Retiree Health Benefit Plans: Modifying and Terminating Legacy Benefits
Evaluating the Alternatives to Contain Costs and Minimize Litigation

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today’s panel features:
Stanley Baum, Partner, Fellheimer & Eichen, Philadelphia

Tuesday, January 12, 2010
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Key Issues For Employers Seeking to Modify or Terminate Retiree Health Benefits

James P. McElligott, Jr., Richmond, Virginia
804-775-4329  jmcelligott@mcguirewoods.com
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Challenges in Predicting and Controlling Retiree Health Costs in the Future.

• Health care for current employees: relentlessly increasing cost, need for financial limits, greater employee contributions, consumer directed health care and wellness strategies. Some changes in design of plans is likely in the future, particularly for retiree medical.
• For example, health care reform bills would repeal tax deduction companies get for funding the Medicare Part D subsidy.
• Under what circumstances can the company redesign or terminate a retiree’s health benefits?
• FASB 106 requires companies to account for OPEB (“Other Post Employment Benefits) in financial reports.
• GASB 45 requires public entities to account for OPEB on financials. State and local government bodies often have huge unfunded liabilities.
Employer with Unions Face Special Problems in Designing Benefit Plans

• Need Union agreement to new design or termination of former plan structure.
• Changing healthcare or retirement are hot issues for union membership.
• Union leadership often more concerned with hanging on to current benefits and staying in power than in working with the company to address the issues.
Legal Structure for Public Employers

• ERISA, NLRA, LMRA do not apply to government employers
• State public employer bargaining laws
• State statutes
• State constitutions
• Local ordinances
• State and local government promises contained in policy manual, employee handbooks, communications
• State contract law
• Internal Revenue Code and regulations
• Governmental Accounting Standards Board Regulation Statement No. 45
• Where there’s disagreement over the nature of the promise, jury trial, or arbitration (in some states) may be involved.
The Statutory And Regulatory Framework For Private Sector Employers

Federal labor law, ERISA, and Internal Revenue Code *all* apply to collectively bargained retirement and welfare benefits (health, life, disability, severance, etc.)

1. National Labor Relations Act
2. Labor Management Relations Act
3. ERISA, DOL regs, IRS regs.
Labor Agreements & SPD’s Control

Collective Bargaining Agreement ("CBA") and the ERISA plan documents are the key legal documents for courts, arbitrators, and NLRB to interpret in determining what benefits promises have been made and to what extent an employer may amend/terminate future benefits (such as retiree health benefits).
Benefits Bargaining under the NLRA and ERISA

• NLRA requires the employer and union to meet, confer, and negotiate in good faith.
• Duty to bargain extends to “wages, hours and other terms and conditions of employment,” which include pension and welfare benefits.
• The above subjects of bargaining are mandatory where bargaining is timely.
• NLRA does not require the parties to agree.
How Much Benefit Detail to Bargain?

- Courts and the NLRB have sometimes found that a change in an insurer or TPA can be a mandatory subject of bargaining, depending on the circumstances.
- The employer wants as much authority as possible in the CBA so that the employer can administer the plan, change providers, and even make design changes.
CBAs May Incorporate Plan (or SPD) by Reference

• Many CBAs incorporate the summary plan description by reference.
• Courts have enforced very broad SPD language (for example, giving the employer the unilateral right to amend or terminate the plan) where CBA provided that SPD was part of CBA. *U.A.W. v. Rockford Powertrain*, 350 F.3d. 698 (7th Cir. 2003).
• As a result, Unions now read SPDs very carefully.
Retiree Medical Benefits

Whether or not an employer has the right to modify retiree medical benefits depends on:

1. Interpretation of CBA (if any), and
2. Interpretation of medical plan documents, and
3. Interpretation of employer pronouncements/practices with regard to retirees
4. In public sector, look to statutes, ordinances and constitutional provisions.
Bargaining Benefits of Current Retirees

