for the early retirement program standing alone did not contain such a reservation of rights clause. However, the documents distributed to retirees participating in the early retirement incentive program referred to the retiree medical benefit plan. The court found that the reservation of rights clause contained in the plan document was sufficient to defeat a claim that the retirement welfare benefits were vested.

*Hallbach v. Great-West Life & Annuity Insurance Co.*²⁷⁸ The Eighth Circuit remanded this case regarding the promises of continued medical benefits “during the course of your total disability” and “Your benefits will continue until the earliest of the date you are no longer totally disabled” with a reservation of right to amend clause. The case was remanded to have a trial regarding whether the benefits were vested. The class action was brought by disabled former employees to determine if the promise of continued benefits was vested.

(ii) **Collectively Bargained.**

*Newspaper Guild of St. Louis v. St. Louis Post Dispatch.*²⁷⁹ The CBA promised retiree medical benefits under the then in effect insurance policy but reserved the right to make “substantially equivalent benefits” available on a self-insured basis for the remainder of the retired employee’s life and required arbitration of disputes. The company unilaterally modified the retiree medical plan and the parties were ordered to arbitrate the grievance. The court remanded for review of the CBA language to determine if the benefits had vested.

*Hughes v. 3M Retiree Medical Plan and Minnesota Mining and Manufacturing Company.*²⁸⁰ In this case, the Eighth Circuit affirmed the lower court’s grant of summary judgment in favor of the defendants, allowing the employer to increase premiums for retired employees’ medical benefits. The court based its holding on the fact that the summary plan description did not contain vesting language, and unambiguously reserved to the employer the right to amend retirement medical benefits. An earlier booklet given to plan participant did not include vesting language, but the court found that the earlier booklet was not the summary plan description since it was not “sufficiently comprehensive to apprise the plan’s participants and

²⁷⁸ 46 EBC 2010 (8th Cir. 2009).

²⁷⁹ 641 F.3d 263 (8th Cir. 2011).

²⁸⁰ 281 F.3d 786 (8th Cir. 2002).

beneficiaries of their rights and obligations under the plan” as required by the regulations issued pursuant to ERISA.

Jensen v. Sipco, Inc. In *Jensen v. Sipco, Inc.*,²⁸¹ the Eighth Circuit found an employer improperly denied retirees’ lifetime medical benefits where the company’s reservation of rights provision was ambiguous as to whether it applied to those who were already retired or only those retiring in the future. SIPCO had been acquired by an investment firm after the plan and collective bargaining agreement with the promise were effective.

Thus, it is imperative that the plan document contain a reservation of rights clause, and any subsequent agreements or representations explicitly refer to the plan, in order for the employer to maintain the right to modify and reduce benefits of retirees, since all subsequent agreement will be deemed to be part of the plan.

John Morrell & Co. v. United Food and Commercial Workers International Union AFL-CIO. Similarly in *John Morrell & Co. v. United Food and Commercial Workers International Union AFL-CIO*,²⁸² the Eighth Circuit found an employer could unilaterally modify or terminate retiree medical benefits when agreements did not include any vesting language with respect to the retiree medical benefits.

These cases demonstrate that potential acquirers of companies sponsoring retiree medical plans need to look at all summary plan descriptions, plan documents, and related agreements not just the most current one. Furthermore, a potential stock purchaser must carefully examine all representations and descriptions of benefits to ensure that they could not be mistaken, or deemed to be summary plan descriptions, all collective bargaining agreements and all executive contracts for potential retiree medical benefit liabilities. If such representations and descriptions of benefits could be deemed to be a summary plan description, or a plan itself, the potential stock purchaser will want to ensure that the representations or descriptions of rights contain a reservation of rights clause.

*Maytag Corporation v. UAW.*²⁸³ After Whirlpool acquired a facility and terminated the CBA for the facility closed, Whirlpool brought suit seeking a declaratory action that it had the right to make changes to current retirees’ medical benefits. The union sought to have the action dismissed for lacking a case in controversy. The Court found that when the SPD was devoid

²⁸¹ 38 F.3d 945, 18 EBC 2188 (8th Cir. 1994).

²⁸² 18 EBC 2232 (8th Cir. 1994).

²⁸³ 687 F.3d 1076 (8th Cir. 2012).

of vesting language and explicitly reserved the right to modify the benefits, the retirees and beneficiaries had not met the burden of proof that there were vested retiree medical benefits.

i. **Ninth Circuit.**

(i) **Collectively Bargained.**

*Alday v. Raytheon Co.*²⁸⁴ The collective bargaining agreement provided for retiree medical benefits under the plan. A subsequent purchaser, like the original employer bound by the CBA, could not terminate the retirees rights to retiree medical benefits. The plans contained ROR clauses. The Ninth Circuit found the terms of the plan contained in the CBA constituted a contractual commitment and a breach of such commitment is a violation of LMRA § 301 and ERISA. Thus, the District Court's grant of summary judgment is upheld. The retirees' right to premium free healthcare did not expire with the CBA but continued. The Plan's ROR did not impact the contractual obligations under the CBAs.

*Roschewski v. Raytheon Co.*²⁸⁵ The Ninth Circuit affirmed the District Court's dismissal of the claim for an alleged violation of ERISA because the plaintiff failed to raise a dispute that an ERISA plan's provisions established his or his spouse's rights to lifetime retiree medical benefits.

Bower v. The Bunker Hill Co. In *Bower v. The Bunker Hill Co.*,²⁸⁶ the Ninth Circuit found that an employer who ceased operations could not terminate retiree medical benefits because while the collective bargaining agreement did not explicitly state that the benefits were vested, the combined effect of inadequate disclosures in the SPDs, misleading representations by management and provision of benefits during a strike led to contract ambiguity issues and the District Court's grant of summary judgment was improper. One case on retiree medical was dismissed because the plaintiffs failed to qualify for the retiree coverage and thus did not have standing to sue.²⁸⁷

*Electrical Workers IBEW Local 1245 v. Citizens Telecommunications Co. of California.*²⁸⁸ The Ninth Circuit found the union had standing to represent the retirees regarding a change in the retiree medical plan that effectively canceled retiree medical benefits. The District Court's order compelling

²⁸⁴ 693 F.3d 772 (9th Cir. 2012).

²⁸⁵ 471 Fed. Appx. 588 (9th Cir. 2012).

²⁸⁶ 5 EBC 1180 (9th Cir. 1984).

²⁸⁷ *Williams v. Caterpillar, Inc.*, 14 EBC 1682 (9th Cir. 1991).

²⁸⁸ 45 EBC 2051 (9th Cir. 2008).

the union and the company to arbitrate the dispute over the change to the retiree medical coverage was upheld. The disputed change was to cancel retiree coverage for anyone who was Medicare eligible. The union contested the unilateral changes as violations of the collective bargaining agreement reducing the overall level of benefits to retirees and requested rescission of the changes in its grievance. The Ninth Circuit refused the company's request that the union must obtain the consent of the retirees in order to be able to bind them and arbitrate on their behalf and affirmed the District Court's order compelling arbitration.

*Poore v. Simpson Paper Co.*²⁸⁹ The Ninth Circuit considered the summary plan description's reservation of right to amend, modify and terminate clause along with the collective bargaining agreement's statement "all participants covered by the health plans will be subject to the same level of contributions as active employees and to the same health care plan provision changes which take effect from time to time" and construed these to indicate the retirees had no vested interest in the retiree medical benefits. The Ninth Circuit affirmed the District Court's dismissal of the cause for lack of standing and lack of federal subject matter jurisdiction.

(ii) **Non-Collectively Bargained.** None.

(iii) **Collectively Bargained Governmental Plan within the Ninth Circuit.**

*Navlet v. Port of Seattle.*²⁹⁰ The Washington Supreme Court found that state law governed the vesting principles for the retiree medical benefits. The court found that the retirees and participants who had satisfied the eligibility requirements to receive the retiree medical benefits were required to be provided by the Port. The agreement had agreed to provide the level of medical and related benefits "during the duration of this contract and . . . continue the same level of coverage currently provided to eligible employees, eligible retirees and dependants." Eligibility for retiree medical benefits was conditioned on eligibility for pension benefits. The summary plan description included a reservation of the right to modify or terminate the plan. Applying Washington State's law it found that these were like retirement benefits or deferred compensation where they are provided pursuant to an agreement where the parties negotiate for the compensation package and thus they were vested.

j. Tenth Circuit.

²⁸⁹ 544 F.3d 1012, 44 EBC 2537 (9th Cir. 2008).

²⁹⁰ Case No. 78866-9 (Washington Supreme Court, October 16, 2008).

(i) **Collectively Bargained.** None.

(ii) **Non-Collectively Bargained.**

*DeBoard v. Sunshine Mining and Refining Company.*²⁹¹ The Tenth Circuit found that promises of lifetime medical benefits made in a voluntary early retirement program under a “rule of 70” even though the plan and SPD contained a reservation of rights clause were sufficient for the plaintiff’s claim to survive a motion for summary judgment. A similar situation resulted in a temporary restraining order stopping changes for the retirees showing irreparable harm in *Adams v. Freedom Forge Corporation*²⁹² in the Third Circuit.

k. Eleventh Circuit.

(i) **Collectively Bargained.** None.

(ii) **Non-Collectively Bargained.**

*Alday v. Container Corp. of America.*²⁹³ The Company could amend the retiree medical insurance plan for salaried employees to increase premiums because welfare plan benefits are not subject to ERISA’s vesting and the summary plan description clearly reserved the right to amend or terminate the plan.

Heffner v. Blue Cross and Blue Shield of Alabama, Inc. More recently in *Heffner v. Blue Cross and Blue Shield of Alabama, Inc.*,²⁹⁴ the Eleventh Circuit found a district court erred in certifying as a class a group of retirees who brought an action based on the plan increasing deductibles, when it corrected a scrivener’s error showing “no deductible” because each member must prove they relied on the error in the SPD.

*Frulla v. CRA Holdings, Inc.*²⁹⁵ The Company was no longer operating and the retiree medical plan was funded by a trust. The plan was inherited by CRA Holdings, Inc. from a prior acquisition followed by several name changes. The plan’s trust did not have enough funds to continue to provide the benefits to retirees indefinitely. In previous litigation, the plan sponsor had entered into an agreed judgment that it would not change its health insurance benefits from the benefits provided as of that date. The plan covered non-union retirees. A single non-union retiree sued and no class was certified. In a twist from the *Alday*

²⁹¹ 208 F.3d 1228 (10th Cir. 2000).

²⁹² 204 F.3d 475 (3rd Cir. 2000).

²⁹³ 906 F.2d 660, 12 EBC 2211 (11th Cir. 1990), cert denied 498 U.S. 1026 (1991).

²⁹⁴ 37 EBC 1161 (11th Cir. 2006).

²⁹⁵ 45 EBC 1227 (11th Cir. 2008).

decision above, even though the plan had a reservation of the right to amend, modify or terminate the plan, the court found, “Because the level or existence of an employee contribution thus directly affects the value of the benefits received, we hold that not having to pay a contribution is a benefit of a health care plan.” The court found this decision consistent with *Heffner*. The court went further and found, “In light of the foregoing, we conclude that the Agreed Judgment precludes CRA from requiring employee contributions as a precondition to continued eligibility for coverage under the CRA Plan and is not reasonably or fairly susceptible to any other interpretation.” This appears to be a broader finding than what it needs to be since the plaintiff was only an individual and no class was ever certified. It also appears inconsistent with *Alday*.

l. **Federal Circuit.** None noted.

