

Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits

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INTRODUCTION

The American conception of retirement has received a number of significantly jarring assaults in recent years.¹ Employers have increasingly shifted the investment risk of funding retirement to their employees by switching from so-called “traditional” defined benefit plans that promise retirees a predictable paycheck for life to defined contribution arrangements that provide no such assurances.² Other employers have frozen their traditional pension plans or otherwise terminated their employees’ ability to accumulate further credits toward retirement.³ Even President George W. Bush added to the general anxiety about income in retirement by an extended campaign in 2005 that suggested that the federal government’s venerable program for funding retirement—Social Security—was hopelessly outmoded and headed toward bankruptcy.⁴

This Article examines a source of retirement anxiety that has received far less attention but is of paramount importance for prospective and current retirees alike—namely, health insurance in retirement. Indeed, the presence of retiree health insurance is one of the most significant factors determining when people choose to leave the compensated workforce,⁵ especially if declining health is one

1. See generally Patricia E. Dilley, *Hope We Die Before We Get Old: The Attack on Retirement*, 12 ELDER L.J. 245 (2004).

2. See Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53 (2004). See generally JACOB S. HACKER, *THE GREAT RISK SHIFT* (2006); ALICIA H. MUNNELL ET AL., *WHY HAVE SOME STATES INTRODUCED DEFINED CONTRIBUTION PLANS?* (2008), available at http://crr.bc.edu/images/stories/Briefs/slp_3.pdf; EDWARD A. ZELINSKY, *THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA* (2007).

3. See, e.g., Steven D. Jones, *Pensions Likely To Stay Dying Breed*, WALL ST. J., Aug. 29, 2006, at C3; Ellen E. Schultz, Charles Forelle & Theo Francis, *IBM To Freeze Pension Program in '08*, WALL ST. J., Jan. 6, 2006, at A3; Ellen E. Schultz, Charles Forelle & Theo Francis, *Forecast: More Pension Freezes*, WALL ST. J., Jan. 12, 2006, at C1; John D. Stoll, *GM To Freeze Pension Plans of White-Collar Workers*, WALL ST. J., Mar. 8, 2006, at A10.

4. Address Before a Joint Session of the Congress on the State of the Union, 41 WEEKLY COMP. PRES. DOC. 126, 128 (Feb. 2, 2005); see also Richard L. Kaplan, *The Security of Social Security Benefits and the President’s Proposal*, ELDERLAW REP., Apr. 2005, at 1.

5. See Paul Fronstin, *Retirement Patterns and Employee Benefits: Do Benefits Matter?*, 39 GERONTOLOGIST 37 (1999); see also David M. Blau & Donna B. Gilleskie, *Retiree Health Insurance and Labor Force Behavior of Older Men in the 1990s*, 83 REV. ECON. & STAT. 64 (2001); Jeannette Rogowski & Lynn Karoly, *Health Insurance and Retirement Behavior: Evidence from the Health and Retirement Survey*, 19 J. HEALTH ECON. 529 (2000); Erin Strumpf, Presentation at 12th Annual National Research Service Award (NRSA) Trainees Research Conference The Decline in Employer-Sponsored Health Insurance for Retirees and Its Impact on Older Americans (June 24, 2006), available at <http://www.ahrq.gov/fund/training/strumpftxt.htm>.

of the reasons that they are considering retirement.⁶ As an important recent study concluded, without such insurance, “current employees will have strong financial incentives to work longer and retire later.”⁷ Such incentives might therefore impact employment prospects for younger workers if older workers delay their retirement. Thus, this issue is enormously important to anyone connected to the U.S. workplace, regardless of age.

Since 1965, the federal government has operated a health insurance program called Medicare⁸ that specifically covers older Americans.⁹ This program, however, has major gaps in its service coverage, ranging from specified deductibles for hospital admissions to 20% co-payment obligations regarding doctors’ fees and the like.¹⁰ In 2003, Congress undertook a determined effort to patch Medicare’s most glaring coverage gap—namely, prescription medications—in its highly publicized and roundly criticized Medicare Prescription Drug, Improvement, and Modernization Act.¹¹ Notwithstanding this legislation, a prominent financial services company predicts that the typical retired couple will incur over \$215,000 of medical expenses not covered by Medicare,¹² and that estimate does not even consider the cost of long-term care in

6. See RUTH HELMAN ET AL., EBRI 2008 RECENT RETIREES SURVEY: REPORT OF FINDINGS 5-6 (Employee Benefit Research Inst., Issue Brief No. 319, 2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2008.pdf (among surveyed engineers and technicians in the aerospace and defense industries, 46% cited health as an extremely or very important factor in their retirement decision, and 69% indicated that the availability of health insurance was similarly important in determining their “ability to afford retirement”).

7. THE KAISER FAMILY FOUND. & HEWITT ASSOCS., RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS 34 (2006) [hereinafter KAISER/HEWITT SURVEY], available at <http://www.kff.org/medicare/upload/7587.pdf>; see also U.S. GOV’T ACCOUNTABILITY OFFICE, RETIREMENT DECISIONS: FEDERAL POLICIES OFFER MIXED SIGNALS ABOUT WHEN TO RETIRE 32 (2007), available at <http://www.gao.gov/cgi-bin/gettrpt?GAO-07-753> (noting that “workers who have access to health insurance in retirement are substantially more likely to retire before becoming eligible for Medicare at age 65 than those without such access”). This study found that men with access to pre-Medicare health insurance were 86% more likely to retire before age sixty-five, and women were 139% more likely. *Id.*

8. 42 U.S.C. § 1395 (2000). See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 64-95, 103-08 (4th ed. 2006) (explaining the major features of Medicare).

9. 42 U.S.C. § 426(a)(1) (2000).

10. See FROLIK & KAPLAN, *supra* note 8, at 64-82.

11. Pub. L. No. 108-173, 117 Stat. 2066 (2003). See generally FROLIK & KAPLAN, *supra* note 8, at 85-91 (explaining the major features of Medicare’s prescription drug benefit).

12. See News Release, *Fidelity Investments Estimates \$215,000 Needed To Cover Retiree Health Care Costs*, March 27, 2007, available at http://content.members.fidelity.com/Inside_Fidelity/fullStory/1,,7448,00.html; see also PAUL FRONSTIN, SAVINGS NEEDED TO FUND HEALTH INSURANCE AND HEALTH CARE EXPENSES IN RETIREMENT 13 (Employee Benefit Research Inst., Issue Brief No. 295, 2006), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2

an assisted living facility or a nursing home.¹³

To address the numerous gaps in Medicare, many employers have for some time provided supplementary health benefits to their retirees.¹⁴ Such retiree health benefits preceded the 2003 Medicare enactment regarding prescription drugs by several decades and continue to provide important coverage.¹⁵ Retiree health benefits are especially important for those who retire before reaching age sixty-five, generally the qualifying age for Medicare. For these pre-Medicare retirees, employer-provided health insurance may be their only protection from financial disaster. These so-called “early” retirees often find obtaining quality individual health insurance forbiddingly expensive, if not completely impossible, due to pre-existing medical conditions and other underwriting criteria.¹⁶

Yet despite their importance, retiree health benefits for both pre-Medicare and Medicare-eligible retirees have been under persistent assault on several fronts. Some employers have initiated or substantially raised the monthly premiums that they charge retirees for health benefits,¹⁷ without regard to these retirees’ often-fixed pension income—effectively reducing these retirees’ spendable retirement income by considerable amounts.¹⁸ Indeed, one recent report found that median premium contributions by retirees had more than quadrupled over the past decade.¹⁹ Moreover, a recent survey of employers with at least 1000 employees found that 80% of such employers plan to increase further the contributions required of retirees.²⁰ Some companies have increased

0061.pdf [hereinafter FRONSTIN, Issue Brief No. 295] (calculating that \$295,000 would be needed for a sixty-five-year-old couple retiring in 2006 who live to average life expectancies). For an extended simulation effort to determine the funds needed for health care costs in retirement, see PAUL FRONSTIN, SAVINGS NEEDED TO FUND HEALTH INSURANCE AND HEALTH CARE EXPENSES IN RETIREMENT: FINDINGS FROM A SIMULATION MODEL (Employee Benefit Research Inst., Issue Brief No. 317, 2008), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_05-20081.pdf.

13. See generally Richard L. Kaplan, *Retirement Planning’s Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407 (2007) (examining the nature and cost of long-term care, particularly when such care is provided in an institutional setting).

14. See MADELON LUBIN FINKEL & HIRSCH S. RUCHLIN, *THE HEALTH CARE BENEFITS OF RETIREES I* (1991).

15. See *id.* at 62.

16. See *infra* text accompanying notes 337-340.

17. See KAISER/HEWITT SURVEY, *supra* note 7, at 19-21.

18. See, e.g., Robert L. Rose, *Firms’ Attempts To Cut Health Benefits Break Calm of Retirement*, WALL ST. J., Feb. 24, 1993, at A1; Ellen E. Schultz, *Companies Transform Retiree-Medical Plans into Source of Profits*, WALL ST. J., Oct. 25, 2000, at A1.

19. RICHARD W. JOHNSON, *WHAT HAPPENS TO HEALTH BENEFITS AFTER RETIREMENT?* 4 (2007), available at http://crr.bc.edu/images/stories/Briefs/wob_7.pdf.

20. KAISER/HEWITT SURVEY, *supra* note 7, at 21. In addition, 40% of employers are very or somewhat likely to increase retirees’ cost-sharing requirements, and 30% are very or somewhat likely to raise the limit on retirees’ out-of-pocket expenses. *Id.*

retirees' cost-sharing obligations or applicable limits on out-of-pocket expenditures,²¹ while others have capped their contributions to the cost of these plans,²² leaving retirees to bear the full cost of future medical inflation. Still other employers have terminated their retiree health benefits outright,²³ leaving the affected retirees—especially pre-Medicare retirees²⁴—exposed to the financial hardships of a major illness or accident. As employers struggle in the current economic crisis, these trends are likely to accelerate further.

This Article begins by tracing the decline in retiree health insurance coverage over the past several decades and setting forth some of the reasons for this dramatic decline. The Article then analyzes the legal posture of retirees who have lost the health benefits that they expected to have in retirement. Finding surprisingly little legal relief for these retirees' dashed expectations, the Article then considers various self-help options currently available to retirees before examining a major public policy alternative—namely, expanding Medicare eligibility to cover retirees younger than sixty-five years of age.

I. DECLINING SCOPE OF RETIREE HEALTH COVERAGE

Retiree health benefits originated as an extension of employer-provided health insurance for employees, a phenomenon that itself began largely as an employer response to wage controls imposed by Congress during World War II²⁵ and was later canonized by a tax law provision that excluded such insurance from employees' taxable income.²⁶ The pervasiveness of industrial unions during this period further contributed to the expansion of various employer-provided job benefits, most especially health insurance.²⁷ As an outgrowth of this

21. *See id.* at 19; *see also* U.S. GEN. ACCOUNTING OFFICE, RETIREE HEALTH BENEFITS: EMPLOYER-SPONSORED BENEFITS MAY BE VULNERABLE TO FURTHER EROSION 10 (2001).

22. KAISER/HEWITT SURVEY, *supra* note 7, at 13-14 (among employers with at least 1000 employees and that offer retiree health benefits, 46% have caps on their plans for pre-Medicare retirees and 50% have caps for Medicare-eligible retirees); *see also* PAUL FRONSTIN, THE IMPACT OF THE EROSION OF RETIREE HEALTH BENEFITS ON WORKERS AND RETIREES 6 (Employee Benefit Research Inst., Issue Brief No. 279, 2005), *available at* <http://www.ebri.org/pdf/briefspdf/0305ib.pdf>.

23. *See* FRONSTIN, Issue Brief No. 295, *supra* note 12, at 9, 11.

24. *See* AARP PUB. POL'Y INST., DATA DIGEST: HEALTH COVERAGE AMONG 50- TO 64-YEAR-OLDS 3 (2007), *available at* http://assets.aarp.org/rgcenter/health/dd155_coverage.pdf (reporting that the number of retirees aged fifty to sixty-four without health insurance increased more than 25% between 2000 and 2005).

25. *See History of Health Insurance Benefits*, FACTS FROM EBRI (Employee Benefit Research Inst., Washington, D.C.), Mar. 2002, at 1, *available at* <http://www.ebri.org/publications/facts/index.cfm?fa=0302fact>.

26. I.R.C. § 106 (2008).

27. *See* Thomas C. Buchmueller, John Dinardo & Robert G. Valletta, *Union Effects on Health*

phenomenon, employers agreed to maintain such health insurance after their workers retired, an especially valuable benefit during the period prior to the enactment of Medicare.²⁸ Employers were generally amenable to providing these benefits, because health care costs were not expensive, life expectancy was rather limited, and no actual expenditures were required until many years into the future.²⁹ As Americans began living longer in retirement, however, these benefits became much more expensive at the same time that they became more valuable to covered retirees.

But far more than general retirement trends was at play here. First, the cost of health care has increased in recent years, often dwarfing increases in general inflation.³⁰ Second, exogenous events, particularly pronouncements from accounting regulators, have forced employers to project *and report* the anticipated future expense of their retiree health benefit obligations. This Part considers both of these factors.

A. Rising Cost of Health Care

Health care costs consume an ever-increasing share of this country's gross domestic product³¹ and are a perennial source of anxiety for many Americans.³² Health care reform proposals of varying scope have been a central issue in U.S. presidential election campaigns since the implosion of President Clinton's 1993 proposal,³³ focusing particularly on the plight of those Americans who have no

Insurance Provision and Coverage in the United States, 55 INDUS. & LAB. REL. REV. 610 (2002).

28. See generally THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000) (discussing the historical and political context in which Medicare developed).

29. See generally FINKEL & RUCHLIN, *supra* note 14, at 62; G. Lawrence Atkins, *The Employer Role in Financing Health Care for Retirees*, in PROVIDING HEALTH CARE BENEFITS IN RETIREMENT 100, 108 (Judith F. Mazo, Anna M. Rappaport & Sylvester J. Schieber eds., 1994) [hereinafter PROVIDING HEALTH CARE].

30. Professor Gruber has recently concluded that "the rapid rise in health care costs has been driven by quality-improving technological change." Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 603 (2008); see also Paul Krugman & Robin Wells, *The Health Care Crisis and What To Do About It*, N.Y. REV. OF BOOKS, Mar. 23, 2006, available at <http://www.nybooks.com/articles/18802> (agreeing that "new medical technology" is the principal factor driving health care costs higher).

31. See Krugman & Wells, *supra* note 30 (noting that the percent of U.S. gross domestic product spent on health care rose from 5.2% in 1960 to 16% in 2004).

32. See, e.g., GARY CLAXTON ET AL., *EMPLOYER HEALTH BENEFITS: 2006 ANNUAL SURVEY 1* (2006), available at <http://www.kff.org/insurance/7527/upload/7527.pdf>; Sudeep Reddy, *Census Income Report Feeds Health-Care Debate*, WALL ST. J., Aug. 29, 2007, at A3.

33. Health Security Act of 1993, H.R. 3600, S. 1757, 103d Cong. (1993). See generally THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* (1996).

health insurance. And in 2007, Michael Moore's controversial movie, *Sicko*,³⁴ tapped into the concerns and financial fears harbored by even those Americans who have health insurance.

Employers, for their part, have been trying to assert control over the ever-burgeoning cost of the health insurance that they provide to their employees. Some companies have increased employees' monthly premiums, co-payments, deductibles, and other cost-sharing mechanisms, and some employers have reduced service coverage or ceased providing health insurance to their employees altogether. Certain employers, however, have taken a different approach, instituting so-called "wellness" programs that seek to implement preventative approaches, including lifestyle changes like regular exercise, smoking cessation, and weight loss regimens.³⁵ Others have lowered or even eliminated the employee cost of prescription medications to ensure that these pharmaceuticals are taken regularly and that expensive hospitalization episodes are thereby prevented.³⁶ The latest attempt by policymakers to make employees more responsible for their own health care costs and perhaps more cost-conscious in this regard is the introduction of Health Savings Accounts.³⁷ These arrangements pair a pre-tax account from which an employee can spend as she chooses on "qualified medical expenses"³⁸ with a high-deductible health insurance policy that covers catastrophic expenses.³⁹

In the context of these conflicting trends, there has been a decline in employees with employment-based health insurance. According to recent data from the Employee Benefit Research Institute, only 64.2% of Americans aged eighteen to sixty-four years have some form of employer-provided health insurance, a number that has declined from 69.3% as recently as 2000.⁴⁰ This trend has persisted despite the presence of an unlimited income tax exclusion that

34. *SICKO* (The Weinstein Company 2007).

35. See, e.g., Howard M. Leichter, "Evil Habits" and "Personal Choices": Assigning Responsibility for Health in the 20th Century, 81 *MILBANK Q.* 603, 609 (2003); Kris Maher, *Companies are Closing Doors on Job Applicants Who Smoke*, *WALL ST. J.*, Dec. 21, 2004, at B6.

36. See Vanessa Fuhrmans, *A Radical Prescription*, *WALL ST. J.*, May 10, 2004, at R3.

37. See I.R.C. § 223 (2008). See generally Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 *MCGEORGE L. REV.* 535 (2005); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 *TUL. L. REV.* 777 (2006).

38. I.R.C. § 223(d)(2)(A) (2008).

39. *Id.* § 223(c)(2). See *infra* Subsection III.A.3 (outlining more information on Health Savings Accounts).

40. PAUL FRONSTIN, *SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2007 CURRENT POPULATION SURVEY 7* (Employee Benefit Research Inst., Issue Brief No. 310, 2007), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20071.pdf.

applies to such insurance,⁴¹ a reality that suggests that the tax law may not be the *deus ex machina* that virtually all would-be health reformers seem to think it is.⁴² That is, health reformers from all points on the political spectrum seem to believe that changing the current tax treatment of employer-provided health insurance is essential public policy,⁴³ without noting that despite the current law's alleged generosity, the prevalence of employer-provided health insurance continues to decline.

In any case, retiree health coverage is particularly vulnerable. Employers who diminish or terminate their coverage of employees' health care costs risk losing employees to employers who provide better benefits. Affected workers who do not leave, moreover, might complain, reduce their output in protest, or even organize a debilitating strike against their employer if they are represented by a labor union. But retirees faced with similar cutbacks enjoy no such leverage over their former employers. Accordingly, when employers consider various strategies to lower their costs of providing health insurance, the first group to be targeted is often former employees who are now retired.⁴⁴

This last point is particularly salient in light of the changing composition of the American workplace. Manufacturing jobs represent an ever-diminishing share of U.S. employment in favor of financial services, retail, and other service industries.⁴⁵ Yet, manufacturing companies—especially firms in large-scale industries like automobiles and steel—are much more likely to offer retiree

41. I.R.C. § 106 (2008).

42. See Holman W. Jenkins, *The Biggest Secret in Health Care*, WALL ST. J., Feb. 7, 2007, at A14 (noting that analysts across the political spectrum believe that changing the tax exclusion for health insurance premiums is an essential element of health care reform).

43. See, e.g., 2008 PRESIDENTIAL CANDIDATE HEALTH CARE PROPOSALS: SIDE-BY-SIDE SUMMARY, available at <http://www.health08.org/sidebyside.cfm>; CONG. RESEARCH SERV., TAX BENEFITS FOR HEALTH INSURANCE AND EXPENSES: OVERVIEW OF CURRENT LAW AND LEGISLATION (2007), available at http://opencrs.cdt.org/rpts/RL33505_20070720.pdf; PAUL FRONSTIN & DALLAS SALISBURY, HEALTH INSURANCE AND TAXES: CAN CHANGING THE TAX TREATMENT OF HEALTH INSURANCE FIX OUR HEALTH CARE SYSTEM? (Employee Benefit Research Inst., Issue Brief No. 309, 2007), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-20071.pdf; Joseph R. Antos, *Is There a Right Way To Promote Health Insurance Through the Tax System?*, 59 NAT'L TAX J. 477 (2006); Len Burman et al., *An Evaluation of the President's Health Insurance Proposal*, 114 TAX NOTES 1013 (2007); Jason Furman, *Two Wrongs Do Not Make a Right*, 59 NAT'L TAX J. 491 (2006).

44. See Susan E. Cancelosi, *Revisiting Employer Prescription Drug Plans for Medicare-Eligible Retirees in the Medicare Part D Era*, 6 HOUS. J. HEALTH L. & POL'Y 85, 104 (2005) (“[P]rotecting employee health as a means to enhance productivity and reduce absenteeism obviously does not extend to retirees who, by definition, no longer contribute actively to the workplace.”).

45. Regina T. Jefferson, *Rethinking the Risk of Defined Contribution Plans*, 4 FLA. TAX REV. 607, 683 (2000).

health benefits in any form than new economic powerhouses like Wal-Mart and Google.⁴⁶ Those old-line industries, moreover, have reduced their U.S. workforces to such an extent that their number of current employees is often dwarfed by their number of retirees.⁴⁷ These reduced payrolls, in turn, make it even more attractive from an employer's standpoint to slash health care coverage for retirees. In other words, not only are health care costs higher and rising faster on a per-person basis for retirees than for current employees,⁴⁸ there are also more retirees—in some cases, many more retirees—than current employees.⁴⁹ These pressures provided the backdrop for General Motors' dramatic decision in mid-2008 to eliminate retiree health benefits for its non-unionized Medicare-eligible retirees.⁵⁰ Only one year earlier, the company had shifted all responsibility for health care costs of its unionized retirees to a new union-controlled entity in exchange for a one-time transfer of funds.⁵¹ The point is that the rising cost of health care has combined with larger trends affecting the composition of the American workplace to seriously imperil the provision of retiree health benefits.

B. Accounting Disclosure Requirements

Compounding these cost-reduction tendencies in the face of rising health care costs, the Financial Accounting Standards Board (FASB) began requiring nongovernmental employers to disclose the projected cost of future retiree health benefits. FASB's fateful Statement No. 106, entitled "Employers' Accounting for Postretirement Benefits Other Than Pensions," first effective in 1992,⁵²

46. See CLAXTON ET AL., *supra* note 32, at 134 (noting disparity in retiree health benefit availability by industry); FINKEL & RUCHLIN, *supra* note 14, at 65-66 (same).