- Future retiree benefits of current employees are a mandatory subject of bargaining. *Mississippi Power Co. v. NLRB*, 284 F.3d 605, 614 (5th Cir. 2002).
- Generally current retirees cannot enforce benefit claims under grievance/arbitration provisions of CBA.
- Retirees sue under Section 301 of the LMRA (jury trial may be available) to enforce the CBA and/or ERISA (no jury trial) to enforce the plan document.
Vesting of benefits - the key issue in Retiree Medical

- Benefits that have "vested" may not be amended or terminated.
- Courts look to the CBA and the ERISA plan documents to determine whether vesting has occurred.
- There is no obligation to vest retiree health benefits under ERISA, but an employer may contractually agree to vest benefits. “[U]nless an employer contractually cedes its freedom, it is generally free under ERISA, for any reason at any time, to adopt, modify, or terminate its welfare plan.” *Inter-Modal Rail Employees Ass’n v. Atchison, Topeka and Santa Fe Ry. Co.*, 520 U.S. 510 at 515 (1997).
Vesting of benefits - the key issue (continued)

- Whether a company has promised to vest retiree medical benefits is a question of interpretation of the CBA and medical plan.
- Where the CBA is unambiguous, a court will decide the issue by interpreting it as a matter of law.
- If the agreement is ambiguous, interpretation of the agreement becomes a factual issue for a jury to decide at trial.
- In a jury trial, court may admit other evidence such as testimony about intent and past practices as part of the trial evidence.
- In the public sector, issue may turn on interpretation of statute, ordinance or state constitution.
Reservation of Rights Clause Avoids Vesting Claims

- A reservation of rights clause in a benefit plan document gives the employer an unambiguous right to modify the language of the ERISA contract at its discretion. *U.A.W. v. Rockford Powertrain, Inc.*, 350 F.3d. 698 (7th Cir. 2003).

- *Vallone v. CNA Financial Corp.*, 375 F.3d 623 (7th Cir. 2004) (dealing with the issue of "lifetime" benefits contained in an agreement that also has a reservation of rights clause).
Variations on Vesting/Lack of Vesting

- Company has unilateral right to amend or terminate current retiree’s health benefits. (Salaried employees).
- Seventh Circuit adopts a presumption that current retiree’s rights to health benefits are fixed only for the term of the contract. Company can renegotiate different benefits for current retirees when CBA expires. Some courts assume this unless contrary language or evidence. *Rossetto v Pabst*, 217 F.3d 539 (7th Cir. 2000)
- Sixth Circuit adopts a presumption that retirees are vested once they retire unless contrary language in CBA/SPD. (*Autoworkers v Yard-Man*, 716 F.2d 1476 (6th Cir. 1983)
- Other Circuits all over the lot, but essentially courts attempt to interpret the CBA/SPD under principles of contract interpretation.
Right to Jury Trial?

• Generally no jury trial in ERISA benefits suit.
• Courts split on whether jury trial is available under benefits suit under LMRA.
  – Recent cases have focused on equitable relief needed and denied jury trial. *Reese v. CNH America*, 574 F.3d 315 (6th Cir. 2009).
Class Actions

- Litigation over changes in retiree medical are natural class actions under Rule 23.
- Some employers have attempted “reverse class actions” and raced the plaintiffs to file first to obtain favorable venue.
- Advantages of class action is the ability to bind the entire class, frequently with a settlement, to a definite arrangement.
- Auto manufacturers and UAW structured their VEBA retiree medical plan with a class action settlement.
Claims Based on Breach of Fiduciary Duty

- Third Circuit held that Unisys breached ERISA fiduciary duties by misleading retirees into believing that they would have free or low-cost health benefits for life. *In re Unisys Corp. Retiree Med. Benefits ERISA Litig.*, (3d Cir., No. 07-3369, September 2, 2009).

- According to Third Circuit, Plaintiff must prove: (i) defendant acted in fiduciary capacity, (ii) defendant made affirmative misrepresentations or failed to adequately inform plan participants, (iii) misrepresentation or inadequate disclosure was material and (iv) plaintiff detrimentally relied on the misrepresentation or inadequate disclosure.

- Second Circuit held in *Ladouceur v. Credit Lyonnais* (2nd Cir. September 2009) that plaintiffs could not prevail on a breach-of-fiduciary-duty claim based on oral representations made by employer purporting to alter an ERISA benefit plan.
Avoid inconsistent or ambiguous language regarding benefits entitlements in plan documents and employee communications.