3. **Misrepresentations give rise to liability and other limitations on the employer’s right to amend.**

a. **First Circuit.** None noted.

b. **Second Circuit.**

(i) **Collectively Bargained – District Court within Second Circuit.**

*Poole v. City of Waterbury.*²⁹⁶ Retired firefighters, and the surviving spouses of retired firefighters, brought an action against the City of Waterbury, Connecticut, when the city decided to convert the plaintiff’s medical benefits from a plan with traditional indemnity features, to a managed health care plan utilizing a preferred provider option. The city’s decision to switch benefits was prompted by the financial crises facing the city. The plaintiffs claimed an entitlement to benefits under two plans which were the result of a collective bargaining agreement between the firefighter’s union and the city. The court found that the proposed new managed health care plan was “inherently more inflexible” than the old plan, but that it was not clear that the plaintiffs would fare worse under the new plan. Nevertheless, the court found the plaintiffs had a vested contract right to the specific health care plan to which the collective bargaining agreement referred, and that the city was not allowed to substantially modify the benefits or substitute a significantly different plan without the retirees’ consent, unless it was impossible to continue to provide the current plan. The court found that the collective bargaining agreements contractually obligated the city to provide each retiree the health plan he

²⁹⁶ 2002 Conn. Super. LEXIS 2859 (Conn. Super. Ct. Aug. 14, 2002).

elected as of the date of his retirement. The court granted the plaintiff's requested injunctive relief by prohibiting the city from involuntarily terminating any of the plaintiffs from the health care plan which the plaintiff elected at the time of his retirement or otherwise involuntarily transferring or enrolling any plaintiff in the managed health care plans proposed by the city.

c. Third Circuit.

(i) Non-Collectively Bargained.

*Leuthner v. Blue Cross and Blue Shield of Northeastern Pennsylvania.*²⁹⁷ The Third Circuit reviewed a claim by retirees and a widow of a retiree that they were misled into believing that they had 100% paid lifetime retiree medical benefits and did not know Blue Cross could alter the plan's benefits. However, the alleged misrepresentations had no impact on her status as a plan beneficiary and the plaintiffs failed to have status as a plan participant or beneficiary and thus their claims were dismissed for lack of standing.

*In Re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation (Unisys II).*²⁹⁸ In *Unisys II*, the Third Circuit court found that when a plan administrator fails to provide information when it knows that the failure to do so might cause harm, it has breached its fiduciary duty to the individual plan participants.²⁹⁹ In 2003, a group of the plaintiffs and Unisys settled this litigation as noted in the subsequent fee litigation.³⁰⁰

d. Fourth Circuit.

(i) Non-Collectively Bargained – District Court within Fourth Circuit.

Hensley v. P.H. Glatfelter Co. A U.S. District Court in North Carolina did not dismiss the plaintiffs' claim that the employer breached its fiduciary duties by not giving them full and complete information about the terms of the company's impending acquisition.³⁰¹ In this case, the plaintiffs (former employees of the company) alleged that their former employer materially misled them by representing that their benefits would be fully protected after the sale of the company. The buyer

²⁹⁷ 454 F.3d 120 (3d Cir., 2006), 2006 WL 1881438 (3d Cir. 2006); 549 U.S. ____, *cert. denied*, Feb. 20, 2007, No. 06-651).

²⁹⁸ 57 F.3d 1255 (3d Cir. 1995), *cert. denied* 26 EBC 2920 (U.S. Sup. Ct. 2001).

²⁹⁹ *See also Glaziers & Glassworkers Union Local No. 252 Annuity Fund v. Newbridge Sec., Inc.*, 93 F.3d 171 (3d Cir. 1996).

³⁰⁰ *In re Unisys Corporation Retiree Medical Benefits ERISA Litigation*, 2007 U.S. Dist. LEXIS 89317 (E.D. Pa. 2007).

³⁰¹ *Hensley v. P.H. Glatfelter Co.*, 2005 U.S. Dist. LEXIS 31136 (W.D.N.C., 2005).

eventually filed for bankruptcy, at which point the plaintiffs discovered that the seller's obligation to provide retiree benefits was conditioned on the buyer's ability to reimburse seller for the cost of such benefits. The court recognized the seller's ability to terminate benefits, but found that the seller did not have the right as an ERISA fiduciary to make material misrepresentations to participants. The court found that a reasonable jury could find that the seller's failure to disclose the full terms of the acquisition would mislead a reasonable employee in making a decision about if and when to retire.

e. **Fifth Circuit.** None noted.

f. **Sixth Circuit.**

(i) **Non-Collectively Bargained.**

James v. Pirelli.³⁰² The Sixth Circuit allowed plaintiffs in this case to maintain a claim under section 502(a) of ERISA for breach of fiduciary duty against an employer upon finding that the employer provided the plaintiff retirees with materially misleading and inaccurate representations about their benefits. The court stated that under common law, when an employer amends or terminates a plan, or benefits thereunder, the employer is acting in its capacity as employer, and is not a fiduciary to the plan. However, conveying information about the future of the plan's benefits is a discretionary action giving rise to a fiduciary duty, which can be breached if the employer either responds to a participant's inquiry with misleading information, or provides misleading or inaccurate information on its own initiative. Importantly, the court found that a reservation of rights clause allowing the employer to amend or terminate benefits under the plan does not insulate the employer from liability for breach of fiduciary duty.

This case undermines a seller's argument that retiree medical benefits do not represent an actual liability since they can be amended or terminated at any time since such representation will not always be true, particularly if the employer has made misleading representations to the employees. This case also highlights the importance in ensuring that the stock seller retains liability for his past acts and representations with respect to the retiree medical benefit plan, which will dictate the structure of the merger and acquisition transaction, as discussed below. Indemnification provisions should address the stock seller's liability for all representations made prior to the acquisition with respect to retiree medical benefits.

³⁰² 305 F.3d 439, 2002 U.S. App. LEXIS 19071 (6th Cir. 2002).

(ii) **District Court within Sixth Circuit – Non-Collectively Bargained**

Armbruster v. K-H Corporation.³⁰³ The plaintiffs in this case were former employees of Fruehauf Corporation, which became K-H Corporation. K-H Corporation (the “Seller”) sold a portion of its business to Fruehauf Trailer Corporation (the “Buyer”). Under the explicit terms of the purchase agreement, the Buyer was to assume all debts, liabilities and obligations of the Seller, including liabilities under the employee benefits plans offered to the employee’s of the Seller. The Seller maintained a retiree medical benefit plan under which the Seller paid the entire insurance premium for eligible retirees and their spouses. Representations in the plan and summary plan description, as well as oral and written representations made on behalf of the plan, indicated that the retirees would be entitled to company-paid medical insurance for life. However, the plan and SPD contained a reservation of rights clause, allowing the employer to modify or terminate the plan.

After the sale, the Buyer reduced the benefits available under the retiree plan by mandating that retirees pay a portion of the applicable insurance premiums. Initially, the retirees sued the Buyer for reducing their benefits. However, the case was dismissed when the Buyer was forced into a Chapter 7 liquidation bankruptcy. Thereafter, the retirees received a letter from the Seller (the retirees’ original employer prior to the sale) saying that the Seller would provide retiree medical benefits after they were no longer provided by the Buyer. It was at this point that the retirees decided to sue the Seller for their reduction of benefits. The theory of their case was that the Buyer violated ERISA by modifying the retiree’s benefits under the plan, and that the Seller acted in concert with the buyer. The claims were brought under sections 502(a)(1)(B) (to recover benefits due under the plan or to enforce his rights under the plan) and 502(a)(3) (to enjoin an act or practice in violation of ERISA or plan or to obtain other appropriate equitable relief to redress violations or to enforce ERISA or the terms of the plan) of ERISA.

The court granted the defendant’s motion for summary judgment based on the fact that the plaintiff’s claims were time barred and lacked merit. The plaintiffs put forth two arguments for why their complaint should not be time barred. First, the Plaintiffs alleged that the Seller’s actions constituted “fraud and concealment” since the Seller knew, and did not disclose to the retirees, while the Buyer’s bankruptcy was pending, that if the Buyer failed to perform the assumed obligation under the

³⁰³ 206 F. Supp. 2d 870 (E.D. Mich. 2002).

purchase agreement with respect to retiree medical benefits, the Seller could be a potential subject of suit. The court did not find this argument persuasive, saying that silence is not enough to trigger the fraud and concealment provisions of ERISA.³⁰⁴

The second argument advanced by the plaintiffs against the expiration of their claims was that the plaintiffs did not know to join the Seller in the action until they received the letter from the Seller indicating that upon the Buyer's cessation of benefits, the Seller would continue benefits. If the statute of limitations had begun running on the date the retirees received notice of the Seller's intent to continue benefits, the plaintiff's claim would not be time-barred. The court found that under contract law, unless the person to whom benefits are owed (in this case the retirees) agrees otherwise, neither the delegation of duties, nor a contract to assume the duties made with the obligor (the seller) by the person assuming the duties (here the buyer) discharges the duties of the obligor (the seller). Because this is a basic principal of contract law, the retiree's should have known to join the Seller in the lawsuit at its initiation.

Following the line of cases discussed above in Section III.(A)(1) regarding the sponsor's right to modify or terminate benefits, the court also found that the plaintiff's claim lacked merit since all documents contained an explicit reservation of rights clause allowing the sponsor to modify or terminate benefits. Furthermore, oral representations did not give rise to a valid bilateral contract since the written documents were unambiguous. Finally, because there were no misrepresentations made by the Seller, the plaintiff's claim for breach of fiduciary duty lacked merit.

g. Seventh Circuit.

(i) Non-Collectively Bargained.

*Vallone v. CNA Financial Corporation.*³⁰⁵ In this case the representatives from the employer's human resources department represented in a meeting that retiree benefits would be available for life. When the employer was acquired by another company, the acquiring company decided to terminate the retiree benefits. An earlier decision found that nothing in the retiree health plan literature created a vested interest in lifetime benefits since the literature contained a reservation of rights clause allowing the

³⁰⁴ 29 U.S.C. 1113 (West 2002), § 413 of ERISA.

³⁰⁵ *Vallone v. CNA Financial Corporation*, 30 EBC 1293 (DC N. Ill., 2003), *aff'd* 375 F.3d 623, 33 EBC 1000 (7th Cir. 2004).

employer to terminate or modify the plan at any time.³⁰⁶ The issue in this case was whether, in the face of the reservation of rights clause, the oral misrepresentations constituted a breach of fiduciary duty. The court found that an employer did not breach its ERISA fiduciary duty since the retirees in this case did not present any evidence that the employer set out to deceive them or disadvantage them. Rather the human resources representatives merely gave out incorrect information. The District Court said that upholding oral representations of future benefits which were inconsistent with the representations present in the written plan documents would be inconsistent with the general ERISA principle of adherence to plan documents. The Seventh Circuit has held there is a presumption against vesting where there is “silence” that indicates that welfare benefits are not vested.³⁰⁷

(ii) **District Court within Seventh Circuit – Non-Collectively Bargained**

Estate of Retherford.³⁰⁸ The court held that a notice the company was ceasing business did not give the participants constructive notice of the exact date the plan would cease and that claims submitted only a few days later would not be paid. While welfare plans are free to terminate at any time by following plan procedures, that does not include providing a constructive notice of plan termination to notify participants. The plan termination notice must clearly state the plan termination date and when it will cease paying claims submitted.

h. Eighth Circuit.

(i) **District Court within Eighth Circuit – Collectively Bargained (multiemployer)**

Swanson v. Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund.³⁰⁹ A disabled worker was told her specific health insurance contract would not be terminated yet the plan included the reservation rights clause permitting the plan sponsor to terminate, amend or otherwise restrict benefits or eligibility. The trust agreement stated the plan would continue in operation indefinitely. The SPD stated “nor shall you accrue any rights because of any statement in or omission from this booklet, the right has been reserved to amend . . . and to terminate the Plan.” The fully insured plan converted to self insured status as

³⁰⁶ *Vallone v. CNA Financial Corporation*, 25 EBC 2714 (DC N. Ill., 2000), 30 EBC 1293 (DC N.Ill. 2003), aff’d 375 F.3d 623, 33 EBC 1000 (7th Cir. 2004).