47. See Anna M. Rappaport & Carol H. Malone, *Adequacy of Employer-Sponsored Retiree Health Benefit Programs*, in PROVIDING HEALTH CARE, *supra* note 29, at 59-61 (noting that the ratio of retirees to current workers is three to one); Jeffrey Zaslow & Gregory L. White, *For GM Retirees, It Feels Less Like 'Generous Motors,'* WALL ST. J., Feb. 21, 2003, at A1 ("GM's 460,000 retirees and surviving spouses now outnumber active employees in the U.S. nearly 3 to 1.").

48. See HEWITT ASSOCIATES, TIAA-CREF INST., THE RETIREE HEALTH CARE CHALLENGE 2 (2006), available at http://www.tiaa-crefinstitute.org/pdf/research/dvds_books/110106.pdf.

49. See *id.* at 3 (retiree health care costs represent 29% of total health care costs among large employers offering such benefits).

50. See Bill Vlasic, *With Warning, G.M. Takes Wide Cost Cuts*, N.Y. TIMES, July 16, 2008, at C1 (noting that this elimination of benefits "was unexpected").

51. See Jeffrey McCracken & John D. Stoll, *UAW, GM Near Historic Deal on Retiree Health Costs*, WALL ST. J., Sept. 22, 2007, at A3; Jyoti Thottam, *GM's Get-Well Plan*, TIME, Oct. 1, 2007, available at <http://www.time.com/time/magazine/article/0,9171,1663838-1,00.html>; see also John D. Stoll, *UAW Weighs Health-Care Trust*, WALL ST. J., July 20, 2007, at A8.

52. FIN. ACCOUNTING STANDARDS BD., EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS: STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106 (1990), available at <http://www.fasb.org/pdf/fas106.pdf>.

represented a sharp break with prior practices because most companies do not pre-fund retiree health benefits.⁵³ In contrast to the typical practice of making annual cash outlays to pay future pension obligations, companies generally pay retiree health care costs as the retirees receive this care, with few financial assets set aside in advance.⁵⁴ FASB Statement No. 106 required employers to acknowledge the substantial drain on future profits that they had undertaken with respect to both current and prospective retirees. As one analyst explained,

The rationale was that retiree medical benefits are a form of deferred compensation for current employees, and the future benefits should be reported as they are earned. The underlying theory was that if an employer is going to hold out these benefits to employees in trade for their work, the obligation of paying for them down the line has to be recognized at the time the work earning the benefit is done and the obligation incurred.⁵⁵

From a financial accounting perspective, in other words, incurred costs—including future health care expenses of current employees—should be reflected in an employer's financial results when that employer assumes responsibility for those costs. Notwithstanding the theoretical correctness of this approach, the result was a major increase in the annual cost reported by employers for their operations, in some cases, as much as five to ten times the cost on a pay-as-you-go basis.⁵⁶

Faced with these financial statement disclosures, many companies felt considerable pressure to reduce the extent of their obligations, and many firms initiated cost-reduction strategies to that end.⁵⁷ The impact was calamitous for retirees. Among employers with at least 200 employees, the share of such employers who offer any type of retiree benefits dropped from 66% in 1988 to 35% in 2006.⁵⁸ Even larger employers—namely, those with at least 1000

53. See KAISER/HEWITT SURVEY, *supra* note 7, at 12 (75% of retiree health benefit plans are not pre-funded). Even among employers with 20,000 or more employees, 60% of such plans are not pre-funded. *Id.*

54. See FINKEL & RUCHLIN, *supra* note 14, at 66.

55. Sylvester S. Schieber, *The Outlook of Retiree Health Benefits*, TIAA-CREF RES. DIALOGUE, Sept. 2004, at 3, available at http://www.tiaa-crefinstitute.org/pdf/research/research_dialogue/81.pdf.

56. Deborah J. Chollet, *Is Retiree Health Insurance Crowding Out Retiree Cash Benefits?*, in PROVIDING HEALTH CARE, *supra* note 29, at 17, 20. See generally Rappaport & Malone, *supra* note 47, at 72-74 (cost impact of the FASB pronouncement).

57. See FRONSTIN, *supra* note 22, at 8; TIAA-CREF INST., *supra* note 48, at 3-4; CONG. RESEARCH SERV., HEALTH INSURANCE COVERAGE FOR RETIREES 12 (2006), available at http://openers.cdt.org/rpts/RL32944_20060328.pdf; see also U.S. GEN. ACCOUNTING OFFICE, *supra* note 21, at 10.

58. KAISER/HEWITT SURVEY, *supra* note 7, at 1. Among all private sector employers, the proportion offering retiree health benefits has declined from 20-22% in 1997 to 13% in 2002. See

employees—have diminished their offerings of retiree health benefits steadily, as this chart shows:⁵⁹

Percentage of All Large Firms (1,000 or More Workers) Offering Retiree Health Benefits, 1991-2006

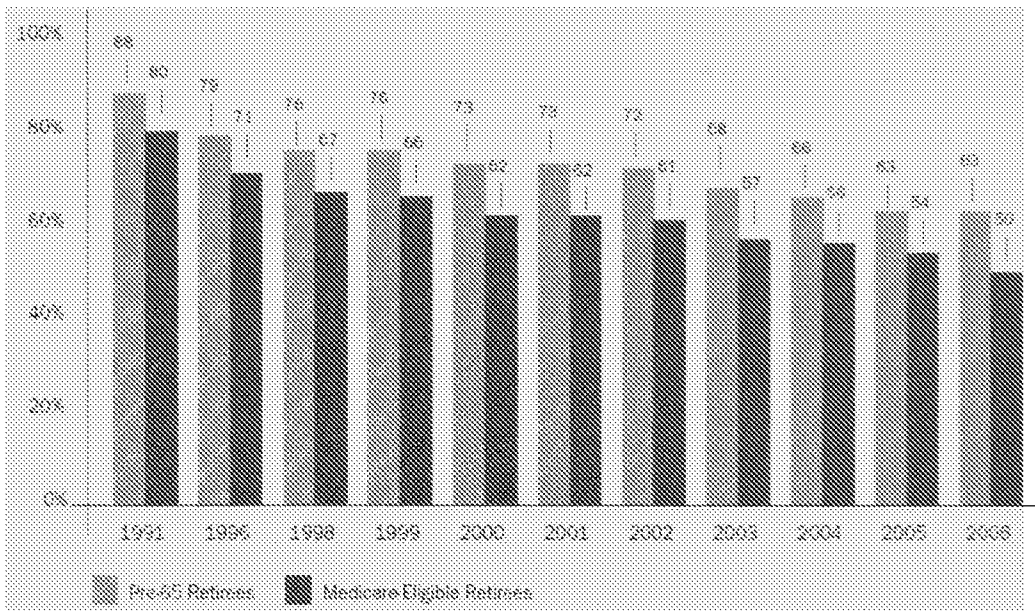


FIGURE 1: Trends in Employer Retiree Health Coverage (1991-2006)

Source: HEWITT ASSOCIATES, TIAA-CREF INST., THE RETIREE-HEALTH CARE CHALLENGE 2 (2006), available at <http://www.tiaa-crefinstitute.org/research/articles/docs/110106.pdf> (reprinted with permission).

Note that pre-Medicare retirees have always fared better than Medicare-eligible retirees, but the trend line for both groups is nevertheless declining.⁶⁰ Note further that among these employers, approximately one in six requires their retirees to pay the *entire* cost of provided health benefits.⁶¹

This erosion of retiree health benefits, moreover, has fallen unevenly across America's retired population. Younger retirees, women, and those without a post-college education are more likely to be affected.⁶² A comprehensive survey involving approximately twenty-six and thirty-one million retirees in 1997 and 2002, respectively,⁶³ found that female retirees were three times as likely as male

FRONSTIN, *supra* note 22, at 4.

59. Reprinted with permission from HEWITT ASSOCIATES, *supra* note 48, at 6.

60. Of these employers, 85% offer health benefits to both pre-Medicare and Medicare-eligible retirees, while 14% offer benefits only to pre-Medicare retirees. KAISER/HEWITT SURVEY, *supra* note 7, at 4.

61. *Id.* at 15; see, e.g., Amy Merrick, *Sears Is To Make Additional Cuts to Retirees' Medical Benefits*, WALL ST. J., Sept. 23, 2005, at A2.

62. See FRONSTIN, *supra* note 22, at 12-13.

63. *Id.* at 12.

retirees to lose retiree health benefits during the period examined.⁶⁴ Non-unionized retired workers were also three times as likely as unionized retired workers to see such a decline.⁶⁵ Thus, the general decline of unionization in the American workplace further undermines the provision of retiree health benefits.⁶⁶

As bad as this situation is, newly effective accounting pronouncements are likely to exacerbate it. In 2006, the FASB promulgated Statement No. 158, which requires that the net obligation for retiree health benefits be shown on the face of the financial statements themselves, rather than being buried in the voluminous notes that typically accompany financial statements.⁶⁷ This change was deemed necessary by the FASB, because “presenting such information only in the notes made it more difficult for users of financial statements to assess an employer’s financial position and ability to satisfy postretirement benefit obligations.”⁶⁸ As a result, public and privately-held companies, as well as nongovernmental not-for-profit organizations, are now required to highlight the expected cost of retiree health benefits beginning with fiscal years that end after June 15, 2007, and in some cases even earlier.⁶⁹ Such heightened disclosure is likely to increase existing pressures on employers to lower the cost of these benefits by reducing their scope of coverage.

A similar pattern may develop in the governmental sector where retiree health benefits are even more common. Fully forty-eight of the fifty states and more than half of all municipalities currently provide such benefits.⁷⁰ Nearly all governmental employers pay the cost of these benefits out of current budgetary receipts with no provision for future expenditures.⁷¹ But this pay-as-you-go approach is being challenged by Statement No. 45 of the Governmental Accounting Standards Board (GASB), entitled “Accounting and Financial

64. *Id.*

65. *Id.* at 14-15.

66. See Buchmueller, Dinardo & Valletta, *supra* note 27, at 626.

67. FIN. ACCOUNTING STANDARDS BD., EMPLOYERS’ ACCOUNTING FOR DEFINED BENEFIT PENSION AND OTHER POSTRETIREMENT PLANS: STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 158 (2006), available at <http://www.fasb.org/pdf/fas158.pdf>; see HEWITT ASSOCIATES, *supra* note 48, at 4.

68. FIN. ACCOUNTING STANDARDS BD., *supra* note 67, at Summary (unnumbered second page).

69. *Id.* paras. 12-14, at 7.

70. Janice Revell, *The Great State Health-Care Giveaway*, FORTUNE, May 2, 2005, at 43, 44; see also Judith F. Mazo, *Introduction to Retiree Health Benefits*, in PROVIDING HEALTH CARE, *supra* note 29, at 9, 11 (noting the “traditional pattern of public employers offering richer benefits than much of the private sector in return for lower cash compensation”); *The Other Benefits Mess*, KIPLINGER’S PERS. FIN. MAG., Sept. 2007, at 17 (82% of public-sector employers provide retiree health benefits).

71. See, e.g., David Denholm, *States Nearing Crisis in Retiree Benefits*, HEALTH CARE NEWS, July 2007, at 15; Chris Edwards & Jagadeesh Gokhale, *A \$2 Trillion Fiscal Hole*, WALL ST. J., Oct. 12, 2006, at A18.

Reporting by Employers for Postemployment Benefits Other Than Pensions.”⁷² This Statement deals with “other post-employment benefits,” which principally includes health care benefits, but can also encompass dental care, vision care, and life insurance.⁷³

GASB Statement No. 45 requires state and local governments to estimate the projected cost of their other post-employment benefits⁷⁴ and to record as a current-year expense the amount that would be needed to fund this projected cost over the next thirty years.⁷⁵ Although the affected governments need not actually transfer cash equal to this expense, they must disclose the amount of this obligation.⁷⁶ Substantially similar to FASB Statement No. 106, GASB Statement No. 45 applies to all governmental entities for fiscal years after December 15, 2008.⁷⁷ While its implementation is only now upon us, and it is impossible to predict what changes these disclosures will precipitate, a re-examination of retiree health care benefits is likely. Some analysts have already described the employers covered by GASB Statement No. 45 as “shocked, simply shocked” by the required revelations,⁷⁸ and the taxpayers who must fund these retiree health care benefits may be similarly surprised by the extent of the future tax obligations that they have unwittingly assumed. To citizens who themselves have lost—or perhaps never even had—employer-provided retiree health care benefits, efforts to reduce these promised benefits may look extremely appealing.⁷⁹ As was the case with private sector employers, state and local government employers may find that the new GASB accounting rules provide an impetus—or “cover” perhaps—to reduce retiree health care benefits that were already under pressure from rising health inflation trends, increasing retiree-to-employee ratios, and tax revenue shortfalls.⁸⁰

72. GOVERNMENTAL ACCOUNTING STANDARDS BD., ACCOUNTING AND FINANCIAL REPORTING BY EMPLOYERS FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS: STATEMENT NO. 45 OF THE GOVERNMENTAL ACCOUNTING STANDARDS BOARD (2004) [hereinafter GASB No. 45].

73. *Id.* para. 7, at 3.

74. *Id.* paras. 19-20, at 13-14.

75. *Id.* para. 13(f)(1), at 9-10.

76. See Ronald Kramer & Mark Casciari, *Government [sic] Accounting Standards Board (GASB) Statement No. 45 Makes Public Employers Revisit Retiree Health Insurance*, 37 URB. LAW. 427, 430 (2005).

77. GASB No. 45, *supra* note 72, para. 36, at 35.

78. See Revell, *supra* note 70, at 44.

79. See generally Stan Wisniewski & Lorel Wisniewski, *State Government Retiree Health Benefits: Current Status and Potential Impact of New Accounting Standards*, AARP PUB. POL'Y INST. 19-25 (2004), available at http://assets.aarp.org/rgcenter/health/2004_08_benefits.pdf. Regarding possible state constitutional constraints on reducing governmental retirees' health benefits, see Kramer & Casciari, *supra* note 76, at 443-46.

80. See Schieber, *supra* note 55, at 9; see also Robert L. Clark, *Financing Retiree Health Care: Assessing GASB 45 Estimates of Liabilities*, CENTER FOR STATE & LOCAL GOVERNMENT

II. LEGAL RECOURSE WHEN BENEFITS ARE REDUCED OR TERMINATED

The Employee Retirement Income Security Act of 1974, better known as ERISA, provides statutory protections for employee benefits generally, including retiree health benefits.⁸¹ This federal law regulates employer-provided pension plans and welfare plans to protect employees' future interests, while encouraging employer development of retiree benefit plans.⁸² Pension plans are essentially future installment income plans paid to employees,⁸³ while welfare plans are maintained to provide employees with "medical, surgical, or hospital care or benefits . . ."⁸⁴ Although ERISA does not require employers to provide employee benefit plans, an employer that chooses to do so becomes subject to its requirements.⁸⁵

ERISA medical plans are subject principally to 1) reporting and disclosure requirements, 2) fiduciary rules, and 3) enforcement and remedial measures.⁸⁶ With respect to reporting and disclosure requirements, ERISA requires the plan administrator to file a fully comprehensive description of the plan with the U.S. Secretary of Labor and to furnish plan participants and beneficiaries with a summary plan description that is "written in a manner . . . to be understood by the average plan participant, and . . . sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights . . . under the plan."⁸⁷

Regarding fiduciary responsibilities, ERISA requires that every employee

EXCELLENCE ISSUE BRIEF 4 (2008), *available at* <http://www.slge.org/> (follow the "Financing Retiree Health Care: Assessing GASB 45 Estimates of Liabilities" hyperlink at left) ("[M]ost plans covering state and local government employees and retirees are amended regularly in an effort to reduce cost increases.").

81. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5, 18, 26, 29, and 42 U.S.C.).

82. *See* 29 U.S.C. § 1001b(c) (2000). Congressional adoption of ERISA was meant to balance competing goals of employee benefit protection and reasonable standards for employers. *See also* Melissa Elaine Stover, *Maintaining ERISA's Balance: The Fundamental Business Decision v. The Affirmative Fiduciary Duty To Disclose Proposed Changes*, 58 WASH. & LEE L. REV. 689, 690 & nn.1-2 (2001).

83. 29 U.S.C. § 1002(2)(A) (2000) (Pension plans "provide retirement income to employees, or result . . . in a deferral of income by employees for periods extending to the termination of . . . employment or beyond.").

84. *Id.* § 1002(1). In this Article, the phrases "welfare plan," "medical plan," and "health care plan" are used interchangeably to refer to post-retirement health care arrangements.

85. For a comprehensive overview of ERISA, see JOHN H. LANGBEIN, SUSAN J. STABILE & BRUCE A. WOLK, *PENSION AND EMPLOYEE BENEFIT LAW* (4th ed. 2006).

86. 29 U.S.C. §§ 1021-1031, 1101-1114, 1131-1147 (2000) (applying to welfare benefit plans).

87. *Id.* §§ 1021(f)(4), 1022(a), 1024(b).

benefit plan “be established and maintained pursuant to a written instrument” and that every plan “provide a procedure for amending such plan . . . ”⁸⁸ To protect the interests of employees and beneficiaries, ERISA imposes the common law duties of a trustee on the fiduciaries of the employee benefit plan.⁸⁹ A legal person is a fiduciary with respect to a benefits plan if that person exercises control over plan management, renders investment advice, or maintains discretionary authority over the plan’s execution.⁹⁰ Corporate benefit administrators, therefore, undertake fiduciary obligations to plan participants by disseminating and managing benefit plans within the employer company. However, these duties attach only when the employer actually functions as a fiduciary rather than as a self-interested business entity.⁹¹ The Supreme Court formulated the so-called “two hats”⁹² doctrine to create a threshold when an employer’s fiduciary duties attach, stating that an employer is subject to fiduciary liability under ERISA only when performing one of the statutorily defined functions.⁹³ Ultimately, an employer’s actions determine its fiduciary status, not simply its position.

With respect to enforcement and remedial measures, ERISA provides that participants and beneficiaries have a cause of action for violations of the reporting and disclosure requirements or the fiduciary responsibilities created by this statute.⁹⁴ A participant or beneficiary also has a cause of action to protect contractually defined benefits.⁹⁵ Moreover, a participant or beneficiary has a cause of action against any person who discharges “or discriminate[s] against a participant or beneficiary for exercising any right . . . under the employee benefit plan . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.”⁹⁶

In the interest of national uniformity, Congress federalized the law of employee benefit plans, except for a few areas such as state regulation of insurers.⁹⁷ Rights and remedies under ERISA are largely limited to reporting, disclosures, and fiduciary responsibilities. In effect, ERISA pre-empted the more

88. *Id.* §§ 1102(a)(1), (b)(3).

89. *Id.* § 1104.

90. *See id.* § 1002(21)(A).

91. *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

92. *See Stover, supra* note 82, at 715-17 (2001). The concept is entitled “two hats” because the company’s actor can wear either a “fiduciary” hat when acting as benefits plan administrator or “business entity” hat when acting in the interests of the business.

93. *Id.* at 698, 717-19 (noting that employer is only subject to ERISA fiduciary duties when wearing its “fiduciary hat” as functionally defined).

94. 29 U.S.C. §§ 1132(a)(1)(A), (3), (4) (2000).

95. *Id.* § 1132(a)(1)(B).

96. *Id.* § 1140.

97. *Id.* § 1144(b)(2)(A).

comprehensive rights and remedies that might have been available under state law. Courts have, on occasion, supplemented ERISA with federal common law.⁹⁸

This Part begins by examining the employer's right under ERISA to change health benefit plans. It then discusses the extent to which this right is limited because an employee's rights have vested and cannot be unilaterally altered by the employer—both in a unionized context and in a non-unionized setting. This Part next considers claims that employers have breached fiduciary duties in changing retiree health benefits. Finally, this Part analyzes claims of estoppel—namely, that the employer's prior actions bar subsequent changes that might otherwise be allowed.

A. Employer's Right To Change Health Benefit Plans

ERISA clearly allows employers to change health benefit plans, as the Supreme Court held in *Curtiss-Wright v. Schoonejongen*.⁹⁹ As long as an employer retains the right to do so, that employer is “generally free under ERISA, for any reason at any time, to adopt, modify, or terminate [its] welfare plan.”¹⁰⁰ Moreover, ERISA does not specify any vesting guarantees for welfare plans, unlike its stipulated mandatory vesting requirements for pension plans.¹⁰¹ In the benefits context, vesting means that an employee has attained an unalterable right to a particular provision. Thus, while pension benefits cannot be changed if they have vested according to ERISA's guidelines, health care benefits have no such statutory protection.

ERISA's silence regarding the vesting of health care benefits has spawned extensive litigation and nuanced jurisprudential hopscotch over whether vesting of welfare benefits can occur in the absence of explicit and unambiguous contractual language in a company's benefits plan agreement. These cases have arisen both in the organized labor context, where benefit plans are formulated through negotiated collective bargaining agreements, and in individual employee benefit plans that are unilaterally written and instituted by the employer. As will be seen shortly, in neither context are retirees automatically vested in welfare benefit plans; rather, they must prove by a preponderance of the evidence that their former employer intended for the retiree health benefits to be vested.¹⁰² But extrinsic evidence about the intent of the parties is considered only when the retirement plan language is ambiguous due to conflicting clauses or multiple

98. See, e.g., *PM Group Life Ins. Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992).

99. 514 U.S. 73 (1995).

100. *Id.* at 78.

101. 29 U.S.C. §§ 1051-1061, 1081-1086 (2000).

102. *Howe v. Varsity Corp.*, 896 F.2d 1107, 1109 (8th Cir. 1990); see also *McMunn v. Pirelli Tire LLC*, 161 F. Supp. 2d 97, 122 (D. Conn. 2001).

plausible interpretations or is otherwise silent as to an employer's intent that the benefits vest.¹⁰³ In the absence of such situations, the plan documents stand on their own.

Although vesting claims are contractual disputes that focus on an employer's failure to honor allegedly vested health care benefits, an employer's fiduciary conduct in benefits communications can also come under legal scrutiny. Employer representatives potentially breach their ERISA-mandated fiduciary duty by making false statements to employees, and these statements can lead to employee claims for misrepresentation and estoppel. Employers may breach their fiduciary duties when their representatives make material misrepresentations either intentionally or negligently, depending on the judicial circuit. Estoppel claims may arise from employers' making false representations that their retirees detrimentally relied upon in making their retirement choices.