- If you don’t talk and act like you have the right to amend, a court may find you don’t have that right.
- Guard against declarations of company officials regarding "lifetime" benefits.
The Language You Want Will Be Language the Union Hates.

- Strike by 70,000 grocery store workers in Southern California focused on the employer’s demand that the employees begin to contribute a portion of the cost of health care coverage ($5.00 a week for employees and $15.00 a week for their families).
If you don't protect your ability to amend/terminate your plan, you can face:

1. High stakes class litigation…
2. by motivated retirees with time to devote to challenge the change in benefits.
3. Jury trial that determines whether the company has agreed that retiree medical vests upon retirement.
Doing your Homework

• Evaluate the CBA and plan terms
  – Study existing contract language to determine what changes need to be made
  – Collect all union plan documents, SPDs, contracts, amendments, and employee communications to determine obligations.
Win Flexibility At The Table

- CBA and plan language ideally should allow change of carriers, deductibles, features, investment options, etc. without union interference
- Some companies use CBA language to cap company costs
- Be firm but realistic in working toward these goals
Companies are rapidly reducing or eliminating retiree medical subsidies

- From 1993 to 2005, the per cent of employers with 500+ employees offering pre-Medicare Retiree Health declined from 47% to 32%.
Options

- Pre-fund the benefit through a VEBA, Section 501(c)(9) trusts, Public employers may prefer to use Internal Revenue Code §115 accounts.
- Internal Revenue Code §401(h) medical subaccounts within qualified defined benefit pension plans.
- Reduce or eliminate the benefit, perhaps on a “grandfathered” basis.
- Cap the benefit (widely used, often not enforced in union settings)
- Defined Contribution Plans: HRAs, HSAs
- Discourage early retirement
EEOC Rule on Coordination of Retiree Medical with Medicare

- Third Circuit upheld EEOC’s regulation exempting retiree medical from age discrimination rules in coordinating retiree health benefits with Medicare. *AARP v. EEOC*, No. 05-4594 (3rd Cir. 2007).

- *Erie County Retirees Ass’n v. County of Erie*, 220 F.3d 193 (3d Cir. 2000) had held that the ADEA did not permit reduction of retiree health benefits upon Medicare eligibility, absent compliance with ADEA standards of “equal benefit or equal cost.”

- EEOC’s proposed rule exempts from the ADEA “the practice of altering, reducing or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or a State-sponsored Retiree Health Benefits Program.” This permits the common practice of decreasing retiree health benefits when retirees become eligible for Medicare, a coordination of benefits that does not meet the technical requirements of the “equal benefit or equal cost” of the ADEA, 29 U.S.C. § 623(f)(2)(B)(i). The EEOC exemption recognizes the need to “bridge” pre-65 retirees until they are eligible for Medicare health coverage.
Health Reform Developments

• Section 110 of the House Bill would create a new ERISA Section 717 that would generally prohibit employers from 1) increasing a retiree’s share of the cost of coverage by more than 5% or 2) reducing the actuarial value of the retiree’s benefit package by more than 5%.
• Under House Bill, reductions in retiree medical permissible only if equivalent reduction made to active employees or if employer gets DOL waiver for undue hardship. Section 717 would be effective immediately on the date of the enactment of healthcare reform legislation.
• No comparable provision in Senate’s healthcare reform bill, the Patient Protection and Affordable Care Act, passed by Senate.
• Both House and Senate bills would repeal tax deduction for funding Medicare Part D subsidy.
Changes to Retiree Health Benefits in Bankruptcy

James P. McElligott, Jr.
One James Center, Richmond, Virginia 23219
804-775-4329 jmcelligott@mcguirewoods.com
www.mcguirewoods.com
Bankruptcy Code Section 1114

- Employer who files for bankruptcy under Chapter 11 may not unilaterally terminate or modify retiree welfare benefits provided at time of bankruptcy. 11 U.S.C. §1114(a).
- Retiree benefits modified or terminated within 180 days before Chapter 11 filing when employer insolvent must be reinstated unless balance of equities clearly favors the modifications. 11 U.S.C. §1114(l).
Suppose Employer Has Contractual Right to Modify or Terminate?