³⁰⁷ *Vallone*, 375 F.3d at 632.

³⁰⁸ 2002 WL 31423057 (N.D. Ind. 2002).

³⁰⁹ 2002 WL 1402536 (D. Minn. 2002).

of February 1, 2001. The conflicting provisions in the plan document and summary plan description and the plaintiff's allegations of HIPAA violations led the court to issue an injunction precluding the plan and fund from changing her benefits until the litigation is resolved.

- i. **Ninth Circuit.** None noted.
- j. **Tenth Circuit.** None noted.
- k. **Eleventh Circuit.** None noted.
- l. **Federal Circuit.** None noted.
- m. **U.S. Supreme Court.**

In *Varity Corp. v. Howe*,³¹⁰ a corporation engaged in a reorganization it entitled "project sunshine" whereby it intended to transfer its retiree medical benefit liability along with its money losing divisions to a new entity. The new entity was insolvent and filed for bankruptcy within two years of its creation. The employees and retirees sued Varity Corp. for breaching its fiduciary duty by misleading the employees to transfer to the new entity where they then lost the pension and retiree medical benefits. The court found that Varity Corp. did mislead the participants and that it breached its fiduciary duties under ERISA. The court found the retirees and former employees had standing to pursue the breach of fiduciary duty and reinstatement of benefits.

- 4. **Standing is Key.** Surviving spouses of retirees challenged a prior amendment to a retiree plan that terminated the surviving spouse's coverage but their claims were dismissed for lack of standing.³¹¹
- 5. **Interplay between the sponsoring employer's contractual right to terminate retiree medical benefits and the bankruptcy code.** Interesting issues arise when an employer sponsoring a retiree medical benefit plan files for bankruptcy. The bankruptcy code in effect prior to the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (the "Prior Bankruptcy Code") contained several provisions aimed at protecting retiree medical benefits. Specifically, section 1114 of the Prior Bankruptcy Code allowed a chapter 11 (reorganization) debtor to modify retiree welfare benefits by negotiating with the retiree's representative and reaching an agreement.³¹² Section 1114(g) of the Prior Bankruptcy Code permitted a retiree representative to apply to the court for an order to increase benefits upon an appropriate showing. For example, an appropriate showing for purposes of section 1114(g) of the Prior Bankruptcy Act might be that the modification process was not followed properly, or that the

³¹⁰ 516 U.S. 489 (1996).

³¹¹ *Leuthner v. Blue Cross and Blue Shield of Northeastern Pennsylvania*, ___ F.3d ___, 2006 WL 1881438 (3rd Cir. 2006); 549 U.S. ___, *cert. denied*, Feb. 20, 2007, No. 06-651).

³¹² 11 U.S.C. 1114 (2003).

debtors could reasonably afford to increase benefits. Additionally, section 1129(a)(13) of the Prior Bankruptcy Code required a reorganization plan to provide for continued payment of retiree welfare benefits according to the pre-chapter 11 contract, or modifications made under section 1114.³¹³ However, the Prior Bankruptcy Code was not clear on whether these sections prohibit the termination of retiree welfare benefits as allowed by the terms of the contract. In one case described below, the court held that the sections in the bankruptcy code which provide protection for retiree medical benefits do not preclude an employer from terminating retiree medical benefits under the terms of the benefit plan.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (“2005 Act”), which became effective for bankruptcies filed on or after October 17, 2005, modified portions of section 1114 of the Prior Bankruptcy Code. Under the bankruptcy code, as modified by the 2005 Act, in the event that a retiree plan was modified within 180 days prior to the bankruptcy filing, and at a time when the debtor was insolvent, upon motion of any party in interest, the benefit plan will be reinstated as it was prior to the modifications, unless the “court finds the balance of equities clearly favors such modification.” This amendment protects retirees in that it permits retirees to seek to undo pre-petition negotiated reductions before the commencement of the bankruptcy process. However, because “any party in interest” to the bankruptcy case (not just parties in interest with respect to the plan) can seek to undo otherwise lawful pre-petition arrangements, the modification may actually place retirees at a disadvantage in reaching a consensual agreement. The 2005 Act did not modify section 1129(a)(13) of the Prior Bankruptcy Act.

The following cases were decided under the Prior Bankruptcy Act.

- a. ***In re N. Am. Royalties, Inc.***³¹⁴ In this case, the court found that sections 1114 and 1129(a)(13) do not restrict the employer’s right to terminate retiree medical benefits as allowed in the reservation of rights clause in the governing plan document. The court stated that if the bankruptcy code limited the debtor’s rights to terminate the contract, as allowed by the terms of the contract, then the filing for chapter 11 bankruptcy would have the effect of vesting retiree welfare benefits that were not previously vested. Such a result would provide better protection for retiree welfare benefits than the bankruptcy code provides for pension benefits created under a collective bargaining agreement. Furthermore, the court reasoned that barring the right to termination allowed by the terms of the contract would lead to widely disparate treatment of debtors, their other creditors and retirees, according to whether the employer terminated the retiree medical benefits contract before or after filing for chapter 11 bankruptcy. The court therefore concluded that section 1114 and section 1129(a)(13) were enacted against the background of ERISA which allows a contract for retiree welfare benefits to provide the employer with the right to terminate.

³¹³ 11 U.S.C. 1129(a)(13) (2003).

³¹⁴ 276 B.R. 860 (Bankr. E.D. Tenn., 2002).

b. ***Nelson v. Stewart***. The Seventh Circuit held that section 1114 of the Bankruptcy Code does not preempt state law claims against the union by retirees seeking lost health care benefits that were promised in a collective bargaining agreement, where the employer and union had agreed, without the retiree's knowledge, to reject the collective bargaining agreement and implement a contract that did not provide for retiree medical benefits.³¹⁵ The Seventh Circuit found that section 1114 was a statute designed to serve the limited role of providing retirees with representation in bankruptcy proceedings and does not purport to provide any federal cause of action for inadequate representation, and so any such cause of action arising under state law, is not preempted.

6. **Merger Agreements with Benefit Mandates**. In *Halliburton Company Benefits Committee v. Graves*,³¹⁶ Halliburton NC, Inc. had merged with Dresser Industries, Inc. and in the agreement Halliburton was obligated to continue Dresser's benefit programs for its employees for a limited period and for retirees unless the benefits were similarly changed for active employees. Halliburton maintained the benefits for six years after the merger for both groups, but then wanted to redesign its retiree benefits and sought a declaratory judgment that it could change the plans under the merger agreement. The Dresser retirees replied with their own cross claim. The Dresser plan provided the administrator can only make minor inexpensive changes to the plan, but the court found that termination of benefits for an entire class of beneficiaries is a major change. The court found the changes proposed by Halliburton were major changes and could not be done by the plan administrator.

The District Court and the Fifth Circuit found the merger agreement amended the plan and was a contractual obligation. Halliburton's commitment to not modify the retiree benefits except to the extent active employee benefits were consistently changed bound Halliburton. The District Court and the Fifth Circuit found Halliburton's CEO's signature on the merger agreement was sufficient to adopt the amendment in the form of the merger agreement. The merger agreement obligated Halliburton to bear significant costs by maintaining indefinitely retiree benefits that are equal to employee benefits even though the present plan required a vice president of human resources to sign the amendment. Furthermore, internal documents circulated by such vice president acknowledged Halliburton's obligation to the Dresser retirees. The retiree benefits were not vested, but were contractually conferred in permanent parity. The plan's reservation of right clause did not save it from the covenants in the merger agreement. The plan's appeal claiming the "reservation of rights clause" saved it from the retirees' claim and the "no-third party beneficiary clause" precluded the retirees from pursuing their claim based upon the merger agreement was dismissed by the Fifth Circuit because it failed to consider the provision in the

³¹⁵ *Nelson v. Stewart*, 422 F. 3d. 463 (7th Cir., 2005)

³¹⁶ 2004 U.S. Dist. LEXIS 25684 (Civ. Act. H-04-280) (S.D. Tex., Dec. 20, 2004, amended January 5, 2005); 463 F.3d 360, Case No. 06-20632 (5th Cir. 2006), *rehearing en banc denied*, February 13, 2007, No. 06-20632, (5th Cir. February 13, 2007).

merger agreement providing parity in benefits for the Dresser retirees.³¹⁷ Halliburton's petitions for rehearing and for a rehearing *en banc* were both denied by the Fifth Circuit, but the Fifth Circuit in its opinion denying the request for rehearing *en banc* specifically stated, "This is not a case, for example, in which an acquiring company limited a benefit continuation amount to a specific time period or included an express statement that the merger agreement was not intended to modify or amend any particular plan. We express no view on whether such language would successfully limit the application of ERISA or a plan participant's right to sue."³¹⁸ Thus, the court left open other alternatives for companies to use to potentially limit their exposure in merger agreements.

In *Coffin v. Bowater, Inc.*, a federal district judge in Maine granted partial summary judgment to a class of former employees of Great Northern Paper Inc. ("GNP") seeking retiree medical benefits from Bowater, Inc. ("Bowater"), which owned GNP at the time the plaintiffs retired.³¹⁹ The First Circuit affirmed the District Court's decisions on the ERISA claims and LMRA claims. Bowater sold GNP to Inexcon Maine, Inc. ("Inexcon"), and in connection with the transaction, Bowater and Inexcon negotiated an agreement with the unions representing the retiree participants releasing Bowater from the collective bargaining agreements requiring the retiree medical program. When Bowater stopped providing retiree medical benefits to the retirees, GNP began providing retiree medical benefits, although Bowater continued to maintain a retiree medical plan. However, GNP eventually stopped providing retiree medical benefits. The court found that Bowater had the obligation to provide retiree medical benefits, and that the sale of GNP to Inexcon did not eliminate these responsibilities and the Stock Purchase Agreement did not amend or terminate Bowater's obligations under the retiree medical plan under ERISA. The court held that absent any formal termination of the retiree medical plan, the language in the sales agreement did not serve as an automatic termination of rights of the former GNP employees to assert coverage. The court did find that a 2003 restatement of the Bowater plan which excluded coverage to former GNP employees limited the plaintiffs' claims to those accruing prior to the 2003 restatement. The claim under the LMRA failed because the collective bargaining agreement included a clear duration clause with respect to pre-1999 CBA. The 1999 CBAs also did not have any language in the collective bargaining agreement supporting their claim for lifetime retiree medical benefits paid by the Company. This case illustrates the importance of ensuring that plan documents accurately describe the class of eligible employees for participation, particularly in the context of a corporate merger or acquisition and when a plan is amended or terminated. It also clarifies what the First Circuit considers to constitute a plan amendment. Furthermore, this case validates the proposition that the plan document, and not other legal documents or agreements govern the terms of the plan.

³¹⁷ *Halliburton Company Benefits Committee v. Graves*, 463 F.3d 360, (5th Cir. August 30, 2006), *rehearing en banc denied*, Case No. 06-20632 (5th Cir. February 13, 2007).

³¹⁸ *Halliburton Company Benefits Committee v. Graves*, 463 F.3d 360 (5th Cir. August 30, 2006), *rehearing en banc denied*, Case No. 06-20632 (5th Cir. February 13, 2007).

³¹⁹ *Coffin v. Bowater, Inc.*, 501 F.3d 80, 41 EBC 1529 (1st Cir. 2007), D. Me., No. 03-227-B-C (2005); 501 F.3d 80, Case No. 06-1964 (1st Cir. September 7, 2007).