For example, the Seventh Circuit's decision in *Vallone v. CNA Financial Corp.*¹⁰⁴ provides an apt starting point for considering retirees' legal claims in lost benefits cases, because it included retiree claims on all three legal theories: contract breach regarding vesting, breach of fiduciary duty, and estoppel. Michael Vallone and two fellow employees at Continental Insurance Company accepted an early retirement package in 1991 that included a provision of "lifetime" welfare benefits known as the Health Care Allowance (HCA).¹⁰⁵ This provision of lifetime HCA benefits was reiterated both orally and in writing to the early retirees.¹⁰⁶ Eight years later, CNA Financial Corporation, the plan's employer-administrator that had acquired Continental Insurance, notified Mr. Vallone and the other early-retirees that their HCAs were being terminated.¹⁰⁷ CNA's basis for retiree benefits termination was a contractual clause that reserved the employer's right to change or amend the plan.¹⁰⁸

In a class action, Vallone brought suit against CNA on three substantive issues: 1) breach of contract under ERISA for not honoring the alleged lifetime nature of HCA benefits (i.e., a vesting argument), 2) breach of its ERISA

103. Helen M. Kemp, *The Employer Giveth and Taketh Away: Retiree Health Benefits Under ERISA-Governed Health Plans*, THE BRIEF (Am. Bar Ass'n, Chi., Ill.), Spring 2005, at 16, 18 (discussing employer-employee disputes over benefit vesting).

104. 375 F.3d 623 (7th Cir. 2004).

105. *Id.* at 626.

106. *Id.*

107. *Id.*

108. *Id.* at 634 (holding that reservation of rights allows stripping of "lifetime" benefits because contractual silence as to vesting presumes non-vested benefit status; also noting that "in the perhaps beady eyes of the law, the 'lifetime' nature of a welfare benefit does not operate to vest that benefit if the employer reserved the right to amend or terminate the benefit, given 'what it takes to overcome the presumption that welfare benefits do not vest'") (quoting *Diehl v. Twin Disc*, 102 F.3d 301 (7th Cir. 1996)).

fiduciary duty by providing informational misrepresentations as plan administrator, and 3) promissory estoppel for the retirees' reasonable reliance on the employer's misrepresentations.¹⁰⁹ The Seventh Circuit affirmed the district court's summary judgment for CNA on all claims.¹¹⁰ First, the court found that the employer's reservation clause was sufficiently unambiguous as to CNA's intentions to not vest welfare benefits in its standard retirement plans, and the early retirement package constituted simply a modification to the existing plan rather than an entirely new plan.¹¹¹ Second, the court held that the employer did not breach its fiduciary duty to the plaintiffs, because CNA's representatives did not intentionally deceive the early retirees when they made material misrepresentations about their benefits.¹¹² Lastly, the retirees could not show a knowing misrepresentation of fact on CNA's behalf to prevail on an estoppel claim; plaintiffs, moreover, did not substantiate their reasonable reliance on CNA's purported misrepresentations.¹¹³ The *Vallone* plaintiffs thus failed to prevail on any of their three legal theories. This case illustrates well that retirees are not likely to prevail on legal challenges to employers who modify the terms of post-retirement welfare plans.

B. Vesting Claims

As a general matter, health benefits plans are reduced to the written terms of the ERISA-governed benefit plan document. While ERISA allows employers a right to amend benefit plans, employers may relinquish this right by affirmatively contracting with their employees for vesting of the employees' welfare benefits, including health care coverage in retirement.¹¹⁴ To this end, retirees who want to protect their benefits must invariably argue that the benefit plan language included an employer commitment to vest and that such vesting was impervious to future employer modification; stated differently, retirees must prove that the employer promised to vest benefits and that the duration of that promise was unlimited within a retiree's lifetime. It is the employees' burden to prove these facts in order to overcome the *Curtiss-Wright* rule that employers are free to modify benefit plans where they have reserved the right to do so. As will be seen below, employee-retirees have significant difficulty prevailing on such claims, whether in a unionized or non-unionized setting.

109. *Id.* at 626-27.

110. *Id.* at 626.

111. *Id.* at 634-35.

112. *Id.* at 640-642 (endorsing the intentional deception standard necessary for breach of fiduciary duty and stating that a "breach of fiduciary duty exists if fiduciaries 'mislead plan participants or misrepresent the terms or administration of a plan'" (quoting *Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 991 (7th Cir. 1993)).

113. *Id.* at 639-40.

114. *See Kemp*, *supra* note 103, at 18.

1. The Unionized Workplace

In a union context, the Collective Bargaining Agreement (CBA) governs benefit plans and provides the basis for deciding the parties' intent and scope of vested benefits. The written document describing the terms of the collectively bargained benefits is called a Summary Plan Description, or SPD, which is the statutorily mandated vehicle by which employees are informed of their coverage.¹¹⁵ SPDs usually contain clauses reserving an employer's right to amend benefit plans at a later time, but other language in the document often suggests that the benefits are unequivocally vested for the employees' lifetimes. These conflicting provisions therefore give rise to litigation when employers later amend plans, and retirees object by claiming that their benefits are vested for life. In such cases of contractual ambiguity, the rules of contract interpretation require the court to assess the intent of the parties.

a. Inter-Circuit Disagreement over Inferring an Employer's Intent to Vest Benefits

The most controversial and widely cited federal case regarding contractual ambiguity and intent of the parties regarding benefits in a union setting is *UAW v. Yard-Man, Inc.*¹¹⁶ This case is well-known for the Sixth Circuit's groundbreaking "*Yard-Man* inference" that silence as to benefits' duration suggests an employer's intent to vest.¹¹⁷ Although the United Automobile Workers (UAW) and the company agreed to provide retiree welfare benefits in a 1974 CBA, the company terminated these benefits after the CBA's three-year term expired.¹¹⁸ Viewing the retiree benefit provision language stating that the company "will provide insurance benefits equal to the active group" as reasonably ambiguous regarding the benefits' duration, the Sixth Circuit allowed extrinsic evidence to be considered under the rules of contract interpretation.¹¹⁹

The court, inferring into the situational context the relative bargaining positions of the parties, ruled that retiree health benefits extended beyond the

115. See 29 U.S.C. §§ 1022(a), 1102 (2000).

116. 716 F.2d 1476 (6th Cir. 1983).

117. See Jason Blumberg, Comment, *Bringing Back the Yard-Man Inference*, 4 U. PA. J. LAB. & EMP. L. 195, 201 (2001).

118. 716 F.2d at 1478.

119. *Id.* at 1480 (internal quotation marks omitted). UAW interpreted the phrase as a characterization of the nature of the benefits (i.e., what benefits they were promised), while the company read it as tying retirees' benefits to those of active employees who were to be terminated at the end of the CBA due to plant closing and the cessation of an active work force. See Douglas Sondgeroth, Note, *High Hopes: Why Courts Should Fulfill Expectations of Lifetime Retiree Health Benefits in Ambiguous Collective Bargaining Agreements*, 42 B.C. L. REV. 1215, 1231-32 (2001) (explaining and defending the *Yard-Man* inference).

expiration of the CBA. It reasoned that retiree benefits were akin to status benefits that “carry with them an *inference* that they continue so long as the prerequisite status is maintained. Thus, when the parties contract for benefits which accrue upon achievement of retiree status, there is an *inference* that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree.”¹²⁰ Retirees had a justified expectation of future welfare benefits, the court found, because retirement benefits are “typically understood as a form of delayed compensation or reward for past services” that would not likely “be left to the contingencies of future negotiations.”¹²¹ In other words, the retiree health benefits had already accrued to retirees in exchange for previously sacrificed wages and were not subject to later agreements.¹²² Having inferred these points and considered all factors, the Sixth Circuit decided that the specific benefits clause vested retiree benefits interminably and ultimately trumped the routine three-year duration clause pronounced for the CBA as a whole. Because the agreement contained specific duration clauses for other less significant benefits, the generalized duration clause could not defeat the specialized benefits language into which the court read an intent to vest.

Two trends have been evident in the jurisprudential wake of *Yard-Man*. First, and far more conventional than controversial, the Sixth Circuit’s application of the interpretive canon that the “specific controls the general” found accord among other circuits that later adopted *Yard-Man*’s distinction between specific and general duration clauses. In *United Steelworkers of America v. Connors Steel Co.*,¹²³ for example, the Eleventh Circuit confronted the issue of whether retiree health benefits terminated at the expiration of the CBA. The agreement provided that retirees “shall not have such coverage terminated or reduced . . . so long as the individual remains retired from the company . . . notwithstanding the expiration of this agreement.”¹²⁴ As in *Yard-Man*, the court held that a specific duration clause overrides a general duration clause. Because contract interpretation is highly factual, courts have sometimes found that the language of the agreement unambiguously provided retirees lifetime benefits that did not end with the expiration of the CBA.¹²⁵

Second, the *Yard-Man* inference spawned chaos among the circuit courts as to its validity, force, and effect, although some commentators have pointed to limiting language in the opinion to say that the Sixth Circuit’s approach was not

120. 716 F.2d at 1482 (emphasis added).

121. *Id.*

122. Sondgeroth, *supra* note 119, at 1232 (explaining the Sixth Circuit’s rationale for the *Yard-Man* inference).

123. 855 F.2d 1499 (11th Cir. 1988).

124. *Id.* at 1505.

125. *See, e.g., Diehl v. Twin Disc, Inc.*, 102 F.3d 301 (7th Cir. 1996); *Policy v. Power Pressed Steel Co.*, 770 F.2d 609 (6th Cir. 1985).

nearly as radical as it has been interpreted by other courts.¹²⁶ The Sixth Circuit itself incorrectly applied its own precedent in *Policy v. Powell Pressed Steel Co.*¹²⁷ by decreeing that “normally retiree benefits are vested,” which substantially overstates the thrust of *Yard-Man*.¹²⁸ But it subsequently corrected its mistake in *In re White Farm Equipment Co.*,¹²⁹ by overruling a federal district court that had found under the federal common law of ERISA that welfare benefits vest automatically on retirement and are nonterminable, despite plain language in the plan authorizing such termination¹³⁰: “[W]e find that . . . ERISA, though silent on this issue, counsels against . . . an absolute rule effectively requiring mandatory vesting at retirement of retiree welfare benefits [W]e discern no basis for finding mandatory vesting in ERISA of retiree welfare benefits.”¹³¹

Other circuits generally agree with *In re White Farm Equipment Co.* that retiree benefits do not automatically vest absent affirmative language to that effect. The Third Circuit has found that “[retiree] welfare benefits do not automatically vest as a matter of law,”¹³² while the Eighth Circuit has said that “Congress explicitly exempted welfare benefits from ERISA’s vesting requirements. It, therefore, seems illogical to infer an intent to vest welfare benefits in every situation where an employee is eligible to receive them on the day he retires.”¹³³ Similarly, the Second Circuit persuasively argued that:

[Congress rejected] [a]utomatic vesting . . . because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning [pensions] are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs.¹³⁴

Still, significant disagreement among circuits has developed since *Yard-Man* regarding the degree of importance that should be attached to the inference of vesting when a contract is ambiguous. Some circuits deem the inference a strong

126. See, e.g., Blumberg, *supra* note 117, at 202 (arguing that the *Yard-Man* inference is only one of many factors to consider, and although the Sixth Circuit made this abundantly clear, some future courts have applied the inference too broadly).

127. 770 F.2d 609 (6th Cir. 1985).

128. *Id.* at 613-14.

129. 788 F.2d 1186 (6th Cir. 1986).

130. *Id.* at 1190.

131. *Id.* at 1192-93.

132. *Molnar v. Wibbelt*, 789 F.2d 244, 250 (3d Cir. 1986).

133. *Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1517 (8th Cir. 1988).

134. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

factor in ascertaining the intent of the parties to a CBA,¹³⁵ while others consider it only selectively. For instance, the Fifth Circuit limits application of the vesting inference to those instances in which retirees have no voice in negotiating a new CBA.¹³⁶ By contrast, a vesting inference has no place in the Seventh Circuit, which has ruled that there is a presumption against vesting beyond the duration of a CBA if the agreement is silent on the issue, unless retirees can show by objective evidence that the agreement is latently ambiguous.¹³⁷ This ruling is compelling for two reasons. First, the union negotiates the terms of the agreement, so it is highly unlikely that the union was naïve about the risks of having ambiguity or silence on an issue. Second, and perhaps more importantly, the ruling treats CBAs and unbargained-for ERISA plans consistently in this regard.

b. Recent Union Cases Show Employers' Diligence in Avoiding Contractual Ambiguity and Precluding the Possibility of an Intent-to-Vest Inference

Despite the significant disagreement among circuit courts regarding an employer's intent to vest benefits, this issue is becoming less significant as courts generally find benefit plans straightforward enough, or sufficiently unambiguous, to preclude the consideration of extrinsic evidence. Furthermore, the decline in union density, changed economic circumstances, and shifting composition of the workforce have weakened the bargaining power of unions to safeguard the benefits interests of their members.¹³⁸ The chronological sampling below of recent Courts of Appeals cases demonstrates that retirees have routinely been unsuccessful on claims of vested benefits and contract breach against their employers.

*i) Hughes v. 3M Retiree Medical Plan (2002)*¹³⁹

A married couple sued their former employer and its retiree medical plan in response to the employer's changes to their medical benefits after they had retired. The employer implemented a revised retiree plan that included

135. See *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648, 654 (6th Cir. 1996); *Keffer v. H.K. Porter Co.*, 872 F.2d 60, 64 (4th Cir. 1989); *United Steelworkers v. Textron, Inc.*, 836 F.2d 6, 9 (1st Cir. 1987).

136. See *Int'l Ass'n of Machinists v. Masonite Corp.*, 122 F.3d 228, 231-32 (5th Cir. 1997); *United Paperworkers Int'l Union v. Champion Int'l Corp.*, 908 F.2d 1252, 1261 n.12 (5th Cir. 1990); *Int'l Ass'n of Machinists v. Masonite Corp.*, 122 F.3d 228, 231-32 (5th Cir. 1997).

137. *Rossetto v. Pabst Brewing Co., Inc.*, 217 F.3d 539, 544, 547 (7th Cir. 2000).

138. See *Maria O'Brien Hylton, The Changing World of Employee Benefits*, 79 CHI.-KENT L. REV. 625, 627-28 (2004).

139. 281 F.3d 786 (8th Cir. 2002).

“additional cost sharing by retirees”; however, plaintiffs contended that the “Your Benefits” booklet given to them by the company following the 1991 union-employer CBA contained vesting language stating that “[i]f you retire with 15 years of pension service regardless of when you were hired, you and your spouse will receive medical benefits for your lifetime at company expense.”¹⁴⁰

The Eighth Circuit found that the benefits booklet cited by plaintiffs was not the correct SPD, as the booklet referred participants over age sixty-five to a separate “Med-Supp Plan” brochure that governed plaintiffs’ plan and contained no language even remotely suggestive of vesting.¹⁴¹ Regardless of which booklet was appropriate, both documents—“Med-Supp Plan” or “Your Benefits”—contained reservation clauses stating that while the company intended to continue the plan indefinitely, it reserved the right to amend or discontinue benefits.¹⁴² These reservation-of-rights clauses sufficed for 3M to unilaterally alter retiree benefits long after the CBA was ratified. Interestingly, whereas the “Your Benefits” booklet for workers under age sixty-five read that the company “reserves the right to amend or discontinue . . . subject to collective bargaining as required,”¹⁴³ the Med-Supp Plan’s reservation clause concluded with “reserves the right to change or discontinue it if necessary.”¹⁴⁴ Although not mentioned in the opinion, it seems that retirees are more at risk than are current employees, since the employer could alter their plan “if necessary” rather than “subject to collective bargaining as required,” the standard applicable to current employees.

*ii) UAW v. Rockford Powertrain, Inc. (2003)*¹⁴⁵

Former union member retirees, surviving spouses of retirees, and their local union sued their former employer, Rockford Powertrain, Inc. (RPI), after RPI cut welfare benefits midway through the term of the instant CBA.¹⁴⁶ RPI had acquired the manufacturing plant of the retirees’ previous employer in 1988, assumed the existing CBA, and thereafter re-negotiated subsequent CBAs periodically with the UAW.¹⁴⁷ Although the latest CBA was to apply through 2001, RPI announced benefit cuts in late 1999 that would 1) reduce medical insurance coverage by increasing retirees’ share of premiums and 2) fully terminate life insurance benefits across its active and retired workforce.¹⁴⁸ Citing recessionary economic pressures, RPI terminated all health benefits for active

140. *Id.* at 789.

141. *Id.* at 792.

142. *Id.* at 792-93.

143. *Id.* at 789.

144. *Id.* at 792.

145. 350 F.3d 698 (7th Cir. 2003).

146. *Id.* at 700.

147. *Id.*

148. *Id.* at 701-02.

employees and retirees the following year.¹⁴⁹

Although all SPDs published by RPI included a reservation-of-rights clause in the “Future of Plans” section of the plan description,¹⁵⁰ plaintiffs alleged that their health benefits had fully vested based on language found in other sections of the document covering post-retirement health and life-insurance benefits. A clause in the retiree health benefits section, which the court dubbed the “lifetime benefits provision,” read that “health coverage is continued . . . until death . . . [and if] you die after retirement, health coverage may be continued for your spouse.”¹⁵¹ However, this language contradicted what the court characterized as a “plan termination clause” found elsewhere in the same section saying that “in the event this group plan is terminated, coverage for you and your dependents will end immediately.”¹⁵² The potential ambiguity of the plan, plaintiffs argued, was further buttressed by silence on both of these matters—vesting and termination—in the post-retirement life insurance benefits section.¹⁵³

The Seventh Circuit, citing its own precedent and that of the Supreme Court, explained that welfare benefits do not vest automatically, but rather are subject to employer modification, amendment, or termination under ERISA when the employer has not contractually “cede[d] its freedom” to do so.¹⁵⁴ Accordingly, the court would adhere to “federal principles of contract construction, meaning that [it would] give contract terms their ‘ordinary and popular’ sense and avoid resort to extrinsic evidence when faced with unambiguous language.”¹⁵⁵ In applying such principles and keying on the canon of interpreting potentially conflicting language to be in agreement with a document’s integrated whole the court determined that the contractual language of the reservation-of-rights, “lifetime benefits,” and “plan termination” clauses did not create ambiguity as to RPI’s intent to vest benefits.¹⁵⁶ While RPI intended to provide lifetime welfare coverage for its retirees when it wrote the plans, such coverage was subject to the employer’s will.¹⁵⁷ Thus, although the SPD purportedly conferred lifetime benefits on its employees, the employer’s right to modify and its explicit

149. *Id.* at 702.

150. RPI’s reservation of rights clause in all SPDs read, “[a]lthough the company expects and intends to continue the plan indefinitely, it reserves the right to modify, amend, suspend or terminate them at any time.” *Id.* at 701.

151. *Id.* (internal quotation marks omitted) (citing potentially contradictory contractual provisions).

152. *Id.* (internal quotation marks omitted).

153. *Id.*

154. *Id.* at 702 (citing *Inter-Modal Rail Employees Ass’n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515 (1997); *Diehl v. Twin Disc, Inc.*, 102 F.3d 301, 305 (7th Cir. 1996)).

155. *Id.* at 702-03 (quoting *Diehl*, 102 F.3d at 306).

156. *Id.* at 703.

157. *Id.* (citing *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90, 99 (2d Cir. 2001); *In re Unisys Corp. Retiree Med. Benefit “ERISA” Litig.*, 58 F.3d 896, 904 (3d Cir. 1995)).

affirmation of such ability in the reservation-of-rights clause could not be read as promising *vested* healthcare benefits. Moreover, because the current union-RPI CBA did not specifically discuss terms of post-retirement welfare benefits, but instead incorporated the terms of an overall insurance agreement for all benefits-related issues that included a reservation-of-rights clause, RPI was contractually empowered to terminate benefits in the middle of the CBA's term rather than waiting until its expiration.¹⁵⁸

*iii) McCoy v. Meridian Automotive Systems, Inc. (2004)*¹⁵⁹

The Sixth Circuit, perhaps in homage to the liberality it expounded in *Yard-Man*, has recently been more lenient toward the plight of retirees losing their health benefits. In this case, the Sixth Circuit upheld a lower court's injunction against an employer's attempt to slash retirees' health coverage based on the theory that the retirees' welfare benefits were directly tied to vested pension benefits granted in the CBA.¹⁶⁰ In so deciding, the court cited *Yard-Man* principles to set the analytical stage—namely, that 1) parties to a CBA may contract for benefits that continue beyond the life of the agreement, 2) the rules of contract interpretation apply to view provisions as part of an integrated whole, and 3) extrinsic evidence is to be considered only when ambiguity remains from such a reading.¹⁶¹

In following these rules and applying post-*Yard-Man* cases, the court resolved two overarching issues in the retirees' favor. First, it determined that the language in the "Supplemental Agreement" between the employer and UAW was sufficiently clear in tying together eligibilities for health benefits and pensions.¹⁶² Second, and more importantly, the Sixth Circuit allowed the Supplemental Agreement to be considered in the proceeding because of its incorporation into

158. *Id.* at 705 ("RPI's unilateral reduction, and later termination, of post-retirement benefits was not an impermissible mid-term unilateral change because the text of the plan—and by incorporation, the text of the CBA—reserved RPI's right to alter the specific terms of insurance.").

159. 390 F.3d 417 (6th Cir. 2004).

160. *Id.* at 420-22.

161. *Id.* at 421-22.