• Most courts say §1114 does not apply where employer has right to modify or terminate benefits. See e.g., In re *CF&I Fabricators*, 163 B.R. 858 (Bankr. D. Utah 1994).

• Some Courts require debtors to comply with §1114 even if debtor has contractual right to amend. See *In re Farmland Indus.*, 294 B.R. 903 (Bankr. W.D. Mo. 2003).
Section 1114 Procedures

• Debtor or bankruptcy trustee must negotiate with representative of retirees (union in case of CBA or representative appointed by Court).
• If no agreement reached, debtor may seek court-approved changes in benefits if
  – Debtor has made proposal meeting §1114 requirements;
  – Authorized representative has refused to accept it without good cause;
  – Balance of equities clearly favors modification.
James P. McElligott, Jr.

Mr. McElligott is a partner in the Richmond, Virginia office of McGuireWoods LLP. He handles employee benefits, executive compensation, and labor relations matters for employers and fiduciaries, and has an active litigation and arbitration practice. He is a Fellow of the College of Labor and Employment Attorneys, and is listed in Chambers USA, Best Lawyers in America, and SuperLawyers under both Employee Benefits and Labor and Employment.

Mr. McElligott is a member of the Employee Benefits Committees of the ABA Sections of Labor and Employment Law and Taxation, a member of the US Chamber of Commerce Employee Benefits Committee, former President of the Federal Bar Association, Richmond Chapter, and former president of the Central Virginia Employee Benefits Council. Mr. McElligott is a Phi Beta Kappa graduate of the University of Illinois and received his law degree, cum laude, from Harvard Law School, where he served as Note Editor on the Harvard Journal on Legislation.
THE END

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Stanley Baum
Fellheimer & Eichen
Philadelphia, PA
267.528.0270
Stanley@fellheimer.net
www.fellheimer.net
• **Can the Retiree Health Benefits Provided By An Employer Be Eliminated, Reduced or Modified?**

• Two ways to reduce or eliminate retiree benefits under ERISA:
  - Refute the claim that any were promised; or
  - Prove that employer reserved the right to reduce or eliminate any promised retiree health benefits

• ERISA does not prevent the modification or elimination of retiree benefits unless the employer has made a specific promise to maintain the benefits for a period after retirement
Where is this promise made?

• Formal plan document

• Collective bargaining agreement

• Insurance contract

• Summary plan description ("SPD"): provided to employee within 90 days after he/she becomes a participant in the plan.

• For retirees, the plan documents that were in effect when he/she retired will likely be the controlling documents.
What does this promise to maintain the retiree health benefits look like?

- Promise must specifically describe health benefits that will continue after retirement, AND

- State that the retiree health benefits will continue at a specified level for a certain period of time, e.g., for life.
Examples:

- "Basic health care coverage will be provided at the company's expense for your lifetime."
- “Retired employees, after meeting age and service requirements will receive health insurance, and this insurance will continue for the retirees for the remainder of their lives.”

This language has held up as a promise to maintain lifetime benefits. Since retiree benefits are not mandated by law, most courts require clear and express language to establish the promise of maintenance. If this standard of clarity is not met, or the language is otherwise too vague, then no promise is created.
**Consequences:**

- If a promise exists, benefits are vested – and cannot be altered, reduced or eliminated UNLESS

- A reservation of rights (ROR) clause in the plan documents provides that the employer has reserved the right to change the terms of the plan. Example: "The company reserves the right to modify, revoke, suspend, terminate, or change the health benefits, in whole or in part, at any time."