In *Prouty v. Gores Technology Group, et al.*, a California appellate court held that a group of employees were intended beneficiaries of a stock purchase agreement, despite language in the stock purchase agreement that the agreement was not intended to confer any rights or remedies upon any person other than a party to the agreement.³²⁰ The agreement provided that if the buyer terminated employees within the first sixty days following the transaction, the employees would be entitled to certain severance benefits. Certain employees were terminated and not given the full amount of severance benefits. The court found that the purchase agreement was amended to benefit the plaintiffs, thus making them beneficiaries capable of enforcing the agreement. The court found that whether a third party is an intended beneficiary is not governed solely by the terms of the agreement, but also by the surrounding circumstances. If the rationale adopted by the California appellate court in this case is adopted by other courts, plan participants (or former plan participants) may have a cause of action arising not only from plan documents, but from corporate transaction agreements, particularly if the purchase agreements deals specifically with benefits issues and the buyer terminates or reduces benefits following the transaction.

The Sixth Circuit rejected an action brought by participants seeking to enforce an agreement Fifth Third Bancorp made with their employer regarding handling of the Suburban Bancorporation's ESOP and suspense account after Fifth Third Bancorp became the successor.³²¹ The Sixth Circuit rejected their attempts to enforce the pre-merger agreement and allegations of misrepresentation and breach of fiduciary duty. The Sixth Circuit found the pre-merger agreement was entered into prior to the time Fifth Third Bancorp was a fiduciary and thus there was no breach of fiduciary duty or alleged misrepresentation. The Sixth Circuit found Fifth Third Bancorp's decision to amend the plan and make its current employees beneficiaries along with the class members (who were employees of Suburban Bancorporation) whose interests in the Plan were diluted by adding new participants to share or the suspense accounts were actions to be regulated by ERISA and thus no state law claim for this amendment could survive because the beneficiaries could not raise a state law claim because such an action was preempted under *Aetna Health, Inc. v. Davilla*, 542 U.S. 200 (2004).³²²

7. **Other Agreements with Benefit Mandates.** In *Bouboulis v. Transportation Workers Union of America*,³²³ the Second Circuit Court of Appeals found a side letter to retirees promising lifetime benefits to surviving spouses did not rise to the level of formality necessary to be a plan amendment. Furthermore, the promise of lifetime benefits to surviving spouses did not imply lifetime benefits to the retiree. The SPD's failure to include a reservation of right to amend clause alone without a promise of lifetime benefits did not create a lifetime promise.

In *Bland v. SMS Demag, Inc.*,³²⁴ the court reviewed a severance agreement's promise of lifetime benefits to an employee and his spouse by a predecessor

³²⁰ *Prouty v. Gores Technology Group*, 121 Cal. App. 4th 1225 (Cal. App. 3d, 2004).

³²¹ *Hutchison v. Fifth Third Bancorp*, 469 F.3d 583, 39 EBC 1705 (6th Cir. 2006).

³²² *Hutchison v. Fifth Third Bancorp*, 469 F.3d 583, 39 EBC 1705 (6th Cir. 2006).

³²³ 2006 U.S. App. LEXIS 6120 (2d Cir. 2006).

³²⁴ 2005 U.S. Dist. LEXIS 18328 (W.D. Penn. 2005).

entity. The court found the plan administrator's decision to deny benefits to be arbitrary and capricious because it did not address the meaning of the "1987 Plan modification, which promised that both Mr. & Mrs. Bland would be included in the company medical plans for life." This case finds a severance agreement with one employee to constitute a plan modification.

C. Successor Liability under Collective Bargaining Agreements under the National Labor Relations Act and Other Contractually Based Claims.

These cases look at contractually based claims. These cases provide considerations for drafting collective bargaining agreements both for what the agreements provide and what is left unsaid.

1. ***Grimm v. Healthmont, Inc.***³²⁵ In *Grimm*, a District Court in Oregon cited Trustees for Alaska Laborers-Construction Industry Health & Sec. Fund. v. Ferrell,³²⁶ as extending successor liability to successor employers under ERISA based upon a federal common law doctrine of successor liability. The court stated, "[u]nder the federal common law as applied to ERISA claims, an employer is liable for a previous employer's obligations under an ERISA plan if the subsequent employer is a bona fide successor and had notice of the potential liability." The purchaser is a successor employer, "if it hires most of its employees from the previous employer's work force and conducts essentially the same business as its predecessor without a fundamental change in working conditions." This analysis extends liability for retiree medical benefits to purchasers in many asset acquisitions. This involved a union negotiated plan for retiree medical benefits.
2. ***Bish v. Aquarion.***³²⁷ In *Bish* (Bish) the court did not grant a successor employer's motion to dismiss, in part, because the successor employer may be liable under a theory of successor liability.

In *Bish*, retirees were provided retiree medical benefits under a collective bargaining agreement ("CBA"). The retiree's former employer, US Filter, had a contract with the city to provide waste water treatment services. Prior to the expiration of the CBA, Aquarion entered into a contract with the city to provide waste water treatment services and agreed to hire the employees of US Filter. Aquarion sent several letters to US Filter indicating that there would be no disruption of pension benefits. However, there was nothing in the letters regarding Aquarion's assumption of responsibility for retiree medical benefits. US Filter sent a letter to retirees indicating that the buyer had assumed responsibility of the CBA and would therefore be responsible for the provision of retiree medical benefits. Subsequently, Aquarion sent a letter to the retirees indicating that Aquarion had not assumed responsibility under the CBA, and was currently in the process of negotiating CBA's with various groups. The retirees sued both US Filter and Aquarion under various ERISA and LMRA claims.

³²⁵ 2002 WL 31549095, 8 (D. Or., 2002).

³²⁶ 812 F.2d 512 (9th Cir. 1987).

³²⁷ *Bish, et al. v. Aquarion Services Co., et al.*, 289 F. Supp. 2d 134, (D. Conn., 2003).

Aquarion sought a motion to dismiss based on the fact that it never employed the retirees, and was never a party to the CBA extending retiree medical benefits.

The court found that the retirees' allegations that Aquarion had assumed the obligations of US Filter under the CBA were sufficiently pled, and if proven, would serve as the basis for Aquarion's liability under ERISA and the LMRA. The court pointed to representations in letters from Aquarion indicating that pension benefits would not be disrupted as evidence that Aquarion intended to assume responsibility of the CBA.

Aquarion also sought dismissal based on the fact that Aquarion was never the retirees' employer or plan administrator, and thus, the retirees' could not sustain an ERISA section 502(a)(1)(B) claim against Aquarion. The court found that because courts have recognized successor liability under ERISA in similar contexts, dismissal was not appropriate.

US Filter sought a dismissal on the theory that the retiree's had not exhausted their administrative remedies under the plan. The court did not grant the motion. The court stated that the administrative remedies scheme was aimed at resolving disputes about particular benefits, and found that under the facts of the case, exhausting administrative remedies would be futile since the basis of the dispute was not whether or not particular benefits were covered, but which party was liable for the benefits.

3. ***LaForest v. Honeywell International Inc.***³²⁸ In this case the court issued a preliminary injunction requiring an employer to restore the retiree health benefit and prescription drug program guaranteed by employer's predecessor upon finding that the termination of the benefits would result in irreparable harm to the retirees, and that without the preliminary injunction, retirees would face a substantial risk to their health, severe financial hardship, and anxiety caused by uncertainty with respect to their medical coverage. In this case the court had previously found that the successor employer, as successor in interest, was liable for retiree medical benefits promised by the predecessor employer. The only outstanding issue was whether the successor employer was entitled to contribution from the predecessor employer. This involved a union negotiated retiree medical benefit plan.
4. ***Cleveland Electric Illuminating Company v. Utility Workers Union of America, Local 270.***³²⁹ The Sixth Circuit found that since the collective bargaining agreement addressed retiree medical benefits, the claim related to changes in such benefits was arbitral under the collective bargaining agreement. However, because the retirees have separate contractual rights and are not current union members, the union must obtain the consent of the retirees to bring the claim on their behalf.
5. **Contractual Liability.** In some situations, multiemployer welfare plans have sought to impose contractual withdrawal liability for welfare and retiree medical

³²⁸ *La Forest v. Honeywell International Inc.*, 31 EBC 2502 (DC WNY, 2003).

³²⁹ 440 F.3d 809 (6th Cir. 2006), No. 04-3566/3567.

benefits. In *Craddock v. Apogee Coal Co.*,³³⁰ Landmark Corp. contracted with Apogee to do reclamation work. Apogee was bound by the National Bituminous Coal Wage Agreement of 1993 (the “NBCWA”). The NBCWA required an employee’s last signatory employer to provide the employee’s lifetime health benefits. The agreement between Landmark and Apogee required Landmark to hire workers from a panel of laid off Apogee employees. The agreement further provided that Apogee would remain liable for the lifetime medical benefits for the first 20 laid off employees Landmark hired. Landmark subsequently filed for bankruptcy. Both Landmark and Apogee sought to avoid liability for the post-retirement health benefits. The Fourth Circuit found that Apogee remained liable for the benefits under its agreement with Landmark regardless of Landmark’s bankruptcy.

In *Accuride Erie, L.P. v. International Union, Automobile, Aerospace & Agricultural Implement Works of America, Local Union 1186*,³³¹ first the arbitrator resolved the conflict by looking at the May 1, 1997 collective bargaining agreement that allowed the union members to make a one time irrevocable election to either receive the Kaiser Aluminum Corporation retiree medical benefits or the Accuride (the purchaser) active employee medical benefits. In 1998 a subsequent collective bargaining agreement extended the 1997 agreement through August 2003. In 2001 medical benefits were not being covered by the Kaiser retiree plan, a retiree submitted a claim to Accuride and Accuride denied it because the individual had irrevocably elected out of the Accuride plan in 1997. In September 2003, a new collective bargaining agreement was signed that did not say anything regarding Kaiser employees who had previously elected Kaiser retiree medical coverage, and it only provided that Accuride will provide “eligible employees” with medical benefits. The 2003 collective bargaining agreement also required grievances to be submitted within 14 days of the occurrence giving rise to the grievance. In April 2004 Accuride learned that Kaiser had petitioned the bankruptcy court to terminate its retiree medical benefits and on May 31, 2004 it terminated the retiree medical benefits. On June 8, 2004 the union filed a grievance demanding that Accuride provide medical benefits for all of the affected employees. The arbitrator ruled that the 2003 collective bargaining agreement did not preclude receipt of benefits because it provided benefits for “all eligible employees” and that the irrevocable election was terminated by the 2003 collective bargaining agreement. He found the grievance was timely because the act occurred on May 31, 2004 when Kaiser terminated the retiree medical plan. The District Court upheld the arbitrator’s award relying upon the 2003 collective bargaining agreement and the absence of any language incorporating the elections from the prior collective bargaining agreement and determined those elections did not survive the 2003 collective bargaining agreement. The Third Circuit agreed that the elections did not survive the 2003 collective bargaining agreement in part because the elections were not mentioned in the 2003 collective bargaining agreement and easily could have been mentioned and due to the “zipper clause” that explicitly negated all past agreements.

³³⁰ 4th Cir. No. 05-1352 (unpublished 4th Cir. February 9, 2006).

³³¹ 2007 U.S. App. LEXIS 28717 (3rd Cir. December 11, 2007).

In International Chemical Workers Union Council of the United Food and Commercial Workers Union and its Local 45C and 776C v. PPG Industries, Inc.,³³² the Third Circuit found that a collective bargaining agreement and plan that stated the employer “will provide” and “will continue” or that such benefits “may be continued” or “will continue” were not sufficient to show that the retiree medical benefits were vested or that PPG would pay for health benefits for the life of the retiree.

- D. Executive Benefits.** Historically, executives have frequently obtained contractual rights to post-retirement or post-separation from service continued health benefits. When such post-employment health benefits continue on a discriminatory basis, there are a number of issues raised.