162. *Id.* at 422. The Supplemental Agreement stated that "[t]he Company shall contribute the full premium or subscription charge for Health Care . . . coverages continued in accordance with Article III, Section 5, for: (i) a retired employee (including any eligible dependents) provided such retired employee is eligible for benefits under Article II of the Company's Hourly-Rate Employees Pension Plan. . . . The Health Care . . . coverages an employee has under this Article at the time of retirement . . . shall be continued thereafter provided that suitable arrangements for continuation can be made with the Carrier(s)." *Id.* at 419. Furthermore, "the Supplemental Agreement similarly tied retirees' spouses' medical benefits to pension benefits." *Id.*; see also *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996).

the CBA by reference.¹⁶³ In other words, the CBA language alluded to the Supplemental Agreement on the subject of pension plans and insurance programs, and thus the Supplemental Agreement provided intrinsic—rather than extrinsic—evidence about the contractual intent of the parties.¹⁶⁴

Finally, in distinguishing the force and effect of the employer’s reservation-of-rights clause from its anti-employer injunction, the Sixth Circuit held that this clause operated simply to “alert [future retirees] that the company may discontinue the retirement benefits of employees *who have yet to retire* when the agreement ends.”¹⁶⁵ Thus, the Sixth Circuit has favored employees a bit more recently but only where the contractual language strongly links health benefits and vested pension benefits.¹⁶⁶

*iv) Cherry v. Auburn Gear, Inc. (2006)*¹⁶⁷

Three years after its stark treatment of union-employer disputes over welfare benefits in *Rockford Powertrain*,¹⁶⁸ the Seventh Circuit confronted a more determined union litigant. In this case, the retirees’ former employer instituted various changes over the preceding two decades that increased retiree co-payments and charged monthly premiums. These changes culminated with Auburn Gear’s notification in 2002 of its intention to terminate retiree benefits outright, and the union responded by having its active employees strike immediately.¹⁶⁹

Ruling against the retirees, the court progressed through the same contract principles as in previous cases to arrive at its decision. Reviving its language from earlier decisions, it admitted that “this story does not have a happy ending”:

We are mindful of the burden placed upon retired individuals with fixed income who now must bear an unexpected increase in healthcare costs. “However, we are bound to determine only whether a legally sufficient agreement between the parties exists to support plaintiffs’ claim.” If a union “want[s] to assure that employer-paid health benefits for the workers they represent are vested[,] they will have to insist on explicit language to this

163. *McCoy*, 390 F.3d at 423-24.

164. *See id.* at 419.

165. *Id.* at 425.

166. *See Noe v. PolyOne Corp.*, 520 F.3d 548 (6th Cir. 2008) (noting the critical linkage of retiree health benefits to pension plan benefits); *Yolton v. El Paso Tenn. Pipeline Co.*, 435 F.3d 571 (6th Cir. 2006).

167. 441 F.3d 476 (7th Cir. 2006).

168. *UAW v. Rockford Powertrain, Inc.*, 350 F.3d 698 (7th Cir. 2003); *see also Barnett v. Ameren Corp.*, 436 F.3d 830 (7th Cir. 2006) (holding that retiree health benefits do not vest unless there is an unambiguous indication in the agreement that they do).

169. 441 F.3d at 479-81.

effect.” In this case, Union failed to obtain the necessary contractual language.

The distinction between lifetime benefits and vested benefits is “a legal distinction that understandably escaped” many of the retirees. “It is difficult to imagine that someone without legal training would be able to fully comprehend a reservation of rights clause and how the court would interpret such a clause.” To avoid this information gap, Union representatives must be mindful of their responsibility to deliver the benefits they have promised and not guarantee benefits they have failed to obtain through explicit contractual language.

The contractual language at issue in this case was clear: “lifetime” benefits extended only so long as the collectively bargained insurance agreement remained in effect.¹⁷⁰

Thus, the Seventh Circuit has been consistently unsympathetic to retiree efforts to protect their evaporating health care benefits, as the law of ERISA and contractual principles weigh heavily against retirees.

v) *Coffin v. Bowater Inc. (2007)*¹⁷¹

Finally, the First Circuit joined this parade by allowing a subsequent benefit plan adoption to unilaterally abrogate the health care benefits that retirees possessed under a predecessor arrangement. In a convoluted situation involving a subsidiary’s acquisition and subsequent disposition, Bowater Inc. argued that such transactions automatically terminate a parent company’s health benefit obligations to that subsidiary’s retirees. On this point, the court held for the retirees, noting that “parent companies tend to terminate ERISA plans when selling a subsidiary, [but] there is nothing automatic about this correlation.”¹⁷² Such companies, according to the court, must satisfy certain procedural requirements in ERISA that “alert employees that the parent was terminating responsibility for its welfare benefits upon the sale of the subsidiary.”¹⁷³

The First Circuit then noted the applicable requirements:

[A]n ERISA plan amendment must be in writing; it must be executed by a party authorized to amend the plan; the language of the amendment must clearly alert the parties that the plan is being amended; and the amendment must meet any other requirements laid out for such amendments in the plan’s governing documents.¹⁷⁴

These requirements, the court observed, were not met by the stock purchase

170. *Id.* at 486 (citations omitted).

171. 501 F.3d 80 (1st Cir. 2007).

172. *Id.* at 88.

173. *Id.*

174. *Id.* at 91-92.

agreement that Bowater executed when it sold the relevant subsidiary.¹⁷⁵

The retirees' victory, however, was short-lived. In 2003, Bowater established a "unified plan to replace the various plans under which its employees received health and welfare benefits."¹⁷⁶ This "unified plan" excluded Mr. Coffin and the other retiree-plaintiffs, and the plan's explicit declaration that it "supersedes and replaces any program document defining the terms of or describing a Benefit Program that is not incorporated and made part of the Plan" meant that the retirees' benefits were no more.¹⁷⁷

2. *The Non-Unionized Workplace*

In contrast to the Sixth Circuit and selected other circuits' cases that may follow *Yard-Man* in a union context, courts historically do not recognize a presumption or inference of vesting of benefits in unbargained-for welfare plans, nor are they inclined to distinguish between general and specific duration clauses. As such, courts interpreting contracts are less friendly to retirees with unbargained-for retiree health benefit plans. For example, in the 1995 case of *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*,¹⁷⁸ the Third Circuit considered whether an employer could unilaterally reduce retiree health benefits where the plan described the duration of benefits as "lifetime" and "rest of your life," while at the same time expressly reserving the employer's right to terminate or change benefits under the plan for any reason.¹⁷⁹ Absent any consideration of a vesting inference, the court reconciled the arguably inconsistent language by reasoning that "the promise made to [the Unisys] retirees was a qualified one: the promise was that retiree medical benefits were for life provided the company chose not to terminate the plans, pursuant to clauses that preserved the company's right to end them at any time or for any reason."¹⁸⁰ In other words, even "vested" retiree health benefits are conditional upon an employer's continued willingness to provide such benefits—a rather nuanced interpretation, to say the least, of what "vested" benefits represent.

Similarly, in *Sprague v. General Motors*,¹⁸¹ retirees challenged General Motors' (GM) ability to unilaterally terminate retiree welfare benefits as reserved in the plan document, but in contradiction to a subsequent SPD that promised lifetime benefits without alluding to GM's right to terminate. The Sixth Circuit held that the plan terms and the SPD were not inconsistent, because the plans and

175. *Id.* at 91.

176. *Id.* at 92.

177. *Id.* at 93.

178. 58 F.3d 896 (3d Cir. 1995).

179. *Id.* at 904.

180. *Id.* at 904 n.12.

181. 133 F.3d 388 (6th Cir. 1998).

the SPDs unambiguously reserved GM's right to amend or terminate the plan. In addressing whether omissions in a SPD about vesting of medical benefits could create an ambiguity between the plan and SPD, the court answered in the negative because "Congress did not require [disclosure of] such information for *welfare* plans; neither did the Department of Labor in its ERISA reporting and disclosure regulations."¹⁸² The court addressed the issue of whether there is a presumption of vesting by stating,

To vest benefits is to render them forever unalterable. Because vesting of welfare plan benefits is not required by law, an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest must be found in the plan documents and must be stated in clear and express language.¹⁸³

The Sixth Circuit ultimately reasoned that GM had made a qualified promise to provide lifetime retiree health benefits, a promise that held true as long as the company did not change its mind. Such an interpretation renders whatever benefits retirees continue to receive a mere gratuity, a product of GM's forbearance, or perhaps its generosity.

The following is a sampling of recent cases of non-union retiree vesting claims that underscore the legally precarious position of retirees with regard to post-employment health benefits.

*a. Abbruscato v. Empire Blue Cross & Blue Shield (2001)*¹⁸⁴ and *Devlin v. Empire Blue Cross & Blue Shield (2001)*¹⁸⁵

Plaintiff-retirees left employment either through the ordinary course of business or through early retirement severance packages between 1989 and 1998.¹⁸⁶ Both cases involved the same fact pattern, except that the *Devlin* retirees based their claims on pre-1987 SPDs, while the *Abbruscato* retirees focused on benefit plan descriptions from 1987 and beyond. The key difference between the two cases was that a newly written employee handbook ("Your Handbook") introduced in 1987 was the first version to include a reservation-of-rights clause. This handbook provided that "the company expects and intends to continue the Plans in your Benefits Program indefinitely, but reserves its right to end each of the Plans, if necessary. The company also reserves its right to amend each of the Plans at any time."¹⁸⁷

Those plaintiffs accepting early retirement packages received written

182. *Id.* at 402.

183. *Id.* at 400.

184. 274 F.3d 90 (2d Cir. 2001).

185. 274 F.3d 76 (2d Cir. 2001).

186. *Abbruscato*, 274 F.3d at 93.

187. *Id.* at 94.

materials that described the specialized terms of their incentive-laden departures, and both plans contained reservation-of-rights language concerning the benefits.¹⁸⁸ Furthermore, the early retirement packages included a “Separation Agreement and General Release” in which the employer “reserve[d] the right to change or eliminate, at any time, these retiree medical and life insurance benefits” and asserted that “the agreement constituted the sole and complete understanding between the parties.”¹⁸⁹ Thus, there were three categories of plaintiffs across these two cases: 1) pre-1987 SPD regular retirees in *Devlin* whose plan lacked a reservation-of-rights clause, 2) “Your Handbook” regular retirees from 1987 forward who were subject to a reservation-of-rights clause, and 3) early retirees whose plans also contained a reservation-of-rights clause.

As to the early retirees, the *Abbruscato* court found that there were intrinsic grounds in the plans to create ambiguity about the meaning of “lifetime” benefits and overturned the lower court’s summary judgment for Empire.¹⁹⁰ The Second Circuit deemed the eligibility formulas to conflict with the generalized reservation-of-rights clauses found elsewhere in the plans. The purported reservation clauses could be “interpreted to mean that Empire merely reserved the right to change the program for those individuals who have not already retired under the terms described, not the right to alter the described benefits for those individuals who had retired under those terms.”¹⁹¹

By contrast, the same court found no such ambiguity that would allow the “Your Handbook” regular retirees to pursue their benefit claims against Empire. Instead, the Second Circuit ruled that a generalized reservation-of-rights clause plus termination language about a specific benefit provided a clear message to retirees about the nonvesting nature of their benefits.¹⁹² One commentator’s reading of *Abbruscato*’s holding explained that “employees cannot reasonably believe that their benefits are vested if the same document that promises lifetime benefits also clearly informs employees that those benefits are subject to change.”¹⁹³

Finally, the court upheld the motion of the pre-1987 SPD plaintiffs in *Devlin* by ruling that there was adequate written language in the SPDs “‘capable of reasonably being interpreted as creating a promise’ to survive an employer’s summary judgment motion.”¹⁹⁴ Since the pre-1987 SPDs lacked a reservation-of-rights clause, and certain other sentences read that “retired employees, after

188. *Id.* at 94-95.

189. *Id.* at 95.

190. *Id.* at 98.

191. *Id.*

192. *Id.* at 99.

193. Kemp, *supra* note 103, at 19.

194. *Devlin*, 274 F.3d 76, 84 (2d Cir. 2001) (quoting *Am. Fed’n of Grain Millers v. Int’l Multifoods Corp.*, 116 F.3d 976, 980 (2d Cir. 1997)).

[meeting a condition precedent] *will be insured*” and that life insurance benefits “will remain at [the annual salary] level *for the remainder of their lives*,” there were reasonable grounds to interpret an intent to vest life insurance benefits.¹⁹⁵

Setting aside their intricacies, the two *Empire* cases demonstrate that the evidentiary burden on retirees makes it difficult to even withstand an employer’s summary judgment motion, let alone defeat an employer’s benefits-slashing. The *Empire* retirees required either 1) an absence of an employer reservation-of-rights clause (in the case of pre-1987 plaintiffs), or 2) an SPD containing a generalized reservation-of-rights clause coupled with a specific clause that was sufficiently ambiguous in order to proceed. Thus, a generalized reservation-of-rights clause, standing alone, is apparently sufficient to sustain an employer’s motion for summary judgment.

*b. Stearns v. NCR Corp. (2002)*¹⁹⁶

A group of early retirees brought suit against their former employer for reducing health benefits granted to them in their severance package.¹⁹⁷ The plaintiffs accepted an Enhanced Retirement Program package in 1993 that provided, inter alia, a better health care package than was currently offered under the company’s standard medical plan.¹⁹⁸ Six years later, the company instituted sweeping changes, including higher premiums, increased deductibles and co-payments, and cancellation of the company’s Medicare supplement plan.¹⁹⁹ Plaintiff Stearns represented the retiree class, arguing that NCR’s purported reservation-of-rights provision in the Plan Amendment subsection of the group benefits plan was invalid.

The Eighth Circuit ruled for the employer, citing its precedent from *Hughes v. 3M Retiree Medical Plan*²⁰⁰ that an unambiguous reservation-of-rights provision is sufficient to defeat a claim that retirement welfare plan benefits are vested.²⁰¹ Explaining the framework of contract analysis, the court said that extrinsic evidence could only be considered in cases of facial ambiguity or conflict with other plan provisions.²⁰² Finding neither situation, the Eighth Circuit held that NCR could terminate benefits according to the reservation-of-rights clause.

195. *Id.* at 84-85 (internal quotation marks removed).

196. 297 F.3d 706 (8th Cir. 2002).

197. *Id.* at 708.

198. *Id.*

199. *Id.* at 709.

200. 281 F.3d 786 (8th Cir. 2002).

201. *Stearns*, 297 F.3d at 712.

202. *Id.*

*c. Bland v. Fiatallis North America, Inc. (2005)*²⁰³

In this case, there was no reservation-of-rights clause. The plaintiff-retirees protested their employer's "onion solution" to gradually peel away layers of retiree benefits over time, and initiated suit on grounds that the contract language was ambiguous and subject to extrinsic evidence of an intent to vest.²⁰⁴ The Seventh Circuit recognized that although health benefits do not vest automatically, they may be so triggered by an affirmative contractual promise by the employer.²⁰⁵ While the court noted that a contract that is silent about vesting holds a presumption that the employer did not intend to grant vested benefits, this presumption is defeated by what Judge Richard Posner called "any positive indication of ambiguity, [or] something to make you scratch your head."²⁰⁶ The Seventh Circuit was made to scratch its proverbial head in this case, as plaintiff-retirees pointed to multiple instances of "life-time" language in the plan documents, even though there was no explicit promise to vest nor any reservation of a right to modify benefits.²⁰⁷ Ultimately, in the absence of contrary evidence where the language was ambiguous, the Seventh Circuit determined that "lifetime" within the plan documents was used as a durational term that equated to "good for life unless revoked or modified."²⁰⁸ Accordingly, it reversed the lower court's granting of summary judgment for the employer and remanded the case to decide the scope of vested benefits that were ostensibly promised by the employer.

*d. Boubolis v. Transport Workers Union of America (2006)*²⁰⁹

In an interesting twist on the typical fact situation, this case presents an employee union as the benefits-slashing employer. The plaintiff-retirees were former New York City Transit Authority workers who became staff employees of the local union chapter, Local 100, of the Transport Workers Union of America.²¹⁰ The retirees alleged that they were given assurances at various junctures during their employment with Local 100 that they would have "lifetime health insurance coverage" under Local 100's plan, which provided better health benefits than those available to them as former employees of the Transit Authority.²¹¹ Accordingly, when new union leadership of Local 100 terminated

203. 401 F.3d 779 (7th Cir. 2005).

204. *Id.* at 781-82.

205. *Id.* at 783-84.

206. *Id.* at 784.

207. *Id.* at 785.

208. *Id.* at 786.

209. 442 F.3d 55 (2d Cir. 2006).

210. *Id.* at 58.

211. *Id.*

the health care benefits of all retirees who were otherwise eligible for health insurance coverage from another employer, these retirees sued to enforce their right to be covered by Local 100's plan rather than the inferior Transit Authority plan.²¹²

The retirees first argued that their health benefits were "lifetime" in nature because, although the SPD lacked explicit vesting language, it listed only two conditions—ceasing employment and death—by which benefits could terminate.²¹³ Because they were already retired, plaintiffs reasoned that they could lose their benefits only upon death; i.e., the end of their lifetime.²¹⁴ Unfortunately for the retirees, the Second Circuit rejected this argument based on the widely held rule that the absence of vesting language does not create a promise to vest by the employer. The SPD therefore did not, on its own, vest lifetime health care benefits in the retirees.²¹⁵

Boubolis shows that even the unions that bargain with employers and pursue litigation in the interests of their employees can have an alter-ego as a self-interested employer or business entity. In this situation, the union engaged in the same sort of objectionable action that it would normally oppose on behalf of its members. By cutting retiree benefits and breaking its promise, regardless of whether the retirees had available insurance coverage from another source, the union maligned and disenfranchised its retirees exactly as employers have done in the ERISA-related vesting cases. And as in the vast majority of other benefits cases, the employer is legally allowed to do so under the courts' interpretation of ERISA.²¹⁶

Because retirees' vesting arguments are rarely successful in either the union or the non-union context, plaintiffs invariably allege that the employer's actions breached its fiduciary duties. It is this type of action—breach of the fiduciary duty—to which we now turn.

C. Breach of Fiduciary Duty Claims

Because ERISA mandates that employers acting as benefit plan administrators are performing fiduciary functions, the oral representations that are made by human resources personnel and other benefits-related personnel in a company often come under scrutiny in cases of benefits-stripping. That is, when

212. *Id.*

213. *Id.* at 61.

214. *Id.*

215. *Id.*

216. *See, e.g.,* *Balestracci v. NSTAR Electric & Gas Corp.*, 449 F.3d 224 (1st Cir. 2006) (affirming summary judgment for the employer due to the SPD's reservation of the right to terminate "lifetime" dental benefits, even though informal summaries provided to early retirees did not disclose this right).

employees have been told one thing about their expected benefits, but the company later does the opposite, it is possible that the employer breached its fiduciary duties of disclosure, care, and loyalty to the employee-beneficiaries (and future retirees). Such factual scenarios are especially common in cases of early retirement plans where employees, after having been assured that no sweetened severance packages would be forthcoming, depart the company before an enhanced package is unveiled shortly thereafter. As the case law in this area points out, plaintiffs who are seeking restitution for lost benefits must meet two significant evidentiary hurdles. First, they must show that an employer's misrepresentative communication was material. Second, they must substantiate the requisite scienter, or intent threshold, underlying the employer's material misrepresentation, a standard that varies from circuit to circuit. Stated somewhat differently, employees must prove that the company made a significant—rather than trivial—misrepresentation that was either intentionally fraudulent or merely negligent, depending on the circuit involved.

These hurdles originate from the Supreme Court's landmark decision in *Varity Corp. v. Howe*,²¹⁷ the first case to recognize an actionable claim for breach of fiduciary duty under ERISA. In that case, corporate management affirmatively advised and purposefully induced employees to switch their benefit plans from the parent company to an insolvent shell-company subsidiary in a dubious cost-cutting scheme.²¹⁸ The Supreme Court held that the employer's misconduct violated its ERISA fiduciary duties,²¹⁹ yet it left open the questions of 1) what constitutes a material misrepresentation, and 2) whether deceitful intent by the employer is required to make an employee's fiduciary breach claim actionable. These issues were addressed recently by the Seventh Circuit in *Beach v. Commonwealth Edison Co.*²²⁰ and *Vallone v. CNA Financial Corp.*²²¹

1. When Are an Employer's Oral Misrepresentations "Material"?

Beach involved an employee who retired six weeks prior to the announcement of a voluntary separation package amid adamant company assurances that no such plan would be offered anytime soon.²²² The Seventh Circuit ruled on behalf of the employer that, inter alia, the verbal misrepresentations made by the company's representatives to the plaintiff were not material, because the early retirement package that was eventually offered was not sufficiently developed when the misrepresentations were made. In other

217. 516 U.S. 489 (1996).

218. *Id.* at 493-94.

219. *Id.* at 506-07.

220. 382 F.3d 656 (7th Cir. 2004).

221. 375 F.3d 623 (7th Cir. 2004).

222. *Beach*, 382 F.3d at 657.

words, what turned out to be a misrepresentation (e.g., “a new early retirement plan won’t be offered”) may not have been so at the time it was made, because the alternative plan had not yet achieved sufficient managerial ratification. Mr. Beach failed to show that the formative stages of the voluntary separation package were already underway and that its disclosure to employees would have been material to his retirement decision.²²³

The standard used in *Beach* to determine whether a fiduciary breach has been committed is known as the Serious Consideration Doctrine.²²⁴ Under this standard, “a duty of accurate disclosure begins when 1) a specific proposal 2) is being discussed for purposes of implementation 3) by senior management with the authority to implement the change At that point, details of the amendment become material; until then, there is only speculation.”²²⁵

The Seventh Circuit found that the employer’s misrepresentations were not material and that the employer had no duty to disclose managerial speculation regarding possible benefits plan changes.²²⁶ In endorsing the Serious Consideration Doctrine, the court concluded that the certainty of the deal’s structure is the touchstone for triggering disclosure to employees.²²⁷ The court also warned that absent a Serious Consideration Doctrine threshold, high-level executives might ostracize benefits counselors to avoid the risk of confidential strategies being prematurely shared with employees.²²⁸ Such action would render human resources personnel useless and might breed rumor circulation and mistrust among employees within the company.²²⁹

Beach’s endorsement of the Serious Consideration Doctrine finds significant support in the First, Fourth, Sixth, Eighth, Ninth, Tenth, and Eleventh Circuits.²³⁰ The Second and Fifth Circuits, however, have departed from the Serious Consideration Doctrine’s rigidity, holding that materiality of information is not solely a function of the employer’s internal deliberations.²³¹ Instead, these

223. *Id.*

224. *Id.* at 659-60.

225. *Id.* at 659 (internal citations omitted).

226. *Id.* at 660-61.

227. *Id.* at 659-60.

228. *Id.* at 660 (“Giving firms a duty to forecast accurately . . . would just induce employers to tell the human resources staff to say nothing at all.”).