First, if the plan is fully insured and the coverage is promised for a period beyond the duration of COBRA continuation coverage under Code section 4980B, the insurer may refuse to continue the coverage leaving the promising employer self-insuring the cost of coverage. If the plan is self-insured with stop-loss coverage, the stop-loss carrier may refuse to consider claims arising out of the promise as applicable toward the specific or aggregate stop-loss limits, again leaving the promising employer self-insuring the claims.

Second, Code section 105(h) imposes nondiscrimination requirements on self-insured health plans and requires highly compensated employees to be taxed on their discriminatory benefits under the plan. The executive could be taxed on the discriminatory portion of his benefits, resulting in additional compensation paid post-termination to be considered in determining golden parachute payment tax liabilities.

Third, unless the executive is involuntarily terminated so that his post-termination pay may qualify as “separation pay” under Treasury Regulation § 1.409A-1(b)(9)(v)(B), (m) and (n), if all other requirements are satisfied, the reimbursement of medical expenses may constitute deferred compensation. If the arrangement cannot fit within the separation pay exemption, the plan may be able to be designed to comply with Code section 409A payment requirements by amending the plan to comply with Treasury Regulation § 1.409A-3(i)(1)(iv) so the payments qualify as payments on a specified date and the plan is amended to comply with the written document requirements of Code section 409A.

The final Code section 409A regulations provided an exemption for continued medical benefits to the extent the separation pay plan, including a plan providing for payments for a voluntary separation, entitles an executive to reimbursement from the former employer for medical expenses incurred and paid by the former executive but not reimbursed by any other source and that are allowable as Code section 213 medical expenses (ignoring the 7.5% of adjusted gross income floor on the deduction). The reimbursement of medical expenses may not extend beyond the period the individual would have been entitled to continuation coverage under a group health plan of the employer under COBRA (Code section 4980B) if the former executive had elected such coverage.³³³

³³² 236 Fed. Appx 789, 2007 U.S. App. LEXIS 14095 (3rd Cir. 2007).

³³³ Treas. Reg. § 1.409A-1(b)(9)(v)(B).

Additionally, there are other exceptions that may apply to exclude some payments such as the in-kind benefits and direct service recipient payments,³³⁴ limited payments,³³⁵ and payments of medical benefits may also be designed to comply with Code section 409A(a) requirement that payments be made at a specified time or fixed schedule if those payments as reimbursed or in-kind benefits of the arrangement that provides for the reimbursement of medical expenses referred to in Code section 105(b) beyond the COBRA continuation coverage period, if those amounts are paid pursuant:

- (1) to a plan that has an objective determinable nondiscretionary definition of the expenses eligible for reimbursement or of the in-kind benefits to be provided;
- (2) the plan provides for reimbursement of expenses incurred or the provision of the in-kind benefits during a objectively and specifically prescribed period;
- (3) the plan provides that the amount of expenses eligible for reimbursement for a taxable year may not affect the expenses eligible for reimbursement in another year, but for medical expenses this does not mean that a plan cannot place limits on the benefits reimbursable over some or all of period in which the reimbursement arrangement remains in effect;
- (4) the reimbursement of an eligible expense is made on or before the last day of the executive's taxable year following the taxable year in which the expense was incurred; and
- (5) the right to reimbursement or in-kind benefits is not subject to liquidation or exchange for another benefit.³³⁶

Executive contracts should be further reviewed for accounting for post-retirement benefit obligations and liabilities and for SEC reporting, if applicable.

Executive benefits may be difficult to maintain after the Health Reform Acts are effective. For the first plan year beginning on or after September 23, 2010, insured group health plans will be subject to nondiscrimination testing similar to that applied to self-insured group health plans under Code section 105(h).³³⁷ The application of such nondiscrimination rules to the fully insured medical plans for executives will cause discrimination issues and potential penalties for failure to comply.³³⁸

IV. Role of Post-Retirement Medical Benefits in Negotiations Leading up to Merger and Acquisition Transaction

Because of the large and growing costs associated with retiree medical benefit plans and the potential liabilities they place on a plan sponsor, retiree medical benefits should be considered early in the negotiation process for a corporate merger and acquisition. As discussed above in Section III, entitled "Amending or Terminating Post-retirement Medical Benefits," the sponsor's

³³⁴ Treas. Reg. § 1.409A-1(b)(9)(v)(C).

³³⁵ Treas. Reg. § 1.409A-1(b)(9)(v)(D).

³³⁶ Treas. Reg. § 1.409A-3(i)(1)(iv).

³³⁷ PPACA § 1001.

³³⁸ PPACA §§ 1001, 1004 and 1251 and Code section 105(h).

ability to amend and terminate a retiree medical benefit plan will not always foreclose the potential for liability. Therefore, a potential buyer will want to conduct careful due diligence with respect to retiree medical plans.

A. What a potential buyer should look for in conducting due diligence. In conducting due diligence prior to the transaction, a potential buyer will need to find out whether there are retiree medical obligations, and if there are, whether there are FAS 106 liabilities. Additionally, a potential buyer will want to examine the plan document for the retiree medical plan, any amendments to the plan document, all summary plan descriptions, and any modifications to the summary plan descriptions. The buyer must ascertain whether the plan documents and summary plan description contain an express reservation of rights clause allowing the employer to amend and terminate the retiree medical plan, and what representations have been made to employees who are receiving, and are entitled to receive retiree medical benefits. Furthermore, the potential buyer will want to examine all severance agreements, prior merger agreements, union agreements, early retirement windows, reductions in force and correspondence between the persons receiving or entitled to receive retiree medical benefits and the employer or the employer's human resources department. The potential buyer should pay close attention to any promises of life time benefits, or unchanged benefits that could be construed by a court to vest the benefits available under a plan. Additionally, the potential buyer will need to find out if retiree medical benefits are offered pursuant to any collective bargaining agreement that the seller is a part of, and when the applicable collective bargaining agreement expires. Finally, the potential buyer will want to obtain representations and warranties in the purchase agreement regarding the accuracy of the aforementioned items. Document to review during due diligence:

1. Plan documents.
2. Collective bargaining agreements.
3. VEBA trust documents.
4. VEBA determination letters.
5. Any VEBA private letter ruling submission.
6. Actuarial reports on funding for tax and financial accounting purposes.
7. Actuarial assumptions for tax and financial accounting purposes.
8. If there has been a transfer of liability to a VEBA, any settlement agreement, court approvals or related orders, Exchange approvals of the accounting treatment, the VEBA trust, actuarial reports and schedules of funding obligations, and any applicable prohibited transaction exemption or application for the same.
9. Summary plan descriptions.
10. Early retirement window program, RIF documents, employee handbooks and related documents or communication materials.

11. Description of who is eligible for retiree medical benefits in plan documents, summary plan descriptions, employee handbooks, all current prior union contracts and employment contracts and severance agreements.
12. For 2006 and later, information on prescriptive drug benefits and records on all subsidies received and any cost or other reports.
13. Executive employment agreements for contractual benefit promises and for Code section 409A reporting and compliance issues.
14. The group health plan's privacy notice, privacy policies and procedures, the plan amendment for privacy, the business associate agreements for the plan's vendors (third party administrator, pharmacy benefit manager, auditor, attorney, etc.).
15. The group health plan's operations for privacy compliance omissions in safeguards or record keeping.
16. Review all prior collective bargaining agreements and agreements with multiemployer plans regarding potential liabilities.
17. SEC disclosures on executive compensation or VEBA settlements in Form 8K as material agreements.
18. Audited financial statements and filings regarding post-retirement benefit obligations.
19. SEC filings regarding executive benefits and perquisites.
20. Employment agreements, severance or change in control policies for benefit continuation potentially subject to Code section 409A.
21. Does the retiree plan cover any active employees at the beginning of the plan year; if so, how many?
22. Has the retiree medical plan been using the exemption for plans with less than 2 active employees to avoid complying with some of the requirements under Code section 9831(a)(2) or ERISA section 732(a)?

B. Negotiations and structuring the transaction. In the negotiation process, the seller will want to be able to assure its former employees that the benefits will continue after the transaction. Furthermore, the seller will want to transfer benefit liabilities to the buyer, and to avoid the administrative problems associated with continuing to cover former employees under their plans. The buyer on the other hand will want to ensure that the seller remain liable for any violations of the law that occurred prior to the transaction and that adequate reserves are transferred for the liabilities transferred. While the presence of a welfare benefit plan generally will not, in itself, dictate the structure of a merger and acquisition transaction, if the buyer believes that there have been past violations of the law with respect to a welfare benefit plan or in other areas, the buyer may push for the transaction to be structured as an asset sale rather than a statutory merger, or stock purchase.

1. **Asset Sales.** If the merger and acquisition transaction is structured as an asset sale, the seller will remain liable for any violations of the law (e.g., misrepresentations giving rise to a breach of fiduciary duty) occurring prior to the merger and acquisitions transaction. Furthermore, the buyer will generally be able to determine whether to adopt the plan and assume responsibility of plan sponsor.

The purchase agreement should reflect to which employees the buyer is responsible to provide benefits. Usually, if the seller is a continuing enterprise, the current retirees will continue to be the obligation of the seller. The extent to which a seller assumes responsibility for employees who are eligible to retire on the date of the sale will be the subject of negotiation. When the seller remains liable for such employees' benefits, the termination of employment on the date of the sale will be treated as the date of retirement. The treatment of the seller's employees who are not yet eligible to retire will also be determined in negotiations. If the buyer intends to continue the retiree medical benefit plan, the buyer may seek in negotiations for the seller to agree to pay for a portion of the cost of the benefits determined based on an employee's relative length of service with the buyer v. the seller and when the employee retires and to fund such obligations. If the buyer does not intend to continue the retiree medical benefits and terminates it, employees who are not eligible to retire on the date of the sale will generally not receive benefits from either the buyer or the seller.

If the buyer intends to continue the retiree medical benefit plan, the buyer must be precise as to what liabilities are being assumed. The purchase agreement should cover the division of responsibilities between the buyer and the seller. Generally, the buyer will become responsible for the performance of all the responsibilities and duties required of a plan sponsor. The seller will be responsible for all liabilities arising out of past violations of the law. Finally, the buyer and seller should negotiate the division of responsibilities relating to contributions, reporting requirements and administrative duties for the current and preceding plan year (many obligations are fulfilled in the following plan year, such as filing Form 5500).

2. **Stock Sales.** On the other hand, if the transaction is structured as a stock sale, the buyer will not be able to avoid responsibility for prior operation of the plan, and the buyer will automatically adopt the plan by virtue of purchasing the stock of the plan sponsor. (However, the buyer in a stock purchase will not be required to adopt the plan if the buyer is purchasing the stock of a seller's subsidiary and the parent of the seller corporation takes over the obligation of maintaining the plan.) Because the buyer must assume responsibility for prior operation of the plan in a stock sale, the buyer must be more careful about identifying potential liabilities. Even if the purchase agreement in a stock sale contains representations and warranties that the operations of the plan have complied with the law, the representations and warranties will not provide much protection to the buyer after the merger and acquisition transaction has occurred. For this reason, if the buyer suspects that the seller has violated the law with respect to the retiree medical benefit plan, the buyer should push for the transaction to be structured as an asset sale rather than a stock sale, so that the seller remains liable for past legal violations. The buyer should use care in drafting the agreement to ensure that duration clauses are applied to any covenants regarding continuation

of benefits as well as to apply no third party beneficiary clauses to such covenants.

3. **Negotiation Considerations.** Which plan will cover each group of retirees or potential future retirees must be ascertained. This includes which individuals who are currently retired, those who are eligible for retiree benefits in the future, but who have not yet received the criteria to begin receiving retirees from which business for individuals who split their time between different businesses, including ones other than the one which was acquired (for these individuals there may need to be an allocation of expected expenses). Which benefit must be continued and for how long and what restrictions exist on making changes must be negotiated along with the duration clause and no third party beneficiary clause applicable to each such provision.
4. **Post Health Reform Acts Change Considerations.** The Health Reform Acts require review of whether the retiree medical plan has been using the exemption and if it can continue to rely on any exemption. The Health Reform Acts require the plan sponsor to review costs in light of the loss of the deduction for the Medicare Part D subsidy, the cost of increases in retiree prescription drug benefits necessary to continue to constitute creditable coverage with the Health Reform Acts increases in Medicare Part D benefits, and the early retiree reinsurance that must be passed through to participants, yet requires administration by the employer. Interim Regulations specifying the application requirements were issued on May 4, 2010.³³⁹

V. Privacy, Security and Mergers and Acquisitions

- A. **During the Transition Period Prior to April 14, 2004.** Until all group health plans became subject to the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) at 45 C.F.R. Parts 160 through 164 (the “Privacy Regulations”) on April 14, 2004, parties engaged in corporate transactions should use caution in merging plans immediately following an acquisition because a plan merger or increase in the number of participants could trigger an earlier compliance date for the plan by moving it to over \$5 million in receipts category with an earlier compliance date.³⁴⁰ Furthermore, in smaller plans increasing the number of participants can not only trigger an earlier compliance date, but could also move a plan within the definition of “group health plan” by making it cover more than 50 participants.³⁴¹ As of April 14, 2004, all group health plans became subject to the Privacy Regulations and the level of receipts to fund such benefits must be determined only with respect to the effective date for compliance with the electronic security regulations for electronic protected health information. As of April 20, 2005 and 2006, HIPAA security regulations also apply to group health plans with the date delayed for small plans. The HIPAA Security regulations apply to electronic protected health information created, received, maintained or transmitted by a covered entity.³⁴² Privacy and security are not just an issue of documenting policies and providing a notice, but also requires a review of

³³⁹ 75 Fed. Reg. 24450 (May 4, 2010).

³⁴⁰ 45 C.F.R. § 164.534 (2002).

³⁴¹ 45 C.F.R. § 160.102 (2002).

³⁴² 45 C.F.R. § 164.302 (2003).

the plans operations and identification of all business associates providing services to the plan so that contracts with such persons can be modified to satisfy the standards. It was reported that 5400 complaints had been received by the Department of Health and Human Services (“HHS”) through March 31, 2004, the first 11 and ½ months that the Privacy Regulations applied. A security violation resulting in an inappropriate disclosure is governed by the same penalties as a privacy violation and the same sorts of transition issues apply. Following enactment of the American Recovery and Reinvestment Act of 2009³⁴³ a “breach” can also result in notice of the plan’s failure being publicized not only to the affected individuals, HHS, but also to the public so compliance is now incentivized by not just civil penalties, but the threat of public embarrassment.

B. Privacy Liability Exposure.

- 1. Civil Penalties.** If a covered entity under the Privacy Regulations fails to comply with the requirements under such regulations, the Department of Health and Human Services may investigate and assess civil penalties of up to \$100 per day per violation of each standard per person.³⁴⁴ The civil penalties may accumulate to up to \$25,000 per standard violated. There is no limit on the number of standards that may be violated and on which the civil monetary penalty may be assessed. A civil penalty will only be precluded from being imposed if criminal enforcement is actually imposed for penalties imposed on or after February 17, 2010.³⁴⁵ If a violation is alleged due to willful neglect, a formal investigation is required and if willful neglect is found, a penalty must be imposed.³⁴⁶

In a stock purchase, the purchaser of the employer sponsoring the plan would inherit any violations of the prior plan sponsor. The penalty would apply to the covered entity or plan so that any entity assuming the responsibility for the plan would inherit the penalties carried with the plan. Thus it is important for a purchaser to review the plan’s privacy practices, policies, procedures, forms and business agreements to determine the plan’s compliance.

The Secretary of HHS may not institute an action for a civil monetary penalty later than six years after the date of the occurrence that is the basis for the penalty.³⁴⁷ A civil penalty can only be imposed after the individual is given written notice and an opportunity for a determination to be made on the record after a hearing at which the individual may be represented by his own counsel or by himself.³⁴⁸ The U.S. Department of Health and Human Services Office for Civil Rights (“OCR”), to the extent practicable, will seek cooperation in obtaining compliance with the Privacy Regulations.³⁴⁹ If an individual fails to respond and request a hearing within 60 days after receipt of a proposed

³⁴³ P.L. 111-5.

³⁴⁴ 45 C.F.R. § 160.306 and § 160.312 (2002) and 42 U.S.C. § 1320d-5.

³⁴⁵ Section 13410(a) of the American Recovery and Reinvestment Act of 2009 (the “Recovery Act”) P.L. 111-5.

³⁴⁶ Recovery Act § 13410(a) and (b).

³⁴⁷ 42 C.F.R. § 1320a-7a.

³⁴⁸ 68 F.R. 18895, 18896 (2003).

³⁴⁹ 68 F.R. 18895, 18897 (2003).

determination,³⁵⁰ the Secretary must impose the proposed penalty or a less severe penalty.³⁵¹ Once the penalty is imposed, it must be collected.³⁵² The individual can respond and request a hearing before an administrative law judge and the regulations or imposition of civil monetary penalties detail the procedural requirements for the hearing. The Secretary has the exclusive authority to settle any case or issue without the consent of the administrative law judge; thus, it is imperative that upon receipt of a notice of proposed determination the party respond within 60 days and begin addressing the issue.³⁵³

2. **Criminal Penalties.** The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) also included criminal sanctions for violations of the Privacy Regulations issued pursuant to HIPAA’s legislative regulatory authority. The criminal sanctions apply to any person who knowingly and in violation of the Privacy Regulations uses or causes to be used a unique health identifier, obtains or discloses to another person individually identifiable health information may be fined not more than \$50,000 and imprisoned not more than one year or both. If the above offense is committed under false pretenses, the individual may be fined not more than \$100,000 and imprisoned not more than five years or both. If the offense is committed with the intent to sell, transfer or use individually identifiable health information for commercial advantage, personal gain or malicious harm, the individual may be fined not more than \$250,000 or imprisoned not more than 10 years or both.³⁵⁴

3. **Private Right of Action.**

a. **Under ERISA.** The incorporation of the privacy provisions in the plan document as required by the Privacy Regulations³⁵⁵ provides the participants the right to seek to enforce the terms of the plan document under section 502(a)(3) of ERISA. However, the remedy for seeking to enforce the plan’s terms is limited to appropriate equitable relief and what exactly constitutes equitable relief remains to be determined following *Great-West Life & Annuity Ins. Co. v. Knudson*.³⁵⁶

b. **Preemption and State Causes of Action.** After Congress enacted the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),³⁵⁷ Congress was given 36 months in which to enact legislation protecting the privacy of individually identifiable health information. When Congress failed to act within the 36 month period, the U.S. Department of Health and Human Services was required to promulgate final regulations on the privacy of individually identifiable health information. While Congress did not enact any legislation, many

³⁵⁰ 45 C.F.R. § 160.514 (2003).

³⁵¹ 45 C.F.R. § 160.516 (2003).

³⁵² 45 C.F.R. § 160.518 (2003).

³⁵³ 45 C.F.R. § 160.536 (2003).

³⁵⁴ 42 U.S.C. § 1320d-5.

³⁵⁵ 45 C.F.R. § 164.504(f) (2003).

³⁵⁶ 534 U.S. 204, 112 S. Ct. 708, 151 L.Ed.2d 634 (2002).

³⁵⁷ Pub. L. No. 104-191 (August 21, 1996).

states did enact legislation establishing statutes creating private rights and causes of actions for violations in medical privacy. Many states also recognize causes of action in case law for intentional infliction of emotional distress in tort when a tortfeasor either intentionally or recklessly did some act which caused emotional distress. However, this is often difficult to prove without extreme or outrageous conduct.³⁵⁸ The majority of states have recognized a common law invasion of privacy tort for publicity given to private life if something private is made public by communicating it to the public at large.³⁵⁹

HIPAA also contained a number of provisions dealing with preemption. The first provision was contained in Title I, Part A, Group Market Reforms, Subpart 3, Exclusion of Plans, Enforcement and Preemption in Section 2723 of HIPAA which stated with respect to continued preemption with respect to group health plans:

Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.³⁶⁰

This “part” refers to the provision included in the Public Health Service Act dealing with the applicable portability, access and renewability requirements that apply to health insurance issuers under the Public Health Service Act. Part A of HIPAA under Title I did not include the statutory provision with respect to the privacy of individually identifiable health information.³⁶¹

The next provision addressing ERISA preemption under HIPAA was contained in section 2746 of the Public Health Service Act under Part B of Subtitle B of Title I of HIPAA. This provision in section 2746(b) states that:

Nothing in this part (or part C insofar as it applies to this part) shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144).³⁶²

Part B and Part C which are referred to in this section deal with guaranteed availability of individual health insurance, guaranteed renewability of health insurance coverage, certification of coverage, state flexibility in the individual market reform and enforcement of the

³⁵⁸ *Thornburg v. Federal Express Corp.*, 62 S.W.3d 421, 428 (Mo. App. 2002).

³⁵⁹ *Doe v. Methodist Hosp.*, 690 N.E.2d 681 (Ind. 1997); Restatement (Second) of Torts § 652D; *Beaumont v. Brown*, 257 N.W.2d 522 (Mich. 1977); *State of Montana Board of Dentistry v. Kandarian*, 886 P.2d 954 (Mont. 1995); *Y.G. and L.G. v. The Jewish Hospital of St. Louis*, 795 S.W.2d 488 (Mo. 1990).

³⁶⁰ 42 U.S.C. 300gg-23.

³⁶¹ 42 U.S.C. 300gg-23.

³⁶² 42 U.S.C. 300gg-46.

portability rules in the individual market rules. Subtitle C dealt with health coverage availability studies, reports on Medicare reimbursement of telemedicine, allowing federally qualified HMOs to offer high deductible plans, volunteer services provided by health professionals at free clinics and some findings and severability provisions. These were not the parts which contained the provisions authorizing the enactment of the privacy provisions.

The privacy provisions were enacted under Title II of HIPAA which deals with prevention of health care fraud and abuse, administrative simplification and medical liability reform. The privacy provisions were contained in section 264 in Title II. There are two references to ERISA within Title II – one contained in section 250 describing the relationship of the Subtitle dealing with criminal laws to ERISA authority. Section 250 stated, “Nothing in this subtitle shall be construed as affecting the authority of the Secretary of Labor under section 506(b) of ERISA with respect to violations of Title 18, United States Code.”³⁶³ This is with respect to criminal prosecutions dealing with health care fraud offenses.

The second provision that dealt with preemption in Title II was contained in section 264(c), the section enabling issuance of the privacy regulation. In this case the provision for preemption with respect to privacy under Part C of Subtitle F indicated that a regulation promulgated as the result of the statute on the privacy of individually identifiable health information, “shall not supersede a contrary provision of State law, if the provision of State law imposes requirements, standards or implementations specifications that are more stringent than the requirements, standards or implementations specifications imposed under the regulations.”³⁶⁴ There are no other provisions within Title II of HIPAA that explicitly provide ERISA preemption protection or indicate that they are not intended to alter the ERISA preemption as the provisions under Title I of HIPAA provided.

Thus, there is nothing in the HIPAA statute which indicates that the privacy regulations were not intended to alter or were intended to follow the standard ERISA preemption analysis. Since the statute in several places noted that it was not to alter the normal ERISA preemption analysis, but did not also include that language in the provisions dealing with the privacy medical information, it would appear that Congress may have intended to omit such broader protection.