229. *Id.*

230. *Id.*; see, e.g., *Mathews v. Chevron Corp.*, 362 F.3d 1172, 1180-82 (9th Cir. 2004); *Bins v. Exxon Co. U.S.A.*, 220 F.3d 1042, 1048 (9th Cir. 2000) (en banc); *McAuley v. Int’l Bus. Mach. Corp.*, 165 F.3d 1038, 1043 (6th Cir. 1999); *Vartanian v. Monsanto Co.*, 131 F.3d 264, 272 (1st Cir. 1997); *Hockett v. Sun Co., Inc.*, 109 F.3d 1515, 1522-23 (10th Cir. 1997); *Wilson v. Sw. Bell Tel. Co.*, 55 F.3d 399, 405 (8th Cir. 1995); *Elmore v. Cone Mills Corp.*, 23 F.3d 855, 861 (4th Cir. 1994) (stating that a plan “must . . . actually be in existence; the mere decision to create an employee benefit plan is not actionable”); *Barnes v. Lacy*, 927 F.2d 539, 544 (11th Cir. 1991).

231. See *Martinez v. Schlumberger, Ltd.*, 338 F.3d 407, 411-12 (5th Cir. 2003); *Ballone v.*

Circuits have fashioned what I will call the “Expansive Materiality” standard, which essentially equates to a totality of the circumstances test.²³² This standard focuses on the materiality of the information—that is, the material impact that such information may have on an employee’s retirement decision—and takes into account the employer’s “serious consideration” factors as just a few of many variables that are part of the decision-making process. According to these Circuits, the Serious Consideration Doctrine has a fatal flaw in its operation: a “free zone for lying” may arise in which a benefits administrator could knowingly deny or mislead employees simply because plan changes had not achieved sufficient internal ratification.²³³

In *Ballone v. Eastman Kodak Co.*,²³⁴ the Second Circuit ruled that the materiality of Kodak’s misrepresentations was not solely predicated upon the Serious Consideration Doctrine’s three-pronged test. Rather, the materiality inquiry should be whether an employer’s misrepresentation was substantially likely to mislead a reasonable employee in making an adequately informed retirement decision.²³⁵ To assess such materiality, the court held that variables beyond the Serious Consideration Doctrine, such as the egregiousness of the misrepresentation and the availability of contrary extrinsic evidence, should be weighed.²³⁶ The Fifth Circuit’s *Martinez v. Schlumberger, Ltd.*²³⁷ decision further refined the Expansive Materiality Test, holding that the key to assessing materiality was whether a reasonable person would have considered the misrepresentation important in his early-retirement decision.²³⁸ In that regard, the court held that an employer’s statement that it had not made a decision whether “to roll out an enhanced benefits plan in the future . . . could not have been material or misleading until [that employer] had actually decided to implement such a plan.”²³⁹

Disagreement among the circuits between the Serious Consideration Doctrine and the Expansive Materiality Test highlights the varying evidentiary burdens incumbent upon employee-retiree plaintiffs to substantiate a claim that an employer breached its fiduciary duty. While materiality has different meanings in different courts, it is evident that proving materiality is a particularly

Eastman Kodak Co., 109 F.3d 117, 122-23 (2d Cir. 1997).

232. See sources cited *supra* note 231.

233. See *Beach v. Commonwealth Edison*, 388 F.3d 1133, 1135 (7th Cir. 2004) (Ripple, J., dissenting); *Martinez*, 338 F.3d at 428.

234. 109 F.3d 117 (2d Cir. 1997).

235. *Id.* at 122-23.

236. *Id.* at 125 (stating that materiality of false assurances could be assessed by factors independent of the Serious Consideration Doctrine).

237. 338 F.3d 407, 428 (5th Cir. 2003) (adopting *Ballone*’s materiality approach).

238. *Id.* (the overarching question is the impact on employee’s retirement decision).

239. *Id.* at 431.

challenging burden faced by employee-retirees. Moreover, as discussed below, even if the materiality threshold is met, plaintiffs must then prove that the employer's actions were intentional or negligent.

2. *Need To Prove Negligence or Fraudulent Intent*

ERISA imposes on fiduciaries a duty of loyalty and a prudent-man duty of care.²⁴⁰ Assessing these duties, the Supreme Court in *Variety* held that lying to employees in the context of benefits administration violates the fiduciary obligation.²⁴¹ Accordingly, the easy case of intentional deceit, or disinformation, by employers was uniformly adopted by the federal bench as a violation of ERISA.²⁴² But what happens when a fiduciary is not lying, but rather unintentionally conveys a material misrepresentation whose falsity is unknown by him? Must there be deceptive intent, or “scienter,”²⁴³ in an employer's actions to allow a fiduciary breach claim? On this issue, the federal circuits are divided.²⁴⁴

In *Vallone v. CNA Financial Corp.*,²⁴⁵ the Seventh Circuit upheld the employer's termination of early-retirees' “lifetime” welfare benefits based on a contractual reservation-of-rights provision. The court held that, under *Variety* and other Seventh Circuit precedents, “an employer must have set out to disadvantage or deceive its employees . . . in order for a breach of fiduciary duty” claim to succeed.²⁴⁶ Thus, unless an employer engages in intentional misconduct, or disinformation, employees lose out under current law,²⁴⁷ breach of the fiduciary duty arises only through intentional wrongdoing.²⁴⁸

In contrast to the Seventh Circuit, some have argued “[t]he Second, Third, and Sixth Circuits have interpreted *Variety* as permitting claims against a fiduciary even in the absence of . . . intentional misconduct so long as materially

240. 29 U.S.C. § 1104(a) (2000).

241. *Variety Corp. v. Howe*, 516 U.S. 489, 506 (1996).

242. See WILBER H. BOIES & NANCY G. ROSS, COMMUNICATING WITH EMPLOYEES ABOUT BENEFITS: A CENTRAL ISSUE IN ERISA ADMINISTRATION AND LITIGATION 522 (Practising Law Inst. 2001) (describing and analyzing standards used by appellate courts).

243. BLACK'S LAW DICTIONARY 1373 (8th ed. 2004) (“A degree of knowledge that makes a person legally responsible for the consequences of his or her act or omission A mental state consisting in an intent to deceive, manipulate, or defraud.”).

244. See *Beach v. Commonwealth Edison Co.*, 382 F.3d 656, 668-69 (7th Cir. 2004) (Ripple, J., dissenting) (illustrating that disagreement exists regarding the scienter requirement).

245. 375 F.3d 623, 626 (7th Cir. 2004).

246. *Id.* at 642 (endorsing intentional deception standard necessary for breach of fiduciary duty).

247. Appellant's Petition for Writ of Certiorari to the Seventh Circuit, *Vallone*, 375 F.3d (No. 04-502), 2004 WL 2326794.

248. 375 F.3d at 640 (7th Cir. 2004) (citing *Variety Corp. v. Howe*, 516 U.S. 489, 506 (1996)).

misleading information was provided by the fiduciary.”²⁴⁹ If inadvertently incorrect information, or “misinformation,” was conveyed, a claim for fiduciary breach is possible as long as the information provided was materially misleading.²⁵⁰ The key is that an employee’s subjective evaluation of the information matters as much as the actual truth of the information provided. If misinformation is conveyed to an employee who internalizes and acts on it, a breach claim can be levied.²⁵¹

According to the Second, Third, and Sixth Circuits, as well as Judge Ripple’s dissent in the *Beach* case, “importing the intent to deceive requirement . . . into this type of ERISA fiduciary case lacks any grounding.”²⁵² Rather, unintentional misrepresentations suffice as actionable grounds for breach of the fiduciary duty on several bases. First, per Congressional intent and *Varity*’s decree, ERISA duties have greater force than their common law trust pedigree and are more onerous than simply avoiding fraud.²⁵³ Second, analogizing ERISA duties to agency law’s apparent authority doctrine suggests that a beneficiary’s reasonable reliance is important in assessing fiduciary liability, whereas a fiduciary’s subjective intent is irrelevant.²⁵⁴ Third, while ERISA’s trust law roots make no mention of scienter, they do indicate duties to inform and not misinform beneficiaries; a trustee must convey to its beneficiary all material facts related to a transaction that the “trustee knows or should know.”²⁵⁵ Thus, reckless misinformation may be actionable when an employer should have known better.²⁵⁶

In contrast to its sister courts, the Seventh Circuit endorses a strict “disinformation” standard for breach of the ERISA fiduciary duty, a standard whose turnkey issue is employer intent.²⁵⁷ The Seventh Circuit applied this scienter requirement in *Vallone*, eviscerating retirees’ breach claim by showing

249. Appellant’s Petition for Writ of Certiorari to the Seventh Circuit, *supra* note 247, at *1.

250. *Id.*

251. *Id.*

252. *Beach*, 382 F. 3d at 668 (Ripple, J., dissenting) (denouncing Seventh Circuit’s endorsement in dicta of employer scienter requirement).

253. *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (noting that the legislative intent in enacting ERISA was in part to enhance the common law of trusts).

254. RESTATEMENT (THIRD) OF AGENCY § 2.03 (Tentative Draft No. 2, 2001) (apparent authority doctrine); *see also Beach*, 382 F.3d at 669-70 (Ripple, J., dissenting). The apparent authority doctrine is especially poignant because it imposes liability on a corporation that otherwise might circumvent its ERISA obligations by erecting a “Chinese wall” between its plan administrator—a fiduciary—and its human resources counselors who may have non-fiduciary status.

255. RESTATEMENT (SECOND) OF TRUSTS § 173 cmt. d (1959).

256. *See Beach v. Commonwealth Edison Co.*, 382 F.3d 656, 669 (7th Cir. 2004) (Ripple, J., dissenting).

257. *See Vallone v. CNA Fin. Corp.*, 375 F.3d 623, 640-41 (7th Cir. 2004).

that there was no evidence of purposeful deception akin to *Varity*'s "campaign of disinformation."²⁵⁸

The *Vallone* court justified its "disinformation" approach on grounds of allegiance to *Varity*'s scienter requirement and the need to avoid excessive burdens on employers in their duty of care.²⁵⁹ First, the "disinformation" theory asserts that future changed circumstances that are unanticipated at the time of a fiduciary-beneficiary communication cannot provide grounds for fiduciary liability.²⁶⁰ A fiduciary that believes its actions serve the best interests of its beneficiaries cannot, by definition, be in breach of ERISA's § 1004(a)(1) duty of loyalty.²⁶¹ Second, by distinguishing ERISA's duty of loyalty from its duty of care, and showing that the duty of care is not breached by negligence in a corporate fiduciary context, the court denounces negligence as too low a liability standard for ERISA plan administration.²⁶² Finally, the Seventh Circuit took a holistic view of ERISA's duty of care provision by saying that a fiduciary's overall diligence in benefits plan management overrides any discrete instances of oral advice.²⁶³ Thus, the court essentially subjugated the importance of a benefits administrator's communications to his investment and management activities.²⁶⁴

To summarize, *Varity* stands for the undeniable proposition that employer deceit violates ERISA. An employer-fiduciary may not actively lie to employees if and when it chooses to communicate with them, whether through a nonfiduciary agent or by its own accord. Beyond this insidious intent that ERISA condemns outright, the *Varity* court strongly implied that materiality of information is the touchstone for substantiating breach of fiduciary duty. How this materiality should be judged forms the basis of the present circuit split over the Serious Consideration Doctrine versus the Expansive Materiality Test. Furthermore, either the negligence or intent characterizing an employer's misrepresentation is integral to courts' upholding breach of fiduciary duty claims. Viewing these requirements holistically, their inconsistent judicial interpretations, and the significant evidentiary burdens faced by employees, it is fair to say that fiduciary breach actions are exceedingly difficult for employee-retirees to maintain against their employers. As a result, retirees often resort to

258. *Id.* at 641 (Count III for Breach of Fiduciary Duty fails).

259. *Id.* at 640-43 (explaining rejection of negligence standard and adoption of intent requirement).

260. *See id.* at 641-42; *Frahm v. Equitable Life Assurance Society*, 137 F.3d 955, 960 (7th Cir. 1998) (duty of loyalty is unequal to clairvoyance).

261. *See Frahm*, 137 F.3d at 959 (fiduciaries not engaged in *Varity*-type deceit, but rather acted loyally in what they believed to be beneficiaries' best interests).

262. *Id.*

263. *Id.* at 960 (overall management of the plan, and specifically asset management, is targeted by the duty of care).

264. *Id.* at 959-61.

estoppel claims alleging their reasonable reliance on employer misrepresentations that detrimentally impacted their retirement decision-making.

D. Estoppel Claims

Estoppel claims provide the last legal avenue for retirees seeking protection or restoration of their lost health care benefits. Estoppel theories posit that the defendant made a false representation that the plaintiff relied upon to the plaintiff's detriment. In the context of the retiree benefits, the hypothetical employer falsely stated orally and informally (equitable estoppel under common law) or in a quasi-contractual writing (promissory estoppel under ERISA), and beyond the terms of the SPD, that benefits were indefinite or interminable and that this statement induced the retiree to take reasonable action that ultimately damaged his interests. In analyzing the relevant case law in this area, the distinction between promissory and equitable estoppel is inconsequential.

Across retiree health benefit cases, all circuits require the plaintiffs to establish the basic elements of estoppel to prevail on an estoppel claim.²⁶⁵ While the various circuits differ slightly in describing these elements,²⁶⁶ the fundamental components are 1) a material misrepresentation, 2) reasonable and detrimental reliance upon the representation, and 3) extraordinary and extreme circumstances.²⁶⁷ Plaintiffs have experienced daunting obstacles in proving the requisite "material" (or "knowing") nature of the employer's misrepresentation, the "reasonableness" of their own actions in reliance, and the "extraordinariness" of the factual circumstances surrounding their cases.

1. Material Misrepresentation

As with fiduciary claims, the material misrepresentation element of estoppel claims is particularly difficult for retirees to substantiate due to the onerous evidentiary requirements. For a misrepresentation to be material, courts generally require that the employer-administrator knowingly provided false information to the employee-retirees. *Scienter* thus becomes an issue, as "knowing misrepresentation" apparently has fraudulent undertones, meaning that plaintiffs must prove that the employer *purposely* misled the plaintiffs. The *Vallone* court,

265. Kemp, *supra* note 103, at 23.

266. As an example of courts differing in explaining their estoppel test, the Seventh Circuit requires 1) a knowing misrepresentation 2) in writing 3) reasonably relied upon 4) to the plaintiff's detriment, which the court limits to a "narrow scope" of cases justified by extreme circumstances. *Vallone v. CNA Financial*, 375 F.3d 623, 639 (7th Cir. 2004), while the Second Circuit explains it as 1) a promise 2) relied upon 3) causing injury 4) resulting in injustice if not enforced, and it also requires "extraordinary circumstances," *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 85-86 (2d Cir. 2001).

267. Kemp, *supra* note 103, at 23.

for example, seized upon the employer's lack of deceitful intent in finding against the retirees. The Seventh Circuit there said that

the plaintiffs have not shown a knowing misrepresentation of fact. Although "[r]epresentations about plans and intentions could be false if, at the time the statements were made, the speaker actually had a different intention," the district court found that, at the time the VSRP was offered, [the company] had no intention of terminating the "lifetime" HCA benefit.²⁶⁸

The Second Circuit has also referred to the evidentiary need to show employer fraud in an estoppel claim. In *Moore v. Metropolitan Life Insurance Co.*,²⁶⁹ the court had to decide whether nonplan documents and oral communications legitimately modified the terms of the welfare plan. The plan and SPD both mentioned the employer's power to amend or terminate retiree health benefits, but the employer's informational programs and filmstrips did not. The court commented that "absent a showing tantamount to proof of fraud, an ERISA welfare plan is not subject to amendment as a result of informal communications between an employer and plan beneficiaries."²⁷⁰ The court further explained that:

Congress intended that plan documents and the SPDs exclusively govern an employer's obligations under ERISA plans Were all communications between an employer and plan beneficiaries to be considered along with the SPDs as establishing the terms of a welfare plan, the plan documents and the SPDs would establish merely a floor for an employer's future obligations. Predictability as to the extent of future obligations would be lost, and, consequently, substantial disincentives for even offering such plans would be created.²⁷¹

Thus, in addition to finding employer behavior bordering on fraud to constitute "knowing misrepresentation" in the estoppel context, courts also look to the written plan documents and SPDs as powerful defensive shields against estoppel claims.

2. Reasonability of Reliance

Even if plaintiff-retirees overcome the material misrepresentation challenge, they must prove the reasonable reliance element of estoppel. Courts have

268. *Vallone*, 375 F.3d at 639 (7th Cir. 2004) (quoting *Frahm v. Equitable Life Assurance Soc'y*, 137 F.3d 955, 961 (7th Cir. 1998)) (holding that the employer's statement was not a knowing misrepresentation).

269. 856 F.2d 488 (2d Cir. 1988).

270. *Id.* at 492.

271. *Id.*

concluded that if reservation-of-rights clauses and other written plan provisions indicate an employer's right to modify or limit benefits, it is not objectively reasonable for the plaintiffs to rely on *any* alleged statements to the contrary. The Third Circuit explained this rationale in *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*,²⁷² where an unambiguous reservation-of-rights clause in the SPD eviscerated the reasonableness of plaintiff-retirees' reliance on a benefits administrator's oral interpretation of the plan that conflicted with the SPD.²⁷³ In an earlier case, *Frahm v. Equitable Life Assurance Society of the United States*,²⁷⁴ the Seventh Circuit similarly observed that "[i]n federal law, a person cannot rely on an oral statement, when he has in hand written materials disclosing the truth."²⁷⁵

Even among courts that go beyond the bounds of ERISA-based estoppel, there is often little relief for retirees. For example, the Eleventh Circuit recognizes a very narrow common law doctrine of equitable estoppel that requires 1) ambiguous written provisions, coupled with 2) informal interpretations of the ambiguous provisions made by the benefits provider, but even then, an unambiguous benefits plan defeats retirees' estoppel claims.²⁷⁶ Lastly, the reliance aspect clearly requires that an employee-retiree act *subsequent* to an employer's alleged misrepresentation, rather than before it. In the case of *UAW v. Rockford Powertrain, Inc.*,²⁷⁷ the Seventh Circuit concluded that it was impossible for the plaintiffs to have relied on their employer's statements in making their retirement decision, because "plaintiffs admit[ted] in their brief that the statements at issue were made 'during exit interviews after the retirees made their decisions to retire.'"²⁷⁸

3. Extraordinary Circumstances

The final prerequisite to successful estoppel claims is showing the "extraordinary circumstances" context of the employer-retiree dispute. The Seventh Circuit has commented that, "[a]s a guideline for the boundaries of ERISA estoppel, [the court has] emphasized the 'narrow scope' of estoppel

272. 58 F.3d 896 (3d Cir. 1995).

273. *Id.* at 907-08 (unambiguous reservation-of-rights clause means plaintiffs' reliance on contrary statements was unreasonable).

274. 137 F.3d 955 (7th Cir. 1998).

275. *Id.* at 961; *see also* Vallone v. CNA Fin. Corp., 375 F.3d 623, 640 (7th Cir. 2004) (plaintiff's reliance not reasonable).

276. *See, e.g.*, Jones v. Am. Gen. Life & Accident Ins. Co., 370 F.3d 1065, 1069-71 (11th Cir. 2004). "[A]n ERISA plaintiff can only succeed . . . if he can establish that the plan at issue is at least ambiguous with respect to the relevant benefits for which he claims entitlement." *Id.* at 1170.

277. 350 F.3d 698 (7th Cir. 2003).

278. *Id.* at 705-06.

claims and [has] noted that ‘only extreme circumstances’ justify such claims.”²⁷⁹ While the standard to constitute extraordinary circumstances is apparently an assessment of all the facts, it seems clear nonetheless that courts are hesitant to find such circumstances. In *Devlin v. Transportation Communications International Union*,²⁸⁰ an employer unexpectedly amended the retirees’ welfare plan by replacing free medical coverage with monthly premiums, contradicting previous informal company statements, letters, and sworn affidavits.²⁸¹ Nevertheless, the Second Circuit refused to find “extraordinary circumstances,” because it found “no evidence to suggest that employers sought the retirement of any of the [employees] or that the promise of free, lifetime health benefits was used to intentionally induce any particular behavior on the [employees’] part.”²⁸²

Accordingly, the Second Circuit has grafted a fraudulent or deceptive inducement element onto its “extraordinary circumstances” evaluation process. Using this yardstick, the court found extraordinary circumstances present in the two *Empire Blue Cross & Blue Shield* cases (*Devlin* and *Abbruscato*).²⁸³ Based on management depositions in these cases, the Second Circuit determined that the employer had used promises of full benefits to initially garner and subsequently retain qualified employees for many years:

[A] trier of fact could reasonably conclude that Empire intentionally promised lifetime life insurance benefits to lure (and retain) employees away from other firms paying higher salaries and then denied those benefits after the employees were of an age where they could neither make up the salary difference or obtain alternative benefits at a reasonable cost.²⁸⁴

Thus, for the nonearly retirees who sued the employer in *Devlin*, their long years of service were seen by the court as legitimately reasonable reliance on a promise that was ultimately broken by the employer. Furthermore, in *Abbruscato*, the Second Circuit found that a benefit accrued to the employer by the employees accepting early retirement:

[A]ppellants . . . have presumably conferred a benefit on Empire, and prevented it from having to resort to salary reductions, layoffs or firings during those years. A trier of fact could reasonably find that Empire intentionally induced

279. *Vallone*, 375 F.3d at 639 (citing *Sandstrom v. Cultor Food Science*, 214 F.3d 795, 797 (7th Cir. 2000)).

280. 173 F.3d 94 (2d Cir. 1999).

281. See *Kemp*, *supra* note 103, at 23.

282. 173 F.3d at 102; see also *Kemp*, *supra* note 103, at 23.

283. For a refresher on non-union vesting cases, see Subsection II(B)(2), *supra*. *Abbruscato* and *Devlin* (whose cases are often referred to by the second-named plaintiff, Kunkel, to distinguish them from *Devlin v. Transport Communications International Union*) were both plaintiffs against Empire Blue Cross and Blue Shield.

284. *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 86-87 (2d Cir. 2001).

appellants to accept the offer to retire in order to avoid having to take these less desirable steps.²⁸⁵

The Second Circuit's experience shows that the extraordinary circumstances element has a high threshold and probably requires improper inducements proffered by an employer to prospective retirees. Even these cases, moreover, merely allowed estoppel claims to survive motions for summary judgment.

To summarize, estoppel claims in retiree benefits cases are exceedingly difficult to substantiate because of the significant evidentiary requirements. To win, retirees must prove that 1) an employer intentionally deceived retirees in making misstatements about their benefits, 2) the plan documents were sufficiently vague or ambiguous to cause reliance on inconsistent oral statements, and 3) extraordinary circumstances were present. And because estoppel claims are the last legal claim that is routinely alleged in retiree benefits cases, it appears that current law provides little recourse to retirees whose post-employment health benefits have been substantially reduced or terminated.