In fact even though commenters had requested that there be clarification regarding the scope of preemption under ERISA, HHS refused to issue any regulations due to the fact that they had no authority when they issued the final regulations.³⁶⁵ HHS indicated it had no authority to issue

³⁶³ 29 U.S.C. 1136 and Pub. L. No. 104-191, section 250.

³⁶⁴ Compare sections 250 and 264 of Title II to sections 102 and 111 of Title I of Pub. L. No. 104-191.

³⁶⁵ 65 F.R. 82462, 594 (2000).

regulations under ERISA.³⁶⁶ The preamble to the final regulations issued on December 28, 2000, further stated in response to a comment in which the commenter wanted clarification that ERISA preempts all state laws (including those relating to the privacy of individually identifiable health information to permit multi-state employers to use a set of rules to administer their plans.³⁶⁷ The response to a comment regarding ERISA and the “more stringent” or “contrary” definitions and their application to ERISA plan stated the more stringent and contrary definitions implied that these standards would apply to ERISA plans as well as non-ERISA plans responded that the concern underlying this comment is that ERISA plans which are not now subject to certain state laws because of the field preemption provisions of ERISA will become subject to state privacy laws that are “more stringent” than the federal requirements due to the operation of section 1178(a)(2)(B), together with section 264(c)(2).³⁶⁸ HHS disagreed and responded to the comment that:

While the courts will have the final say on these questions, it is argued that these sections simply leave in place more stringent state laws that would otherwise apply; to the extent that such state laws do not apply to ERISA plans because they are preempted by ERISA, we do not think that the section 264(c)(2) overcomes the preemption effected by section 514(a) of ERISA.³⁶⁹

Thus HHS recognizes that the courts will have the final say and indicates that it is HHS’s view that sections simply leave in place more stringent state laws that would otherwise apply. To the extent that those state laws do not apply to ERISA plans because they are preempted HHS did not state that the statutory reference in section 264(c)(2) of HIPAA overcomes the preemption effected by section 514(a) of ERISA. However, the concern remains that there are state laws which will be more stringent, and that may apply or may be drafted in ways that they will apply to not only health plans but to other entities or persons in a manner that they will not be preempted when reviewed by a court. HHS referred in the preamble to the final regulations to the preamble of the proposed regulations wherein it stated:

However, section 514(b) of ERISA, 29 U.S.C. 1144(b)(2)(A) expressly excepted from preemption state laws which regulate insurance. Section 514(b)(2)(B) of ERISA, 29 U.S.C. 1144(b)(2)(B), provides that an ERISA plan is deemed not to be an insurer for purposes of regulating the plan under state insurance laws. Thus, under the deemer clause, States may not treat ERISA plans as insurers subject to direct regulation by State

³⁶⁶ *Id.*

³⁶⁷ 65 F.R. 82461, 82594 (2000).

³⁶⁸ 65 F.R. 82582 (2000).

³⁶⁹ 65 F.R. 82462, 82582 (2000).

law. Finally, section 514(d) of ERISA, 29 U.S.C. 1144(d), provides that ERISA does not “alter, amend, modify, and validate, impair or supersede any law of the United States.”

We considered whether the preemption provisions of section 264(c)(2) of Pub. L. No. 104-191, discussed in the preceding section would give effect to state laws that would otherwise be preempted by section 514(a) of ERISA. Our reading of the statutes together is that the effect of section 264(c)(2) is simply to leave in place State privacy protections that would otherwise apply which are more stringent than federal privacy protections. In the case of ERISA plans, however, if those laws are preempted by section 514(a), they would not otherwise apply. We do not think that it is the intent of section 264(c)(2) to give an effect to State law that would not otherwise have in the absence of subsection 264(c)(2). Thus, we would not view the preemption provisions below as applying to State laws otherwise preempted by section 514(a) of ERISA . . . to date our discussions and consultations have not uncovered any particular ERISA requirement that would conflict with the rules proposed below.³⁷⁰

Thus, the concern becomes if such State statutes are drafted in such a way that they will not be preempted under conflict preemption under section 514(a) of ERISA or complete preemption under section 502(a) of ERISA there may be a state law that will survive ERISA preemption and each must be analyzed under ERISA’s preemption analysis. This means each state law must be reviewed under both ERISA preemption analysis and if the statute survives such analysis, then under HIPAA privacy preemption analysis.

It is important to remember that some State laws have not been preempted and in recent years the scope of preemption has been addressed and limited by the Supreme Court a number of times. In 1995, the Court addressed a tax imposed on health care services paid for by non-insured plans and stated:

In sum, cost-uniformity was almost certainly not an object of preemption, just as laws with only an indirect economic effect on the relative cost of various health insurance packages in a given state are a far cry from those “conflicting directives” from which Congress meant to insulate ERISA plans. See 498 U.S. at 142. Such state laws leave plan administrators right where they would be in any case, with the responsibility to

³⁷⁰ 64 F.R. 59917, 60001 (1999).

choose the best overall coverage for the money. We therefore conclude that such state laws do not bear the requisite “connection with” ERISA plans to trigger preemption.³⁷¹

The “connection with” test was considered again, two years later, when New York’s tax was again before the Court. In this case the Court stated:

The HFA is a tax on hospitals. Most hospitals are not owned or operated by ERISA funds. This particular ERISA fund has arranged to provide medical benefits for its plan beneficiaries by running hospitals directly, rather than by purchasing the same services at independently run hospitals. If the fund had made the other choice, and had purchased health care services from a hospital, that facility would have passed the expense of the HFA onto the fund and supplying beneficiaries through the rates it set for the services provided. The fund would then have had to decide whether to cover a more limited range of services for its beneficiaries, or perhaps to charge its plan members higher rates. Though the tax in such a circumstance would be “indirect,” its impact on the fund’s decisions would be in all relevant respects identical to the “direct” impact felt here. Thus, the supposed difference between direct and indirect impact—upon which the Court of Appeals relied in distinguishing this case from *Travelers*³⁷²—cannot withstand scrutiny. Any state tax, or other law, that increases the cost of providing benefits to covered employees will have the same effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.³⁷³

Furthermore, the court has chiseled further away at what constitutes a law that is preempted by finding that in the *Kentucky Association of Health Plans, Inc. v. Miller*,³⁷⁴ finding that any willing provider statutes regulate insurance even though they specifically were directed toward and cover insured plans as well as self-insured plans. In this case the Court found that, “it suffices that they substantially affect the risk pooling arrangement between the insurer and the insured.” In this case the Court not only adopted new standards to determine whether or not the law regulated insurance, it permitted a law that applied both to self-insured non-ERISA plans, HMOs and insurers, but it also applied to any

³⁷¹ *New York State Conference of Blue Cross Blue Shield Plans v. The Travelers Insurance Company*, 514 U.S. 645, 662 (1995).

³⁷² 514 U.S. 645 (1995).

³⁷³ *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 816 (1997).

³⁷⁴ 538 U.S. 329 (2003).

health benefit plan that included chiropractic benefits to request to include any licensed chiropractor who agreed to apply by the rules to serve as a participating provider.³⁷⁵

While there may be a question of whether the state laws protecting medical privacy will apply, there is still a second question under section 502 of ERISA which deals with what remedy would exist. Under ERISA section 502, the Supreme Court has stated that the civil enforcement provisions contained in section 502 were modeled to be the exclusive remedy provided and found that there was a clear expression of Congressional intent that ERISA's civil enforcement scheme would be exclusive. Thus, any cause of action under state law which attempted to create a new remedy would be preempted.³⁷⁶ Thus, a participant would be left seeking to enforce their rights under any state law or for violation of the privacy provisions in the plan requesting appropriate equitable relief or to enforce the plan under sections 502(a)(1)(B) or 502(a)(2) for appropriate relief under section 409 for a breach of fiduciary duty or under section 502(a)(3) to enjoin any act which violates any provision of the plan, or to obtain other appropriate equitable relief or to enforce the terms of the plan. Thus, any relief sought would be placing the individual back in the inquiry that exists following the *Great-West Life & Annuity Ins. Co. v. Knudson*³⁷⁷ and *Sereboff v. Mid Atlantic Medical Services, Inc.*³⁷⁸ in attempting to determine what is appropriate equitable relief.

Due to the interaction of the ERISA preemption analysis and the more carefully drafted State laws, a medical plan's compliance with HIPAA's privacy regulations should be carefully reviewed to ascertain if potential deficiencies may exist which could expose the purchaser to risks.

4. **Privacy and Due Diligence.** The Privacy Regulations generally permit disclosures for treatment, payment and health care operations.³⁷⁹ Included in the definition of health care operations is:

“The sale, transfer, merger or consolidation of all or part of the covered entity with another covered entity, or an entity that will become a covered entity and due diligence related to such activity;”³⁸⁰ (Emphasis added.)

Thus, when two covered entities under the Privacy Regulations or an entity that will become a covered entity is involved in a corporate transaction, such as a pharmacy, then protected health information can be shared as part of the due

³⁷⁵ *Id.*

³⁷⁶ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); however, note that some administrative appeals provided by state law for insured plans have been upheld. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), and *Unum Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1998).

³⁷⁷ 534 U.S. 204 (2002).

³⁷⁸ 547 U.S. 356 (2006).

³⁷⁹ 45 C.F.R. § 164.502(a)(i) and (ii) (2002).

³⁸⁰ 45 C.F.R. § 164.501 (2002).

diligence related to such activity. However, the sharing of the information must be by the covered entity that is a party to the transaction.³⁸¹

However, when two entities that are merely plan sponsors of covered entities engage in a corporate transaction there is no provision permitting disclosure of protected health information from the health plans sponsored by the entities engaged in the transaction. Thus in transactions in which plan sponsors merge or otherwise acquire or dispose of a trade or business or other corporate assets, until further guidance is issued, it appears that only de-identified information or summary health information or limited data sets may be exchanged between the plan sponsors.

The preamble to the final modifications to the final privacy regulations issued on August 14, 2002, provides that when covered entities merge, then the new owner may immediately use and disclose the records to provide health care services and for purposes of payment and health care operators, this assumes that it must be a covered entity that is a party to the transaction.³⁸² This permits the covered entity that merges to immediately use protected health information in its treatment payment and health care operations, but again, it does not extend to health plans sponsored by employers engaged in corporate transactions when the health plans themselves are not merged as part of the transaction. Frequently, the health plans are not merged when the corporate transaction occurs in order to permit less disruption to the employees or because the nature of the corporate transaction did not result in the health plans under the control of one entity. However, in many asset sales the employees are transferred and cannot stay in the same plan and the new employer wants to make the transition to the new plan easier.

The preamble to the final modifications to the final Privacy Regulations further indicates that if a transaction is not consummated, standard business practices, such as confidentiality agreements that buyers and sellers typically enter into with regard to proprietary information, are sufficient to ensure that the health information transferred is either returned to the original owner or destroyed.³⁸³

However, the preamble's comment is in the context of sharing of protected health information between two covered entities or an entity that will become a covered entity after the corporate transaction and does not provide guidance regarding corporate transactions between non-covered entities that sponsor group health plans. Given that the Privacy Regulations do not expressly address the situations arising when non-covered entities that sponsor covered entities engage in corporate transactions that do not result in the group health plans merging concurrently with the corporate transaction or at a later time, the Privacy Regulations do not currently permit the plan sponsors to cause the group health plans to provide protected health information to the other plan sponsor or group health plan absent an authorization from each covered person. Thus, due diligence can only be completed by using de-identified information, summary health information, or by entering into a business associate agreement with an

³⁸¹ 67 F.R. 53182, 53190 (August 14, 2003).

³⁸² 67 F.R. 53182, 53190 (2002).

³⁸³ 67 F.R. 53182, 53191 (2002).

independent third party to perform health care operations or payment with regard to the plan (such as ceding new coverage) who will analyze the data and provide de-identified information or a report on such analysis to the other party.

5. **Privacy and Plan Transition Issues.** When a corporate transaction occurs between two group health plan sponsors that does not result in the two group health plans merging, frequently the plan sponsors will want to protect the employees by preserving their status in health flexible spending accounts and in the group health plan with respect to amounts satisfied toward deductibles, out-of-pocket maximums or other limits so that they are not required to satisfy those amounts in two plans in the same year as the result of the corporate transaction. While no guidance directly addresses the disclosure or use of the information for such purposes, the definition of health care operations reads:

“(3) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk for health care.”³⁸⁴

and of the definition of payment reads:

“(1) a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan;”

may provide some argument for transferring information from one group health plan to another to facilitate replacement of a contract of health benefits or in order to fulfill its responsibility for coverage and provision of benefits under the health plan.

The disclosures of protected health information by the prior plan to the new plan and the use of such information by the successor plan arguably falls within these definitions when interpreted broadly; however, there is no explicit indication such use or disclosure was intended or contemplated. Such use or disclosure would further the goal of not having the Privacy Regulations disrupt the operation of group health plans in the provision of benefits or in the payment for delivering health care; however, it is not clear this use or disclosure is covered or intended since it was not explicitly dealt with when covered entity mergers were addressed.

While the American Recovery and Reinvestment Act of 2009³⁸⁵ and the Genetic Information Non-Discrimination Act of 2008³⁸⁶ made changes to HIPAA Privacy, those changes did not impact the analysis above, nor did they create a private right of action to enforce HIPAA privacy.

VI. Conclusion

³⁸⁴ 45 C.F.R. § 164.501 (2002).

³⁸⁵ P.L. 111-5.

³⁸⁶ P.L. 110-233.

Due to the large costs associated with retiree medical plans, parties to a merger and acquisition transaction should take care to properly address them in the purchase agreement. The purchase agreement should explicitly divide the responsibilities related to a retiree medical plan, and address which party will be responsible for providing benefits to different classes of retirees and employees. The potential buyer should conduct careful due diligence to assess the liabilities that could arise out of the plan, current and prior collective bargaining agreements and structure the transaction accordingly. The language in any agreement for a merger or acquisition should be drafted carefully to consider that the agreement could be considered an amendment to the plan or a contractual obligation, barring changes to the plan as in *Halliburton Company Benefits Committee v. Graves*³⁸⁷ and also carefully review any prior bankruptcy filing orders considering *Evans v. Sterling Chemicals*.³⁸⁸ Finally, the buyer will want to look at the funding, tax liabilities, and privacy compliance issues and make sure that the purchase price is adjusted accordingly.

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³⁸⁷ See above at III.

³⁸⁸ 660 F. 3d 862 (5th Cir. 2011).

APPENDIX A

Due Diligence Issues

1. How has the company accounted for expenses under FAS 106, 132 and 158?
2. What actuarial assumptions were used for calculating the funding and deduction limit for contributions to the VEBA?
3. Obtain copies of any trust financial statements.
4. What actuarial assumptions were used to calculate the accumulated post-retirement benefit obligations for the retiree medical plan under FAS 106, 132 and 158?
5. What amounts are held in the VEBA and how are the assets invested? Are there any prohibited transaction exemptions related to the VEBA?
6. Obtain actuarial reports for calculation of the liability and for the funding of any VEBA for the post-retirement medical benefits and compare the assumptions for the liability and the funding.
7. Compare the actuarial assumptions used for the funding to the assumptions used in Wells Fargo.
8. Obtain copies of the retiree medical plan document and summary plan description (current and prior), and any stop loss coverage policies if you are acquiring the policy by acquiring the entity via stock transaction.
9. Obtain copies of the retiree medical plan's trust and the IRS determination letter on such trust's tax exempt status.
10. Obtain copies of summary plan descriptions, employee handbook and materials used with any early retirement window, reduction in force ("RIF") or severance arrangement, and related communications, and review to determine risks related to "guaranteed benefits claims."
11. Obtain copies of all collective bargaining agreements (current and past) covering any of the individuals who might be eligible for retiree medical benefits and review for terms and conditions on retiree medical benefits and promises of lifetime benefits.
12. Obtain copies of Forms 5500 for the plan and Forms 990 for the trust.
13. If the plan includes active employees, COBRA records for the individuals offered COBRA coverage and the status of each qualified beneficiary's election, the starting date of COBRA coverage and the duration of each person's COBRA coverage period.
14. Review executive employment and severance agreements regarding retiree medical benefit contractual obligations.
15. Review prior merger agreements regarding covenants on maintaining retiree or other benefits.
16. Request any VEBA private letter rulings for additional restrictions on funds under the ruling.

17. How does the funding calculation methodology match the tax deduction methodology? If a change is required to the tax deduction calculation, is it a change in accounting methods that will require IRS approval?
18. Is the retiree medical plan compliant with HIPAA's privacy and security regulation requirements?
 - Notice
 - Policies and Procedures
 - Plan Amendments for Privacy compliance
 - Business Associate Agreements
 - Operational Issues in Compliance

 - Periodic security analysis

 - Monitoring to prevent breaches

 - Procedure for reviewing potential breaches
19. If this plan also covers 2 or more individuals who are active employees, does the plan comply with the non-discrimination and portability requirements of HIPAA, NMHPA, MHPA and WHCRA and all of Health Reform?
 - Plan design
 - Certificates of Creditable Coverage (must be issued until December 31, 2014)
 - Notice of Intent to Impose Pre-existing Condition Exclusion (Only for plans imposing such and no pre-existing conditions can be imposed on any individual on or after January 1, 2014)
 - Notice of Pre-existing Condition that applies

 - Wellness program compliant with Health Reform and incorporated into plan document to address ADA concerns and keep it part of the bona fide employee benefit plan
20. Is the plan updated for the Claims Procedure regulations as modified by Health Reform for plans covering 2 or more current employees and in compliance with the requirements as they existed prior to Health Reform for plans exempt under the fewer than 2 current employees rule?
21. Does the Plan have appropriate documentations?
 - Plan
 - SPD
 - Notices
 - TPA agreement
 - Agreements with other separate vendors- e.g., Prescription Drug, Wellness
 - Business Associate Agreements
 - Privacy Notice

 - Privacy and Security Policies and Procedures

 - Periodic security analysis of systems in which group health plan information may be maintained

- Monitoring to prevent breaches
 - Procedure for reviewing potential breaches
22. Do the Plan's documents reflect its operations and the information it receives?
 23. If claims experience data is required, consider having the data sent to a business associate of the Plan to have a report prepared or review only de-identified information or summary health information.
 24. Executive employment agreements for contractual benefit promises, and Code section 409A reporting and compliance issues.
 25. Obtain the plan's records regarding the COBRA Subsidy under the Recovery Act
 26. Review the group health plan's operations for privacy compliance omissions in safeguards or record keeping.
 27. Documentation of the group health plan's analysis of the security of its electronic protected health information.
 28. HIPAA privacy and security policies and procedures.
 29. Plan amendment and business associate agreement amendments for HIPAA privacy, security and HITECH compliance
 30. Review HIPAA privacy and security notices and training records for compliance, including HITECH.
 31. Review collective bargaining agreements (current and past), settlements and side agreements for promises.
 32. Review multiemployer agreements for attempts to contractually impose a withdrawal liability for retiree welfare benefits.
 33. Review audited financial statements for post-retirement benefit obligations (including the 10K).
 34. Review SEC filings for required disclosures on executive benefits and perquisites (including Form 8Ks for material agreements).
 35. Obtain copies of any agreements entered into regarding the plan either prior to, concurrently with or after any prior corporate transaction.
 36. Obtain copies of all executive employment agreements, severance policies and change in control policies or plans.
 37. If the Company has tried to transfer its liability for some or all of the retiree medical benefits to a separate VEBA, obtain copies of any settlement agreements, court approvals or related orders, Exchange approvals of the accounting treatment, the VEBA trust, actuarial reports and schedules of funding obligations, any prohibited transaction exemption obtained related to the funding of the VEBA and/or any application or correspondence related to the same.

38. Review documentation of early retiree reinsurance application and claims for benefits.
39. Review if plan was intended to be exempt from HIPAA portability and nondiscrimination requirement and what position was taken with respect to application of Health Reform Acts.
40. Review nondiscrimination testing on benefits in general and particularly for any executive policies.
41. Obtain records regarding hours worked by employees.
42. Review all records related to any reimbursements requested and received from the Early Retiree Reinsurance Program (“ERRP”) and how those funds were used. If any ERRP funds have not been used, obtain records of the employer’s historical contributions toward healthcare coverage for addressing maintenance of contribution requirements inquiries. Remember some employers filed for ERRP on age appropriate COBRA qualified beneficiaries.
43. Review copies of any PTEs obtained or requested.
44. Review copies of any rulings on captive insurers and their treatment for tax purposes.
45. For retiree only plans, review records to determine if any of their former employees may be working for your company and destroy the retiree only plan exemption from Health Reform they had for their retiree plan by putting their plan into your controlled group.
46. Review COBRA notice and election compliance procedures under the retiree plan.
47. Review whether the retiree only plan is exempt and if the company has any policies regarding rehiring retirees.
48. Review records on Medicare Part D Subsidy taken and related deductions until deductions prohibited under Health Reform.
49. If the transaction may cause former retirees to become current employees of the combined entity, prepare a game plan to address such individuals’ coverage under the current retiree only plan prior to the beginning of the first plan year beginning after the transaction
50. Determine if the acquirer will have the records and the obligation to file the Form 1094-C and 1095-C for the acquired entity after the acquisition closes and if so, obtain the records for the portion of the plan year prior to the acquisition.

APPENDIX B

Issues to Address in Negotiations

1. For which retirees is the liability transferring?
2. For which active employees is the liability transferring?
3. Is the liability transferring for any other individuals, such as persons who met the years of service requirement, but are no longer active employees and are not yet retirees?
4. For which dependents will the liability transfer?
5. How are the amounts funded toward each of these groups calculated?
6. What are the liabilities for each group?
7. What amount of assets and which assets are being transferred for the liability?
8. If any benefits are potentially at risk for being not subject to change if challenged in court, how will the funding for the benefits be calculated?
9. Will there be an escrow fund or indemnification pool to cover costs
 - for the violations,
 - for challenges by participants or
 - for funding deficiencies?
10. Who will correct any tax violations on funding limits?
11. Are there any Form 5500 filing deficiencies, if so who will correct?
12. Are there any COBRA obligations requiring indemnification (e.g., retiree gets divorced and ex-spouse loses coverage)?
13. Is this a transaction that is likely to give rise to COBRA liability for M&A qualified beneficiaries? If so, make sure you receive or have access to the documentation on qualifying events, qualified beneficiaries and elections offered to determine if individuals claiming rights to coverage are doing so validly.
14. Are any restrictions tied to limit the changes that can be made to the benefits? Are there time limits on such restrictions?
15. Carefully draft any covenants on continuation of benefits with duration limits and no third party beneficiary clauses.
16. Carefully draft clauses on termination and tie a termination clause directly to the retiree medical benefits.
17. Review impact of Health Reform Acts on retiree medical costs, ability to have a retiree only plan, administration and design.

18. Review impact of ACA compliance on the context of indemnifications, escrows and records obtained.
19. Review proposed structure of entity from acquisition, is it a new entity, how will it be owned, how will the entity's be treated for employer shared responsibility penalty in year of acquisition.
20. Indemnify for ERRP violations or misfiled claims.
21. Indemnification for cost to comply with all of Health Reform Acts if a retiree only plan is not restricted to only retirees.

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