E. Summary

To recapitulate briefly, ERISA generally allows employers to change retiree health benefit plans at any time. Retirees have the burden of proving that their former employer intended their benefits to "vest," thereby making them unalterable, and plan documents are given great deference in establishing the "vested" status of the benefits in question. Where plan documents are ambiguous, different circuit courts apply different inferences, at least in a unionized context. The majority of those courts, however, find that retiree health benefits do not vest unless there is specific language in the plan documents to that effect, which is rarely the case.

In a non-unionized context, no circuit court infers vesting. Rather, vesting must be stated in unambiguous plan document language. But a generalized reservation by an employer of the right to change a plan's terms is usually sufficient to defeat claims by retirees that their benefits have vested. As a consequence, what are labeled "lifetime" retiree health benefits are more accurately described as lasting only as long as the former employer chooses to provide them.

Retirees' claims that employers have been less than truthful have proven difficult to sustain as breaches of the employers' fiduciary duty to their employees. To win such claims, retirees must clear two separate hurdles: first, that the former employer's representatives made material misrepresentations; and second, that the former employer either knew of those misrepresentations, or should have known about them, depending upon which judicial circuit the case

285. *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90, 101-02 (2d Cir. 2001).

involves.

Finally, retirees have tried to claim that they relied to their detriment on an employer's false assurances of future health benefits. But courts have held that presentations to prospective retirees need not mention an employer's right to change benefits, as long as the plan documents themselves contain such references. Small wonder, then, that even retirees who feel genuinely deceived are unable to prove the elements that estoppel claims demand.

III. POSSIBLE APPROACHES FOR RETIREES WHO HAVE LOST HEALTH BENEFITS

For retirees who have lost most or all of their post-employment health benefits, the available options depend entirely on whether the retiree in question is eligible for Medicare, which generally requires that the retiree be at least sixty-five years old.²⁸⁶ The Medicare-eligible retiree is entitled to Medicare Part A coverage of most hospital expenditures,²⁸⁷ some nursing home²⁸⁸ and home health care expenses,²⁸⁹ and the cost of hospice care.²⁹⁰ In addition, Medicare-eligible retirees have available the full panoply of health insurance alternatives that retirees who never had employer-provided post-employment health benefits can access. These alternatives include the following:

- 1) Medicare Part B, which covers physicians' fees, ambulance charges, and most outpatient medical tests and procedures;²⁹¹
- 2) Medicare Part D prescription drug benefit plans;²⁹²
- 3) Private supplemental insurance, generally known as "Medigap" insurance, which covers most of the deductibles and co-payment obligations under Medicare's hospital and physician coverages;²⁹³
- 4) Medicare Part C managed care plans that incorporate many, if not most, of the benefits under Medicare Parts B and D, plus Medigap insurance.²⁹⁴

286. 42 U.S.C. § 1395c(1) (2000).

287. See FROLIK & KAPLAN, *supra* note 8, at 66-68.

288. See *id.* at 68-71.

289. See *id.* at 71-73.

290. See *id.* at 73-75.

291. See *generally id.* at 75-78 (explaining Medicare Part B coverage).

292. See *generally id.* at 85-91 (explaining Medicare Part D prescription drug benefit plans).

293. See *generally id.* at 95-103 (explaining private Medigap insurance coverage and options).

294. See *generally id.* at 103-07 (explaining Medicare managed care plans).

To be sure, these alternatives may be quite difficult to sort out. The Medicare Part D prescription drug plans, in particular, vary considerably from state to state and change annually in terms of medications, dosage amounts, and dosage frequencies covered—an unnecessarily baffling array of options that far surpass all other pharmaceutical arrangements in terms of their complexity.²⁹⁵ Similarly, Part C managed care plans provide comprehensive coverage but generally limit access to specific doctors, hospitals, pharmacies, and drugs, or allow wider access to health care providers but on less attractive financial terms.²⁹⁶

In many cases, the cost of these various alternatives is likely to exceed what the Medicare-eligible retirees would have paid under their former employers' retiree health benefit plans. For example, Medicare Part B costs \$96.40 per month in 2009,²⁹⁷ and this amount is adjusted annually.²⁹⁸ Upper-income retirees, in fact, pay higher amounts depending upon the level of their income as computed for federal income tax purposes.²⁹⁹ Monthly premiums for Medicare Part D plans vary widely depending upon the scope of their covered pharmaceutical formulary and their own set of deductibles and co-payment obligations for generic and name-brand medications.³⁰⁰ Medigap policies are standardized into twelve different benefit packages, and premiums vary by state but are generally higher for more comprehensive benefit arrangements.³⁰¹ Finally, Medicare managed care plans, currently dubbed "Medicare Advantage,"³⁰² exhibit considerable price variation depending upon their

295. See Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT'L ACAD. ELDER L. ATT'YS J. 167, 186 (2005); Medicare, Prescription Drug Coverage, <http://www.medicare.gov/pdphome.asp> (last visited Apr. 20, 2009); see also Jane Zhang, *Expect Changes In Drug Co-Pays For Medicare*, WALL ST. J., Nov. 4, 2008, at D1 (describing the most recent batch of annual changes in prescription drug plans confronting Medicare enrollees).

296. See 2007 MEDICARE HANDBOOK 7-1 to -50 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2007).

297. See Medicare Part B Monthly Premiums in 2009, http://questions.medicare.gov/cgibin/medicare.cfg/php/enduser/popup_adp.php?p_sid=undefined&p_lva=undefined&p_li=undefined&p_faqid=2099&p_created=1221840031&p_sp=undefined (last visited Mar. 31, 2009).

298. 42 U.S.C. § 1395r(a) (2000).

299. See generally Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLAN., May-June 2006, at 22. In 2009, premiums are higher for married couples with more than \$170,000 of income. Medicare Part B Monthly Premiums in 2009, *supra* note 297.

300. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & YOU 2009, at 55-56 (2008), available at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf>.

301. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., 2009 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE (2008), available at <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf>.

302. 42 U.S.C.A. § 1395w-21 (West 2009).

restrictiveness in terms of access to providers and the nature of any additional services that they might include, such as wellness classes and vision care.

These choices may well be much more perplexing and complicated than the employer-provided retiree health benefit packages that Medicare-eligible retirees previously had, but at least these choices are available. The optional components of Medicare—Part B, managed care plans under Part C, and prescription drug plans under Part D—are all available without regard to a prospective enrollee's medical profile. Even Medigap insurance, a private product, cannot be denied for pre-existing medical conditions if an applicant applies for coverage prior to or during the first six months of his or her enrollment in Medicare Part B.³⁰³ Having to navigate this unholy mess certainly adds to the anxiety and confusion that these retirees face, but they are no worse off than Medicare-eligible retirees who never had any retiree health benefits from a former employer.

Pre-Medicare retirees, by contrast, *are* distinctly worse off, and it is to their situation that this section now turns. Their situation is especially problematic given the high range of medical expenditures that this group incurs. The Centers for Medicare and Medicaid Services found that people aged fifty-five to sixty-four years spent an average of nearly \$7800 per person on health care spending in 2004,³⁰⁴ the most recent year for which data are available. Moreover, this figure—as high as it is—masks the uneven distribution of health care costs across this age cohort. A study using 2002 figures found that among persons aged fifty-five to sixty-four years, nearly half of the entire group's health care costs were incurred by the 7% of this group with the highest medical expenses.³⁰⁵ Clearly, pre-Medicare retirees have a particular need for health insurance. In this section, we first examine currently available options, and then we analyze a proposal to expand Medicare to younger retirees.

A. Current Options for Pre-Medicare Retirees

Retirees who are not yet eligible for Medicare have several options depending on their individual circumstances. One such option is health insurance through a working spouse. This option requires that 1) the retiree is currently married, 2) the retiree's spouse is employed, 3) the spouse's employer offers health insurance to its employees and their dependents, 4) the spouse is eligible for this insurance according to the employer's criteria of hours worked and length

303. *Id.* § 1395ss(s)(2)(A) (2000).

304. Ctrs. for Medicare & Medicaid Servs., Total Personal Health Care Per Capita Spending, By Age Group, Calendar Years, 1987, 1996, 1999, 2002, 2004, at 2, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf> (last visited Apr. 20, 2009).

305. See JOHN HOLAHAN, KAISER COMM'N ON MEDICAID & THE UNINSURED, HEALTH INSURANCE COVERAGE OF THE NEAR ELDERLY 35 (2004), available at <http://www.kff.org/uninsured/upload/Health-Insurance-Coverage-of-the-Near-Elderly-Report.pdf>.

of employment,³⁰⁶ and 5) the premiums associated with adding the retiree as a spouse fit within the couple's budget. Only if *all* five of these requirements are met is this alternative feasible.³⁰⁷

A second option is obtaining Medicare as a disabled person prior to reaching age sixty-five.³⁰⁸ Someone who receives Social Security disability payments for twenty-four months is eligible for Medicare, regardless of age.³⁰⁹ Qualifying for such benefits, however, is not easy. The putative disabled person must be unable to perform “*any* substantial gainful activity by reason of any medically determinable physical or mental impairment.”³¹⁰ The process of meeting this standard involves various medical examinations and vocational tests to assess an individual's possible employability.³¹¹ Moreover, an inability to perform “substantial gainful activity” must be expected to last at least one year or result in the death of that person.³¹² In addition, the person's status as “disabled” is reviewed periodically until he or she reaches Social Security's full “retirement age.”³¹³ The qualification process is beset with delays, uncertainty, and successive layers of administrative appeals.³¹⁴ In any case, the “successful” applicant must still cover his or her own medical costs during the requisite twenty-four month period before Medicare eligibility is established.³¹⁵

306. See JEFFREY D. MAMORSKY, *EMPLOYEE BENEFITS HANDBOOK* § 43.09[1] (3d ed. 1992).

307. Among persons aged fifty-five to sixty-four years, active employees as well as retirees, approximately 18% receive health insurance through their spouse. This estimate was derived by authors from CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007*, at 69 (2008), available at <http://www.census.gov/prod/2008pubs/p60-235.pdf>; see also Richard W. Johnson, *When Should Medicare Coverage Begin?*, NAT'L ACAD. OF SOC. INS., Dec. 2003, at 2, available at http://www.nasi.org/usr_doc/nasiBrief_risk6_03.pdf (presenting a comparable estimate of 16% using 1998 data).

308. Among persons aged fifty-five to sixty-four years, active employees and retirees, 9.5% are enrolled in Medicare. DENAVAS-WALT, PROCTOR & SMITH, *supra* note 307, at 69.

309. 42 U.S.C. §§ 426(b)(2)(A)(i), 1395c(2) (2000).

310. *Id.* § 416(i)(1)(A) (emphasis added). A person is presumed to be disabled if he or she earns less than an annually adjusted amount, which in 2009 was \$980 per month. 20 C.F.R. § 404.1574 (2008); Social Security Online, *Automatic Increases in Recent Years*, <http://www.ssa.gov/OACT/COLA/autoAdj.html> (last accessed Mar. 31, 2009).

311. See 42 U.S.C. § 423(d)(5)(A), (B), (f). See generally CHARLES T. HALL, *SOCIAL SECURITY DISABILITY PRACTICE* (2007); 1-3 BARBARA SAMUELS, *SOCIAL SECURITY DISABILITY CLAIMS* (2d ed. 1994).

312. 42 U.S.C. § 416(i)(1)(A) (2000).

313. *Id.* § 416(i)(2)(D). A person's full “retirement age” under Social Security is determined by that person's year of birth. See *id.* § 416(l)(1).

314. See 20 C.F.R. § 404.1520 (2008). See generally FROLIK & KAPLAN, *supra* note 8, at 323-25 (describing appeals procedures).

315. There is no waiting period for individuals with amyotrophic lateral sclerosis. 42 U.S.C. § 426(h) (2000).

Three more generally applicable options for retirees who are not yet eligible for Medicare include the following: 1) continue their former employer's health insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),³¹⁶ 2) purchase health insurance in the individual market, or 3) utilize a health savings account after retirement. As this section will show, none of these three options adequately addresses the problem of early retirees who have lost their employer-sponsored retiree health benefits.

1. Continuation Coverage

COBRA allows former employees, including early retirees,³¹⁷ to continue the health insurance they had through their former employer for up to eighteen months after termination of employment.³¹⁸ Many early retirees, of course, face a gap of much more than eighteen months between the date of their retirement and their sixty-fifth birthday.³¹⁹ This time period is extended until a retiree's death if that retiree's former employer terminates its health insurance coverage through a Chapter 11 bankruptcy organization.³²⁰ There is no such extension for a Chapter 7 bankruptcy liquidation, however.

In any case, COBRA insurance is not always affordable. Retirees must pay the entire cost of this insurance without the employer subsidy that they typically received when they were actively employed.³²¹ As a result, the monthly cost for a former employee might be as much as five times the cost that a current employee would pay.³²² Such a cost increase is especially difficult for a person who is not currently employed.³²³ Perhaps it is not terribly surprising, then, that the most

316. Pub. L. No. 99-272, § 10002(a), 100 Stat. 82, 227-31 (1986) (codified at 29 U.S.C. §§ 1161-1168).

317. See 29 U.S.C. § 1167(2) (2000); MAMORSKY, *supra* note 306, § 36.05[2][d].

318. 29 U.S.C. §§ 1161(a), 1162(1), 1162(2)(A)(i), 1163(2) (2000). The COBRA period is 36 months for the spouse of a current employee who becomes entitled to Medicare. *Id.* §§ 1162(2)(A)(iv), 1163(4).

319. See 42 U.S.C. § 426(a)(1) (2000).

320. 29 U.S.C. §§ 1162(2)(A)(iii), 1163(6) (2000); see also JEFFREY D. MAMORSKY, HEALTH CARE BENEFITS LAW § 7.03[6] (2008).

321. 29 U.S.C. §§ 1162(3)(A), 1164(1) (2000); see also Employee Benefits Security Administration, FAQs About COBRA Continuation Health Coverage, *available at* http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html. Recent national data on the cost of employer-provided health insurance appear in BETH LEVIN CRIMMEL & JOHN P. SOMMERS, EMPLOYER-SPONSORED HEALTH INSURANCE FOR LARGE EMPLOYERS IN THE PRIVATE SECTOR, BY INDUSTRY CLASSIFICATION, 2006 (Medical Expenditure Panel Survey, Statistical Brief No. 211, 2008), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/st211/stat211.pdf.

322. FIDELITY WORKPLACE SERVS., RETIREE HEALTH CARE COSTS: ADDRESSING THE GROWING GAP 17 (2002).

323. See generally FAMILIES USA, SQUEEZED! CAUGHT BETWEEN UNEMPLOYMENT BENEFITS

recent study of this program found that only 9% of individuals eligible for COBRA continuation coverage actually obtain such insurance.³²⁴ On the other hand, at least this insurance is available without medical underwriting.

These twin problems of COBRA—namely, a limited coverage period and high premium costs—were both addressed in the very beginning of President Barack Obama’s administration. His signature economic stimulus legislation, appropriately designated as House Bill 1,³²⁵ provided that persons who lost their employer-provided health insurance after attaining age fifty-five could extend their COBRA coverage until they reached the Medicare eligibility age of sixty-five years.³²⁶ This Bill also provided that the cost of this coverage would be subsidized by the federal government to the extent of 65%, with the individual retiree being responsible for the remaining 35%.³²⁷ This COBRA provision would apply, however, only to persons who were involuntarily terminated from employment between September 1, 2008 and December 31, 2009.³²⁸ Although this provision passed the House of Representatives, the Conference Committee that produced the final version of the American Recovery and Reinvestment Act of 2009³²⁹ further limited its applicability to workers who were within nine months of becoming age-eligible for Medicare.³³⁰

In any case, the Health Insurance Portability and Accountability Act of 1996³³¹ allows persons who previously had group health insurance coverage to obtain individual coverage without being declined for medical reasons.³³² But this statute puts no limits on the price of such coverage. As the Government Accounting Office concluded in a study of insurance policies issued under this statute, these policies “may be cost prohibitive to many retirees.”³³³

AND HEALTH CARE COSTS (2009), *available at* <http://www.familiesusa.org/assets/pdfs/cobra-2009.pdf>.

324. MICHELLE DOTY ET AL., MAINTAINING HEALTH INSURANCE DURING A RECESSION: LIKELY COBRA ELIGIBILITY 3 (Commonwealth Fund Issue Brief 3, 2009), *available at* http://www.commonwealthfund.org/usr_doc/Doty_maintaininghltinsrecessionCOBRA_1225_ib.pdf?section=4039.

325. American Recovery and Reinvestment Act of 2009, H.R.1, 111th Cong. (engrossed as agreed to or passed by the House of Representatives, Jan. 28, 2009).

326. *Id.* § 3002(b)(1)-(3).

327. *Id.* § 3002(a)(1).

328. *Id.* § 3002(a)(3)(A), (C).

329. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115.

330. *See id.* § 3001(a)(2)(A)(i), (ii)(I).

331. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.).

332. I.R.C. § 9802(a)(1) (2008); 29 U.S.C. § 1182(a)(1) (2000). States have the option of establishing high risk pools. *See generally* MAMORSKY, *supra* note 320, § 16.04.

333. U.S. GOV’T ACCOUNTING OFFICE, RETIREE HEALTH BENEFITS: EMPLOYER-SPONSORED BENEFITS MAY BE VULNERABLE TO FURTHER EROSION 19 (2001), *available at*

2. Individual Insurance Market

Retirees who try to purchase health insurance in the individual insurance market face a major obstacle: medical underwriting.³³⁴ Unless state laws require insurance companies to accept all applicants (so-called “guaranteed issue”),³³⁵ private insurers are free to accept or reject whomever they choose. Some states require that insurers apply the same rates to all accepted applicants (so-called “community rating”),³³⁶ but most states allow insurers to price accepted applicants differentially. As a result, a pre-Medicare retiree may be unable to obtain any health insurance in the individual market, much less quality coverage, or to afford whatever health insurance that he or she can obtain.³³⁷ This situation is radically different from the pre-retirement context where the person was part of an employer-based group that included younger and presumably healthier co-workers who effectively subsidized their older colleagues.³³⁸

To put the matter in the bluntest terms, many people simply take their employer-provided health insurance for granted until they try to replace it outside the workplace environment. For example, a 2004 study published by the Kaiser Family Foundation found that middle-income persons aged fifty-five to sixty-four years who claimed to be in “good” health were twice as likely to have no health insurance as those whose self-reported health status was “excellent” or “very good.”³³⁹ It is often the case that retirees in this age group have developed some medical history that diminishes their prospects of securing health insurance.³⁴⁰

<http://www.gao.gov/new.items/d01374.pdf>.

334. See Sarah Rubenstein, *Health Insurers Often Reject 'Near Elderly,'* WALL ST. J., Nov. 16, 2004, at B1; see also COUNCIL OF ECON. ADVISORS, REACHING THE UNINSURED: ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS 2-3 (2000).

335. See COUNCIL FOR AFFORDABLE HEALTH INS., 2007 STATE LEGISLATORS GUIDE TO HEALTH INSURANCE SOLUTIONS AND GLOSSARY 18-19 (2007), available at http://www.cahi.org/cahi_contents/resources/pdf/2007Stateleg.pdf.

336. See *id.* at 11-12.

337. As to the difficulties affecting the individual insurance market generally, including misleading advertising, high rejection rates that rise with an applicant's age, and high nonrenewal rates for those who incur covered expenses, see FAMILIES USA, EMPTY PROMISE: SEARCHING FOR HEALTH INSURANCE IN AN UNFAIR MARKET (2008), available at <http://www.familiesusa.org/assets/pdfs/play-fair-empty-promise-1.pdf>.

338. See Paul B. Grant, *Commentary*, in PROVIDING HEALTH CARE, *supra* note 29, at 93, 95 (noting that the cost of insuring a sixty-year-old employee may be as much as four times the cost of insuring a twenty-five-year-old); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 31-33 (2001).

339. HOLAHAN, *supra* note 305, at 16-17.

340. See Chad Terhume, *Employers Turn to Alternative For Insuring Staff*, WALL ST. J., July 30, 2007, at A1 (noting that “about a quarter of people 55 to 64 get rejected for individual

To be sure, thirty-four states operate some sort of high-risk insurance pool, but sixteen states have none.³⁴¹ Moreover, the high-risk insurance pools that do exist often place limits on their coverage of pre-existing conditions, impose waiting periods on such coverage, or exclude these conditions from coverage entirely.³⁴² Even with these limitations, these policies may be unaffordable.³⁴³

AARP, the older persons advocacy group, has tried to respond to this problem by offering health insurance specifically to persons aged fifty to sixty-four years.³⁴⁴ This plan intentionally has more lenient underwriting criteria; for example, it looks back only five years when someone applies for coverage in considering pre-existing medical conditions.³⁴⁵ Nevertheless, it rejects some applicants and raises prices for others.³⁴⁶ But the point remains that the individual insurance market is fraught with uncertainty,³⁴⁷ a prospect that is especially troubling for early retirees as they enter a phase in their lives when increased health care utilization is more likely than not.

3. Health Savings Accounts

A third alternative utilizes the health savings account (HSA) mechanism that Congress first created in 2003.³⁴⁸ These accounts are combined with a high-deductible insurance policy that covers the cost of accidents and extended illness.³⁴⁹ The central idea is that early retirees may save pre-tax dollars in an HSA and then use funds in that account to cover health care costs that are not covered by the associated insurance policy.³⁵⁰ Among the categories of

coverage”); *see also* FAMILIES USA, *supra* note 323, at 3 (nothing that “those with health problems are likely to find that no insurer will sell them a policy that will cover their pre-existing conditions at any price”).

341. Terhume, *supra* note 340.

342. *See* AMANDA McCLOSKEY & RACHEL KLEIN, FAMILIES USA, TOO FEW OPTIONS: THE INSURANCE STATUS OF WIDOWED OR DIVORCED OLDER WOMEN 17 (2001), *available at* http://www.communityvoices.org/Uploads/om3gfk55hhzyvm00n4_nerbf_20020828085202.pdf.

343. *Id.*; *see also* Catherine Chou, *Insuring Medically Uninsurable Individuals: An Examination of Different State Approaches*, 27 J. LEGAL MED. 443, 448-49 (2006).

344. AARP, AARP Health Products & Services, <http://www.aarphealthcare.com/products/default.aspx> (last visited Apr. 20, 2009).

345. *See* Rubenstein, *supra* note 334.

346. *See id.*

347. *See* Rappaport & Malone, *supra* note 47, at 86 (“Virtually no market exists for individual coverage for retirees not yet eligible for Medicare.”).

348. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1201(a), 117 Stat. 2066, 2469 (codified as amended at I.R.C. § 223). *See generally* Kaplan, *supra* note 37.

349. I.R.C. § 223(c)(1)(A)(i) (2008).

350. Kaplan, *supra* note 37, at 549.

“qualified medical expenses” that can be paid with tax-free withdrawals from an HSA³⁵¹ are premiums on COBRA continuation insurance policies,³⁵² as well as premiums on Medicare Part B coverage³⁵³ once the retiree becomes eligible for that program.

To qualify, the early retiree must have a health insurance policy that meets the definition of “high-deductible.”³⁵⁴ Such a policy must have an annual deductible before coverage starts of at least \$1150 for self-only coverage or \$2300 for family coverage.³⁵⁵ These limits pertain to calendar year 2009 and are adjusted annually for inflation.³⁵⁶ Certain medical expenses may be covered by a “high-deductible” policy before the annual deductible is satisfied, but those expenses relate to “preventive care,”³⁵⁷ a category that generally includes periodic medical examinations, diagnostic procedures, and various screening tests.³⁵⁸ Pharmaceuticals may not, however, be covered until the policy’s deductible has been met. Accordingly, a qualifying “high-deductible” insurance policy can expose the typical early retiree to considerable out-of-pocket medical expenses.

In any case, there is no guarantee that an early retiree will be able to obtain the “high-deductible” insurance policy that an HSA requires. Such policies are subject to the same medical underwriting limitations, including possible unavailability due to an applicant’s pre-existing conditions, that characterize the individual insurance market generally. Consequently, the HSA alternative is less promising than it might appear due to the necessity of securing a “high-deductible” insurance policy.

But if an early retiree manages to secure such a policy, the appeal of the HSA alternative then depends principally upon two independent factors: one, how much is put into the account; and two, how much is withdrawn.³⁵⁹ The owner of an HSA can make pre-tax contributions of an annually adjusted amount.³⁶⁰ In 2009, the maximum annual contribution is \$3000 for self-only coverage and \$5950 for family coverage.³⁶¹ Persons who are at least fifty-five years old, moreover, are allowed to make additional “catch up” contributions of

351. I.R.C. § 223(d)(2), (f)(1).

352. *Id.* § 223(d)(2)(C)(i).

353. *Id.* § 223(d)(2)(C)(iv).

354. *See id.* § 223(c)(2).

355. Rev. Proc. 2008-29 § 2, 2008-22 I.R.B. 1039.

356. I.R.C. § 223(c)(2)(A)(i), (g)(1) (2008).

357. *Id.* § 223(c)(2)(C).

358. I.R.S. Notice 2004-23, 2004-1 C.B. 725.

359. Of less consequence is the investment return earned by the funds in the HSA.

360. *See* I.R.C. § 223(a) (2008).

361. Rev. Proc. 2008-29 § 2, 2008-22 I.R.B. 1039.

\$1000 per year in 2009.³⁶² Funds in an HSA accumulate free of income tax,³⁶³ and any balance that is unspent at year's end simply rolls forward.³⁶⁴ Thus, the optimum strategy is to contribute the maximum amount allowable each year *and* to minimize withdrawals from the HSA.³⁶⁵ In other words, even permissible withdrawals for “qualified medical expenses” should be kept to a minimum to preserve the funds accumulated in the HSA. Suffice it to say, few early retirees are able to meet both of these conditions without suffering some degree of financial hardship.

Even if an early retiree obtains a qualifying “high-deductible” health insurance policy, funds the associated HSA at the maximum levels allowed, and minimizes withdrawals, what might result? The answer depends on the rate of return that the HSA's investments yield, the extent to which those withdrawals are minimized, and the number of years during which this arrangement is maintained. A simulation prepared by the Employee Benefit Research Institute assumed a 5% annual rate of return and maximum annual contributions, including “catch up” contributions.³⁶⁶ According to their results, as modified for current contribution levels, a fifty-five-year-old retiree with self-only coverage would have the following balances in his or her HSA after ten years (i.e., at age sixty-five),³⁶⁷ depending upon the percentage of year-end account balance that is left untouched:

<u>Rollover Percentage</u>	<u>Account Balance</u> ³⁶⁸
50	\$10,473
75	\$20,393
90	\$35,691
100	\$54,966

362. I.R.C. § 223(b)(3)(B) (2008).

363. *Id.* § 223(e)(1).

364. See Sarah Lueck, *Medicare Law Reaches the Under-65 Set, Too*, WALL ST. J., Dec. 16, 2003, at D1.

365. See Sarah Rubenstein, *How to Manage a Health Savings Account To Cover Your Medical Bills in Retirement*, WALL ST. J., Dec. 20, 2006, at D1.

366. FRONSTIN, Issue Brief No. 295, *supra* note 12, at 17.

367. A retiree who is entitled to Medicare benefits may not contribute to an HSA. I.R.C. § 223(b)(7) (2008).

368. Adapted by authors from FRONSTIN, Issue Brief No. 295, *supra* note 12, at 17, and Paul Fronstin, *Savings for Health Care Expenses in Retirement: The Use of Health Savings Accounts*, EBRI NOTES, August 2008, at 12, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_08b-20081.pdf. Maximum contributions to HSAs (excluding catch up contributions) are assumed to increase at a 2.8% annual rate of inflation. See Bd. of Trs. of the Fed. Hosp. Ins. & Fed. Supplementary Med. Ins. Trust Funds. 2008 Annual Report at 7, available at <http://www.cms.hhs.gov/reportstrustfunds/downloads/tr2008.pdf>.

Thus, even in the most optimistic scenario—the 100% rollover, with no withdrawals—the HSA would accumulate only \$54,966 after ten years of maximum contributions. Moreover, the extent to which HSA funds are utilized for “qualified medical expenses” during the ten-year period makes a huge difference in the final result. As the results above show, the difference between the 50% and 100% rollover situation is not merely twice as much available at the end of the period, but 5.25 times as much.³⁶⁹ Furthermore, the possibility of maximizing HSA balance by contributing at maximum levels at a younger age than fifty-five is precluded by the fact that most people would not be eligible for an HSA while employed because their employer-provided health insurance is more comprehensive than a “high deductible” policy. Accordingly, the alternative of a “high deductible” insurance policy coupled with an HSA has limited potential for addressing an early retiree’s health care costs in most circumstances.³⁷⁰

To summarize, continuation coverage under COBRA is limited to eighteen months and can be very expensive. It is available, however, to early retirees without the need to satisfy medical underwriting criteria. Such criteria can be a large, and often insurmountable, barrier for early retirees who seek health insurance in the individual policy market. Even retirees who are able to secure such insurance, moreover, may find that they must accept high-deductible policies to keep the premiums affordable. Given that reality, some early retirees may want to establish an HSA to cover out-of-pocket medical expenses. But such an account is unlikely to generate significant funds except under rather trying conditions of limited withdrawals. In short, the existing options for pre-Medicare retirees who have lost their employer-provided post-employment health benefits are less than appealing.³⁷¹

B. Extending Medicare to Early Retirees

In light of the above discussion, this Section considers the alternative approach of simply extending Medicare coverage to early retirees. Persons under age sixty-five are already eligible if they have received disability payments under

369. $\$54,966 \div \$10,473 = 5.25$.

370. See George Wagoner et al., *Risk-Sharing in Retiree Medical Benefits*, in RESTRUCTURING RETIREMENT RISKS 136, 154, 156 (David Blitzstein, Olivia S. Mitchell & Stephen P. Utkus eds., 2006) (using a simulation to show the inadequacy of HSAs to meet most estimates of projected health care costs in retirement).

371. See EDWIN PARK & ROBERT GREENSTEIN, CTR. ON BUDGET & POLICY PRIORITIES, NEW RETIREMENT MEDICAL ACCOUNT PROPOSAL WOULD CREATE LUCRATIVE TAX SHELTER AND SWELL DEFICITS, BUT DO LITTLE TO HELP LOW- AND MODERATE-INCOME SENIORS (2004), <http://www.cbpp.org/4-19-04health.pdf> (discussing a retiree medical benefit account proposal that was never introduced as legislation).

the Social Security program for twenty-four months.³⁷² The policy question, therefore, is whether retirees who are not disabled should be allowed to join the Medicare program prior to reaching age sixty-five.

In point of fact, President Bill Clinton actually made such a proposal more than a decade ago.³⁷³ On January 6, 1998, he put forward a budget-neutral plan for retirees who were at least sixty-two years old to buy into Medicare at an actuarially full cost.³⁷⁴ And retirees who were at least fifty-five years old would, under this proposal, be able to extend their COBRA coverage until they were eligible for Medicare.³⁷⁵

President Clinton's proposal did not, however, receive much serious attention. Within two weeks of introducing this proposal, the Monica Lewinsky scandal broke,³⁷⁶ and official Washington became obsessed with the political ramifications of that matter. The idea of extending Medicare has remained salient nevertheless, and some version of President Clinton's proposal has been introduced in every subsequent Congress.³⁷⁷ The latest iteration is Senate Bill 3710, the Medicare Early Access Act of 2008.³⁷⁸ Proposed by such prominent Senators as Jay Rockefeller and John Kerry, among others, this Bill provides that individuals who are at least fifty-five years old may enroll in Medicare if they are not eligible for Medicaid, the federal employees' health benefit program, TRICARE, active duty military health care, or any other group health plan.³⁷⁹ For this purpose, eligibility for a group health plan through a COBRA continuation provision would be disregarded.³⁸⁰

1. Eligibility Criteria

To qualify for this proposed "early access" Medicare, an individual would

372. 42 U.S.C. § 426(b) (2000).

373. See Press Release, Dep't of Health & Human Servs., President Clinton Announces New Proposal to Provide Americans Age 55 to 65 Improved Access to Health Insurance (Jan. 6, 1998), available at <http://www.hhs.gov/news/press/1998pres/980106.html>.

374. *Id.*

375. *Id.*

376. See James Bennet, *Defending Himself*, N.Y. TIMES, Jan. 22, 1998, at A1.

377. See S. 3747, 109th Cong. (2006); H.R. 2072, 109th Cong. (2005); H.R. 5218, 108th Cong. (2004); H.R. 4357, 108th Cong. (2004); S. 1935, 108th Cong. (2003); H.R. 3189, 108th Cong. (2003); S. 2679, 107th Cong. (2002); H.R. 4684, 107th Cong. (2002); S. 623, 107th Cong. (2001); H.R. 1255, 107th Cong. (2001); H.R. 803, 107th Cong. (2001); S. 2918, 106th Cong. (2000); H.R. 4938, 106th Cong. (2000); H.R. 3529, 106th Cong. (2000); H.R. 2228, 106th Cong. (1999); S. 202, 106th Cong. (1999); S. 10, 106th Cong. (1999); H.R. 4799, 105th Cong. (1998); S. 1789, 105th Cong. (1998); H.R. 3470, 105th Cong. (1998).

378. S. 3710, 110th Cong. (2008).

379. *Id.* § 101(a)(2).

380. *Id.*

otherwise need to be eligible for Medicare benefits.³⁸¹ This criterion would require a person to be eligible for retirement benefits under the federal government's Social Security program.³⁸² In general terms, such a person must have earned at least forty "quarters of coverage" in employment that was subject to the Social Security payroll tax.³⁸³ Most employment in the United States so qualifies, but there are some exceptions, including employment in most state and local government service and student employment at the college or university in which a student is enrolled.³⁸⁴ A person earns a "quarter of coverage" by earning a stipulated amount that is adjusted annually for inflation.³⁸⁵ Work in 2009 required earnings of \$1090 to count as a "quarter of coverage."³⁸⁶ Alternatively, a person can qualify for Medicare if his or her spouse meets the work requirement,³⁸⁷ and a divorced spouse of an eligible worker can qualify as long as their marriage lasted at least ten years.³⁸⁸

In any case, the proposed legislation would require an enrollee to remain in the program.³⁸⁹ That is, a person who enrolled in "early access" Medicare and then terminated his or her enrollment (except upon reaching age sixty-five) could not subsequently re-enroll in the program.³⁹⁰ An exception would be made, however, for someone who enrolled in a group health plan or other federal health insurance program and then lost eligibility for that program.³⁹¹ But potential enrollees would not be required to exhaust their rights to COBRA continuation coverage before accessing Medicare early.³⁹²

2. *Financing Aspects*

Early access Medicare would not be cost-free by any means, but it would be available to all eligible applicants without regard to their medical history or current health profile. As noted previously, that feature would be a major benefit of this program. Enrollees would be assessed a premium that was calculated in an

381. *Id.*

382. 42 U.S.C. §§ 426(a)(2)(A), 1395c (2000).

383. *Id.* § 414(a)(2) (2000).

384. *See generally* FROLIK & KAPLAN, *supra* note 8, at 285-87 (explaining the scope of covered employment under Social Security).

385. 42 U.S.C. § 413(d)(2) (2000).

386. Social Security Online, Automatic Increases in Recent Years, <http://www.ssa.gov/OACT/COLA/autoAdj.html> (last visited Mar. 31, 2009).

387. 42 U.S.C. § 402(b)(1), (c)(1) (2000).

388. *Id.*; *id.* § 416(d)(1) (2000).

389. S. 3710, 110th Cong. § 101(a)(2) (2008) (at Sec. 1860E-1(b)(2)).

390. *Id.*

391. *Id.*

392. *Id.* (at Sec. 1860E-1(b)(2)(B)).

effort to make the early access program self-sustaining.³⁹³ This program would have its own “trust fund”³⁹⁴ to ensure that the financial condition of the existing Medicare program would not be affected by the introduction of early access Medicare. The U.S. Secretary of Health and Human Services would calculate the national “average annual per capita amount,”³⁹⁵ and enrollees would be responsible for 25% of this cost.³⁹⁶ The proposed legislation would allow persons with existing employer-provided retiree health benefits to choose early access Medicare instead of those benefits³⁹⁷ and suggests—but does not require—that the former employer in such circumstances might pay the enrollee’s 25% cost obligation.³⁹⁸

To ensure that this program will be affordable to the broadest swath of potential enrollees, the remaining 75% of the cost would come from a federal income tax credit.³⁹⁹ This tax credit would be “refundable,”⁴⁰⁰ so that enrollees with limited or no income tax liability would nevertheless benefit from it. Moreover, this tax credit would be in the form of an “advance payment,”⁴⁰¹ meaning that an enrollee would not be required to wait until after he or she files a tax return to receive the financial benefit from the credit. This rather convoluted financing mechanism results in the early access Medicare program’s cost being borne 25% by the enrollee (or possibly the enrollee’s former employer) and 75% by general tax revenues of the federal government. This 25–75 ratio, by the way, is the same cost allocation that applies generally to persons who enroll in Medicare Part B⁴⁰² to get coverage of doctors’ fees, diagnostic tests, and other outpatient services. To reduce the financial impact on the federal government, the means-testing mechanism that currently applies to Medicare Part B could be applied to this program as well.⁴⁰³ It should be noted, however, that none of the early access Medicare proposals that have been put forward contain this particular feature.

Without the 75% subsidy, an early access program would impose no

393. *See id.* (at Sec. 1860E-3(b)(1)).

394. *Id.* (at Sec. 1860E-4(a)(1)); *id.* (at Sec. 1860E-6).

395. *Id.* (at Sec. 1860E-4(b)(1)).

396. *Id.* (at Sec. 1860E-5(b)(2)).

397. *Id.* (at Sec. 1860E-5(a)).

398. *Id.* (at Sec. 1860E-5(b)).

399. *Id.* § 201(a) (at Sec. 36A(a)).

400. *Id.* § 201(a).

401. *Id.* § 201(b).

402. 2009 MEDICARE HANDBOOK § 6.02[C][1], at 6-10 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2009).

403. *See* 42 U.S.C.A. § 1395r(i) (West Supp. 2008) (describing the means testing of Part B). *See generally* FROLIK & KAPLAN, *supra* note 8, at 60-61 (explaining the surcharge for Medicare Part B imposed on higher-income enrollees). For an analysis of the implementation problems involved in means-testing Medicare, see Kaplan, *supra* note 299, at 22.

significant costs on the federal government. Although none of the legislative proposals made since President Clinton's 1998 announcement has been the focus of a Congressional Budget Office (CBO) cost study, the CBO very recently issued a "budget options" report⁴⁰⁴ that included a variant of early access Medicare among its 115 health care proposals.⁴⁰⁵ The option discussed in this Report would cover only persons age sixty-two through sixty-four,⁴⁰⁶ rather than the larger group that the legislative proposals considered above would cover—namely, persons age fifty-five to sixty-four. The CBO report stated that if the government would "set a premium that would cover the costs of the program's participants during the buy-in years . . . the program would not require *any* new outlays."⁴⁰⁷

The CBO report contends that an early buy-in option for Medicare would be very expensive, because it would induce additional Social Security beneficiaries to file for early retirement benefits under that program.⁴⁰⁸ But early retirement benefits under Social Security are actuarially reduced so that over the lifetime of early-claiming beneficiaries, the government's outlays for Social Security are essentially equivalent.⁴⁰⁹ That is, early claimants of Social Security retirement benefits receive more money at younger ages than do beneficiaries who wait until their "full retirement age" to start receiving benefits,⁴¹⁰ but they receive less money after that point. Inducing early claimants under Social Security, therefore, does not increase total lifetime government expenditures for the affected beneficiaries. There will certainly be an increase in near-term government outlays, which is what the CBO report highlighted, but that is strictly a timing phenomenon and does *not* increase Social Security's overall expenditures. As the CBO report itself acknowledges, "the effects on [Social Security] outlays should be minimal, because earlier retirement results in lower annual benefits."⁴¹¹

If the government chooses to subsidize the early access Medicare program, however, there will obviously be an increase in government expenditures. Precisely how much that increase will be depends upon three distinct factors: 1) the cost of the program per enrollee, 2) the number of persons who participate in

404. 1 CONG. BUDGET OFFICE, BUDGET OPTIONS (2008), *available at* <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf> [hereinafter CBO REPORT].

405. *Id.* at 1, 39-40.

406. *Id.* at 39.

407. *Id.* (emphasis added).

408. *See id.*

409. *See* C. EUGENE STEUERLE & JON M. BAKIJA, RETOOLING SOCIAL SECURITY FOR THE 21ST CENTURY 221 (1994) ("The actuarial reduction for early retirement roughly offsets the extra benefits one receives before age 65.").

410. *See* FROLIK & KAPLAN, *supra* note 8, at 289-91 (explaining the computation of "early" Social Security retirement benefits).

411. CBO REPORT, *supra* note 404, at 39-40.

the program, and 3) the degree of premium subsidization that the government provides. On the first factor, the CBO estimated the annual premium cost as \$7600 for calendar year 2011,⁴¹² but this amount includes a 5% “administrative fee” that would be imposed in addition to the actual programmatic cost.⁴¹³ The real projected cost, in other words, would be \$7238 per participant,⁴¹⁴ which seems reasonable given the targeted age group’s incidence of chronic medical conditions.⁴¹⁵

Even this figure is somewhat inflated, however, because of three separate factors. First, the program considered by the CBO would cover only persons over age sixty-one, rather than the larger age cohort of fifty-five to sixty-four-year-olds that the legislative proposals cover. Bringing the younger segment of this age cohort—that is, persons aged fifty-five to sixty-one—into the program would *lower* the per-person cost, because health care costs tend to rise as a person ages.⁴¹⁶ Thus, the per-person cost of a program for fifty-five to sixty-four-year-olds would be less expensive than the amount estimated by the CBO for a program that applies only to sixty-two to sixty-four-year-olds.

Second, the program described by the CBO would be voluntary, so persons anticipating higher expenditures would be more likely to enroll. As the CBO report itself notes, “The premium for the buy-in program would be *higher* than if the entire eligible population was enrolled because the program would be likely to experience adverse selection”⁴¹⁷ To be sure, any nonmandatory health insurance program is subject to this phenomenon, including the legislative proposals analyzed earlier, but it raises the per-person cost nonetheless.

Finally, the CBO did not consider the budgetary *benefit* of providing health insurance to persons who would otherwise enroll in Medicare at age sixty-five, but in worse health. The CBO report acknowledges that “improvements in health status [of pre-Medicare enrollees] . . . could reduce Medicare’s spending for those individuals after they turned 65.”⁴¹⁸ Indeed, an important study in the *New England Journal of Medicine* found that the cost of extending health insurance coverage to pre-Medicare adults would be partially offset by reduced Medicare expenditures when those persons later enrolled in that program,⁴¹⁹ especially for

412. *Id.* at 39.

413. *Id.*

414. Premium cost of \$7600 ÷ 1.05 = \$7238.

415. See Jonathan Gruber, *Health Insurance and the Labor Market*, in 1A HANDBOOK OF HEALTH ECONOMICS 645, 675 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (chart of chronic conditions by age cohort).

416. See Ctrs. for Medicare & Medicaid Servs., *supra* note 304, at 2.

417. CBO REPORT, *supra* note 404, at 39 (emphasis added).

418. *Id.* at 40.

419. J. Michael Williams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 NEW ENG. J. MED. 143, 151 (2007).

persons with cardiovascular disease or diabetes.⁴²⁰ On the other hand, the CBO cautioned that “such improvements in health status might also reduce the number of people who died before turning 65, which would increase outlays for Medicare.”⁴²¹

As for the number of people who would enroll in the program, the CBO report estimated this number as 300,000,⁴²² assuming no premium subsidy would be offered. But the number of enrollees will undoubtedly increase if younger-age persons are eligible, and even more so if the government provides a substantial premium subsidy, as the legislative proposals considered previously provide. The degree of premium subsidy, in other words, is a budget variable that Congress can use to adjust the scope of the program. That is, if the subsidy is low, either in dollar terms or as a percentage of the premium cost, then fewer eligible retirees are likely to participate. But if the subsidy is large, then more eligible retirees will probably participate, thereby raising associated program costs.

Notwithstanding these uncertainties, what would a subsidized early access Medicare program cost? Using the CBO’s per-person estimate of \$7600 (which includes administrative expenses), a 75% subsidy translates into a governmental cost of \$5700 per enrollee. The most likely retirees who would enroll in this program are those who are either uninsured presently or who have individually issued health insurance policies. According to the most recent Census Bureau data, the number of fifty-five to sixty-four-year-olds in these two categories is 7,248,000.⁴²³ Multiplying the \$5700 per-person cost by this population produces a projected government outlay of over \$41 billion.⁴²⁴

This estimate, however, is subject to several major caveats. It is undoubtedly inflated because it is based on the CBO’s per-person cost, which ignores the lower per-person cost that would be obtained if retirees under age sixty-two were included in the program. The estimate is also inflated because it ignores the offsetting benefits of providing better access to health care for pre-Medicare retirees. It is further inflated because it assumes that every retiree who is eligible for the program will choose to enroll in it. But many low-income retirees will not be able to afford the 25% portion of the premium cost that enrollees themselves must pay. To the extent that there will be nonparticipating retirees, therefore, the

420. *Id.*; see also Jack Hadley & Timothy Waidmann, *Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries*, 41 HEALTH SERVICES RES. 429 (2006) (extending health coverage to persons aged fifty-five to sixty-four could offset some of the cost of that coverage with improved health at age sixty-five).

421. CBO REPORT, *supra* note 404, at 40.

422. *Id.*

423. Among fifty-five to sixty-four-year-olds, 4,011,000 had no health insurance and 3,237,000 had individual coverage in 2007. See DENAVAS-WALT, PROCTOR & SMITH, *supra* note 307, at 69.

424. $\$5700 \times 7,248,000 = \$41,313,600,000$.

early access program will cost less than the \$41 billion estimate derived above. On the other hand, the program's cost will exceed this estimate if employers continue to abandon their existing retiree health benefit arrangements, thereby increasing the number of early retirees without adequate health insurance.

Whatever the cost of this program may be, the question of whether the government should extend the social safety net to pre-Medicare retirees is ultimately a normative matter for the political process to resolve. As noted in Part II of this Article, many early retirees believed for decades that their future health care costs would be covered. They placed their faith in the promises of retiree health benefits that their employers made as part of their compensation packages. Had these retirees realized just how ephemeral those promises were, they might have sought other employment or at least higher wages in lieu of retiree health benefits. But now, it is too late for them to pursue those alternatives.

Perhaps the government should have warned prospective retirees to discount employer assurances as meaningless inducements subject to cancellation at a corporate whim, or at least subject to the unknowable vagaries of future economic conditions. Alternatively, Congress could have provided more effective tax incentives for employers to prefund retiree health benefits,⁴²⁵ complete with a government agency guarantee in case of employer bankruptcy,⁴²⁶ akin to the elaborate structure created by ERISA to give pensions the reliability they currently have. When that statute was enacted, the focus was on pensions because they were already significant obligations. The unanticipated increase in the value of retiree health benefits, however, makes these benefits equally worthy of legal protection. But even if Congress acted along these lines tomorrow, such an enactment would provide no benefit for the generation of current and near-term prospective retirees whose health benefits have been curtailed or eliminated outright.

Instead, the courts eviscerated retirees' reasonable expectations by focusing on obscure clauses in impenetrable plan documents without regard to the retirees' level of education, the length of those documents, or the content of employer-provided "general" information. Only long after the fact have retirees learned that employer promises of future health benefits are not what they seemed. Throughout the course of the litigation analyzed previously in this Article, Congress provided no relief—either prospective or remedial—to the innocent victims of these employment benefit "interpretations." Having allowed this state

425. See CONG. RESEARCH SERV., EMPLOYER-SPONSORED RETIREE HEALTH INSURANCE: AN ENDANGERED BENEFIT? 10 (2006) (on file with the Journal) ("The tax code in general does not provide as favorable a tax treatment for prefunding of retiree health benefits as for pension benefits."); EMPLOYEE BENEFIT RESEARCH INST., FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 268 (6th ed. 2009).

426. See FROLIK & KAPLAN, *supra* note 8, at 361 (explaining the function of the Pension Benefit Guaranty Corporation and the scope of its protection).

of affairs to develop, it falls to the government to address these retirees' claims of broken promises.

Extending access to Medicare would advance the original premise of the program—namely, to provide health insurance when private insurers are unwilling to do so.⁴²⁷ Moreover, this extension accords with the sentiments of a substantial majority of Americans regarding access to health care generally. A September 2007 survey conducted by the Harris Poll organization posed the following question: “To what extent do you personally agree or disagree with the following statement . . . ‘It is the government’s duty to ensure that all Americans have adequate healthcare coverage?’”⁴²⁸ Nearly two-thirds of the survey respondents agreed with this statement, including almost half of all self-identified Republicans.⁴²⁹ Thus, expanding Medicare to cover “early” retirees would accord with people’s general conception of the proper role of government regarding health care.

3. Possible Impact on Existing Retiree Health Benefit Plans

One extremely important caveat regarding a proposed extension of Medicare to “early” retirees involves existing employer-provided retiree health plans—namely, would the availability of such a government-subsidized program further encourage employers to drop or substantially curtail their current retiree health benefit arrangements?⁴³⁰ If so, many of the affected retirees would actually be worse off financially. For the most part, employer-provided retiree health benefit plans are easier to understand, more comprehensive, and less expensive than the current Medicare program with its separate components for physicians’ fees, prescription drugs, and Medigap coverage.⁴³¹ Consequently, extending Medicare availability to “early” retirees might be resisted by individuals who fear that their

427. See Marilyn Moon, *Retiree Health Care: Individuals Picking Up Bigger Tab*, TIAA-CREF INST. TRENDS & ISSUES, July 2005, at 3, available at http://www.tiaa-crefinstitute.org/pdf/research/trends_issues/tr070105.pdf; see also FINKEL & RUCHLIN, *supra* note 14, at 62 (“[H]ealth insurance for the elderly person was generally unavailable as a commercial product before 1965.”).

428. *WSJ.com/Harris Interactive Survey Finds That Senator Hillary Clinton Most Trusted on Healthcare Policy Issues, but Trust is Declining*, HEALTH CARE POLL, Oct. 4, 2007, at 5, http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/Hi_WSJ_HealthCarePoll_2007_v06_i16.pdf.

429. *Id.* at 6.

430. See Rappaport & Malone, *supra* note 47, at 86 (stating that “it seems likely that many employers would no longer sponsor retiree health benefit coverage” if Medicare’s eligibility age were reduced).

431. See *supra* text accompanying notes 287-298; see also JOHNSON, *supra* note 19, at 4 (reporting that monthly premiums for Medigap coverage in 2004 were more than double the median monthly retiree contribution in employer-sponsored retiree benefit plans).

former employers will use this new development as an excuse to alter or abandon their present retiree health benefit obligations.

This specific issue of Medicare substitution or “crowd out” was raised during the extensive negotiations that took place when a prescription drug benefit for Medicare was being considered in 2003. With employers eager to rid themselves of retiree health benefit plans anyway, many retirees and policymakers were extremely concerned that a new government-funded alternative for prescription drugs would only make matters worse for persons who currently had retiree health benefits.⁴³² After all, the cost of prescription medications accounts for almost two-thirds of the expense of a typical employer-sponsored retiree health benefits plan.⁴³³ The political imperative, therefore, was “first, do no harm,” a requirement that almost derailed the Medicare prescription drug bill’s very enactment.⁴³⁴

In the end, Congress added an incentive in the form of a federal subsidy equal to 28% of an employer’s annual cost of providing prescription medications of more than \$295 and less than \$6000 (in 2009) per person.⁴³⁵ In effect, employers that offer qualifying drug coverage can receive an annual federal subsidy of as much as \$1597 (in 2009) per covered retiree.⁴³⁶ This subsidy, moreover, is free of federal income tax,⁴³⁷ and does not reduce the employer’s allowable federal income tax deduction for the cost of this expense.⁴³⁸ That deduction is equivalent to a further federal subsidy of as much as 35%, depending upon the employer’s tax bracket.⁴³⁹ But even employers who face no current federal income obligation—such as charitable organizations, state and local governments, and profit-seeking enterprises with significant tax loss carryforwards⁴⁴⁰—can benefit from the 28% federal subsidy.

The critical question, of course, is whether this federal subsidy, perhaps

432. See Patricia Barry, *Anxiety Zone: Will the New Medicare Law Encourage Employers To Drop or Keep Their Retiree Drug Plans?*, AARP BULLETIN, Feb. 2005, at 14; FRONSTIN, *supra* note 22, at 8, 10; Frank B. McArdle et al., *Large Firms’ Retiree Health Benefits Before Medicare Reform: 2003 Survey Results*, HEALTH AFFAIRS, Jan. 2004, at w4-7 available at <http://content.healthaffairs.org/webexclusives/index.dtl?year=2004>.

433. See Schieber, *supra* note 55, at 10.

434. See Laurie McGinley et al., *A Guide to Who Wins and Loses in Medicare Bill*, WALL ST. J., Nov. 18, 2003, at B1.

435. 42 U.S.C. § 1395w-132(a)(3)(A), (B) (2000); Memorandum from Abby L. Block & Paul Spitalnic to All Medicare Advantage Orgs., Prescription Drug Plan Sponsors, and Other Interested Parties 33 (Apr. 7, 2008), available at <http://www.cms.hhs.gov/MedicareAdvgtgSpecRateStats/Downloads/Announcement2009.pdf>.

436. $\$6000 - \$295 = \$5705 \times 28\% = \$1,597.40$.

437. I.R.C. § 139A (2008).

438. *Id.* § 162(a)(1).

439. *Id.* § 11(b)(1) (specifying the corporate income tax rate structure).

440. See *id.* § 172.

combined with the income tax deduction, is sufficient to forestall reductions in employer-provided retiree health benefits. Medicare's prescription drug benefit first became available in 2006,⁴⁴¹ so the results of this natural experiment are still too tentative for a definitive assessment, but early returns are encouraging. Kaiser/Hewitt surveyed private-sector employers with at least 1000 employees who offered retiree health benefits in 2006.⁴⁴² Of this group, only 8% of employers terminated their drug coverage for Medicare-eligible retirees.⁴⁴³ Fully 82% of employers surveyed offered prescription drug coverage that qualified for the tax-free subsidy, and the remainder created a supplement or other type of drug coverage.⁴⁴⁴ To be sure, this group of employers is a rarefied collection, but they comprise 22% of all Fortune 500 companies and are the most likely to offer retiree health benefits generally.⁴⁴⁵ This group indicated, moreover, that they planned to maintain their existing arrangements for the near future,⁴⁴⁶ but there is obviously no way to know for certain whether that will, in fact, be the case. Thus, although Medicare's drug benefit might lead to further reductions in retiree health benefits, the evidence available thus far suggests that the financial incentives created to forestall such reductions have done so. Perhaps, similar financial incentives for employers could be added to an early access Medicare program to prevent or minimize reductions of employer-sponsored retiree health benefit plans.

4. Potential Impact on Retirement Decisions

As noted at the outset of this Article,⁴⁴⁷ the availability of health insurance is often a major factor in timing one's retirement. Indeed, one analyst has observed that "[p]ension and retiree health benefits also have been used to encourage and enable older workers to retire, to create openings for younger workers, and to increase overall productivity."⁴⁴⁸ This phenomenon, however, is not an unbridled societal good. As the same analyst notes, when early retirement is facilitated, "able-bodied workers are removed prematurely from the workplace, the tax base is reduced, and the demand for public benefits is consequently increased."⁴⁴⁹ The essential question, therefore, is whether and to what extent early access to

441. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101(a)(2), 117 Stat. 2066, 2071 (2003) (codified as amended at 42 U.S.C. § 1395w-101(a)(2)).

442. KAISER/HEWITT SURVEY, *supra* note 7, at 2.

443. *Id.* at 24.

444. *Id.*

445. *Id.* at 2.

446. *Id.* at 25.

447. *See supra* note 5 and accompanying text.

448. Atkins, *supra* note 29, at 100, 109.

449. *Id.* at 120.

Medicare would precipitate retirements that would not otherwise take place.

A comprehensive examination of continuation health insurance among men aged fifty-five to sixty-four years suggests that the impact on induced retirement is rather small.⁴⁵⁰ The researchers looked at actual data and concluded that “one year of [continuation health] coverage raised the probability of being retired by about 1.1 percentage points.”⁴⁵¹ Furthermore, such coverage apparently “provide[d] insurance coverage for individuals who would have retired in the absence of [such coverage] even though they would not have been covered by employer-provided health insurance.”⁴⁵² These authors admit, however, that continuation health coverage is more expensive than retiree health insurance and severely time-limited.⁴⁵³ Such insurance, in contrast, would be more likely to affect retirement timing decisions, depending on the scope of its coverage.⁴⁵⁴

A different study created a simulation model to examine this issue theoretically.⁴⁵⁵ According to the model-builders, the impact of lowering Medicare’s eligibility age to sixty-two “would raise retirement rates for both men and women by 7%,” a result that they characterized as “small.”⁴⁵⁶ The Medicare early access proposal that they considered, however, did not apply to persons younger than age sixty-two, so it is possible that the increase in retirement rates might be larger if the eligibility age were fifty-five years instead. On the other hand, the authors noted that “[t]he retirement effects of an expansion of the Medicare program would be *even smaller* if near-elderly adults could obtain Medicare coverage only by buying into the program and paying substantial premiums.”⁴⁵⁷ Accordingly, if induced premature retirement is a major concern of policymakers, they could adjust the effective cost-sharing ratio and make it less generous than the 25-75 split that the current proposals envision.⁴⁵⁸ While hardly a perfect solution, such a trade-off might balance the need of older retirees

450. See Jonathan Gruber & Brigitte C. Madrian, *Health Insurance and Early Retirement: Evidence from the Availability of Continuation Coverage*, in *ADVANCES IN THE ECONOMICS OF AGING* 115 (David A. Wise ed., 1996).

451. *Id.* at 140.

452. *Id.*

453. *Id.* at 141.

454. See Janet Currie & Brigitte C. Madrian, *Health, Health Insurance and the Labor Market*, in *3C HANDBOOK OF LABOR ECONOMICS* 3309, 3379 (Orley Ashenfelter & David Card eds., 1999).

455. See Richard W. Johnson, Amy J. Davidoff & Kevin Perese, *Health Insurance Costs and Early Retirement Decisions*, 56 *INDUS. & LAB. REL. REV.* 716 (2003).

456. *Id.* at 726; see also Melissa A. Boyle & Joanna N. Lahey, *Health Insurance and the Labor Supply Decisions of Older Workers: Evidence from the U.S. Department of Veteran Affairs* (Ctr. for Ret. Research at Boston Coll., Working Paper No. 2007-23, 2007), available at <http://www.bc.edu/crr> (expansion of the Veterans Affairs health care system’s coverage led to “a 2.3% increase in the probability that a treated individual reports being retired”).

457. Johnson, *supra* note 455, at 726 (emphasis added).

458. See *supra* text accompanying notes 396-402.

for some sort of reliable health insurance with society's desire to limit unintended early retirements.

At bottom, of course, the timing of any individual's withdrawal from regular employment is determined by many factors—both financial and nonfinancial. And some particularly salient factors, such as overall health status,⁴⁵⁹ are largely beyond the control of the prospective retiree. Nonetheless, the potential impact of early access to Medicare on retirement, at least at the proverbial margin, cannot be ignored.

CONCLUSION

The United States is presently in the midst of an unprecedented expansion of its older population. The numbers of Americans in the “early” retiree cohort of age fifty-five to sixty-four years and the “typical” retiree cohort of age sixty-five and older are expected to increase dramatically, as Figure 2 indicates:⁴⁶⁰

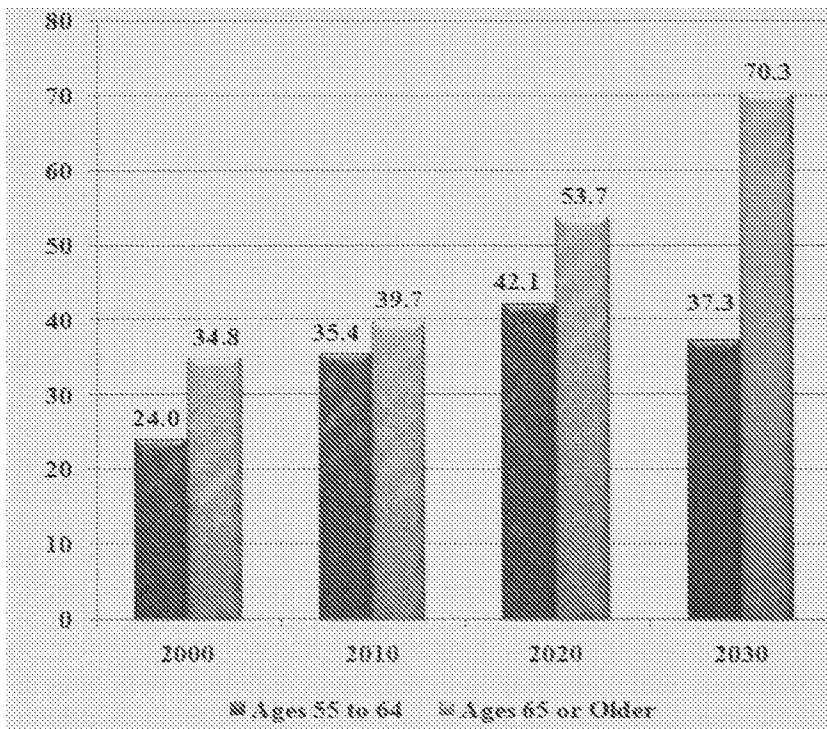


FIGURE 2: Projected Population (in Millions)

Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex with Special Age Categories: Middle Series," selected years 2000 to 2030, January 2000.

For these two cohorts, employer-provided health insurance is an essential

459. See Johnson, *supra* note 455, at 726.

460. U.S. GEN. ACCOUNTING OFFICE, *supra* note 21, at 18.

pillar of their anticipated retirement, and especially so for the pre-sixty-five group that generally cannot yet enroll in Medicare.

But the status of post-employment health benefits is already precarious and likely to become even more precarious in the future. Premium increases and benefit cutbacks, as well as outright plan terminations, have become commonplace throughout the private sector and may start appearing among public sector employers as well due to newly effective accounting disclosure requirements. An important study of retiree health benefits concluded that “[t]hese benefits should be viewed not as a gift but as a form of deferred compensation which cannot be abrogated by the employer.”⁴⁶¹ This Article has demonstrated, however, that such abrogation is widespread and that legal recourse has limited effect. Barring unusually restrictive contract language, employers have been allowed to alter and even end retiree health benefits that had been part of their firm’s culture, literally, for generations.⁴⁶²

Into this abyss, Medicare appears as a distinctly “second best” solution. Age-eligible retirees are almost always worse off with Medicare’s disjointed multi-faceted programs than they were under their former employer’s retiree health benefit plan.⁴⁶³ Like the old Catskills complaint about the food tasting terrible and the portions being small, Medicare generally offers less coordination of benefits, more complexity, and higher cost.

Retirees who are not yet age-eligible for Medicare, however, are in even worse straits. Beyond limited continuation coverage, such retirees must try to secure health insurance in the individual market, but there is a very high likelihood that such coverage will be expensive, unaffordable, or unobtainable. Health savings accounts have limited appeal to these retirees, as such accounts must be accompanied by a “high-deductible” health insurance policy that may or may not be available, depending upon medical underwriting criteria.

For this group, early access to Medicare is likely to be the better approach. Cost considerations, possible crowd out of existing retiree health benefits, and some impact on induced early retirement are certainly important issues to address. But the essential feature of extending Medicare’s universal health coverage to persons younger than age sixty-five is an idea whose urgency has only increased since it was first introduced a decade ago. Further delay is

461. FINKEL & RUCHLIN, *supra* note 14, at 118.

462. *See, e.g.,* Vanessa Fuhrmans & Theo Francis, *Retiree Benefits Take Another Hit*, WALL ST. J., July 16, 2008, at D1 (“Even those who are in or near retirement shouldn’t count on keeping the company coverage they have built up.”).

463. *See* DALE YAMAMOTO, TRICIA NEUMAN & MICHELLE KITCHMAN STROLLO, HOW DOES THE BENEFIT VALUE OF MEDICARE COMPARE TO THE BENEFIT VALUE OF TYPICAL LARGE EMPLOYER PLANS? 3 (Kaiser Family Found., Medicare Issue Brief, 2008), *available at* <http://www.kff.org/medicare/upload/7768.pdf> (finding that even with the new prescription drug benefit, Medicare’s benefit value is lower than the typical large employer plan by more than \$1500).

increasingly untenable and unwarranted.

The political climate for resolving this problem may, in fact, be at hand. President Obama has declared that health care reform is an essential component of the more general economic recovery effort, stating that reforming health care is “not something that we can sort of put off because we’re in an emergency. This is part of the emergency.”⁴⁶⁴ Insuring the uninsured will likely be a major part of this initiative, and the ranks of the uninsured include many early retirees.

Moreover, the chair of the Senate Finance Committee, which has jurisdiction over the Medicare program, included early access to Medicare as part of his “Call to Action: Health Reform 2009” white paper.⁴⁶⁵ This document is a high-concept proposal with few specifics, but it explains that persons aged fifty-five to sixty-four years “face greater risk of illness than their younger counterparts . . . [but] have fewer and fewer affordable insurance options.”⁴⁶⁶ The document proposes that “Medicare would charge enrollees electing the buy-in option an annual premium . . . [such] that the total costs for the buy-in population would be budget neutral,”⁴⁶⁷ asserting that “this option would not create new costs for the Medicare program or for taxpayers.”⁴⁶⁸ Perhaps under the new administration, retirees younger than age sixty-five will finally see change they can believe in.

464. Transcript of Obama’s Health Care Briefing, Dec. 11, 2008, <http://www.nytimes.com/2008/12/11/us/politics/11text-obama.html?emc=eta1> (last visited Apr. 20, 2009); see also Jonathan Gruber, *Universal Health Insurance Coverage or Economic Relief—A False Choice*, 360 NEW ENG. J. MED. 437, 439 (2009) (noting that “universal health coverage for our citizens, can improve both individual health and the economy’s health, both today and in the long run”).

465. MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009, at 21-22 (2008), available at <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>.

466. *Id.* at 21.

467. *Id.* at 21-22.

468. *Id.* at 22.