- If the plan documents have an unambiguous ROR clause -- even if it is “general” in that it applies to the whole plan as opposed to one or more specific benefits --- the courts interpret any promise of the lifetime benefits to be applicable so long as the employer does not choose to revise or terminate the benefits.
Tips for Drafting Reservation of Rights Clauses

• Keep it simple: “The company reserves its right to amend or terminate the plan at any time”

• Don’t add to it: “The company reserves its right to amend or terminate the plan at any time, *except for benefits to which the employees have become entitled*”
  – The added clause may well render the ROR clause ambiguous, and subject to extrinsic evidence, or at worst can itself establish that benefits have vested.
Enforcement Pitfalls

- Some courts may not enforce clear promise language if plan document contains general ROR language.
- Some courts have enforced clear promise language in a SPD where other plan documents contained ROR clause.
- If plan documents are ambiguous regarding benefits or ROR clause, or ambiguity stems from conflicting plan language, or more than one possible interpretation exists, courts consider extrinsic evidence to determine intent.
  - Company/employee testimony, letters, brochures, medical plan booklets, employee handbooks, other written materials, records of board meetings
  - Oral statements generally not evidence of intent -- have been exceptions
  - Individualized agreements with an employee control
• A collective bargaining agreement is the controlling document to determine whether benefits have vested or are negated by a ROR clause – intent of both employer and union.

• The outcome of a suit by former union members claiming entitlement to retiree health benefits depends largely on the circuit in which the suit is brought.

  -- If CBA language unambiguously describes the duration of the retirees’ benefits beyond the term of the CBA, and no there is no ROR clause, the court will enforce this language.

  -- When this language is ambiguous, courts vary in their (1) interpretation and application of the CBA, (2) use of extrinsic evidence, presumptions and inferences, thresholds and burdens of proof, and (3) determination of whether a plan document prevails over the CBA.
THEORIES OF ENFORCEMENT

Promissory Estoppel

Promissory estoppel in the ERISA context varies from circuit to circuit. Generally it arises when

– an employer makes a promise—here to provide non-terminal retiree health benefits for life—to its employees that is an intentional, knowing misrepresentation
– the promise is in writing (usually—see the Ladouceur case below)
– the promise is material
– the employees reasonably rely on the promise subsequent to its making (unaware of the true facts)
– to their detriment,
– in extraordinary and extreme circumstances, e.g., fraud, deception or intention to induce certain behavior.

• Promissory estoppel is best used to establish the right to retiree benefits base on a written promise outside of the plan documents.
Defenses

No reasonable reliance; e.g., A SPD or other plan document already provided or available says otherwise, particularly the unambiguous provisions of a plan

• No extraordinary circumstances. Oral promises have a tough time, due to ERISA’s written plan rule.
**Breach of Fiduciary Duty**

- Employer makes material misrepresentation as to the existence of retiree health benefits when
  - a fiduciary of a plan is acting in his/her capacity
  - the fiduciary makes a misrepresentation (in some circuits, it must be intentional; in others, it need not be)
  - the misrepresentation is material (materiality arises if there is a substantial likelihood that the statement would mislead a reasonable employee in making an adequately informed decision)
  - employees detrimentally rely on the misrepresentation.

- Here, you need a plan, and a plan fiduciary making statements about the plan, but the promise need not be in writing.
**Defenses**

- Statement was not made by a fiduciary -- an employee with authority over a plan
- Statement was not material
  - No detrimental reliance (but can’t point to ROR clause to show lack of reliance -- contrast to promissory estoppel). Example: There is an incorrect statement in an SPD. To obtain relief, the employee must show possible harm flowing from the statement.
Common defense: A release agreement, signed in exchanged for additional benefits like severance pay. (e.g., employee releases employer from “claims arising from or during employee’s employment or termination of employment with the company until the execution date of this release”).

– This precludes promissory estoppels and breach of fiduciary duty claims occurring prior to the signature date, but not likely after that date.

Why not breach of contract as a theory of recovery? ERISA preempts all laws-other than certain insurance laws-pertaining to employee benefits.
Recent Case Law

In re Unisys Corporation Retiree Medical Benefits ERISA Litigation, 579 F. 3d 220 (3d Cir. 2009) (9/2/09) -- retirees prevailed in claim for vested, unalterable health benefits, even though plan SPD contained an unambiguous ROR clause

- Unisys told employees eligible for retirement they could receive retiree health benefits under an existing plan if they retired prior to a certain date; human resource staff and other managers told employees that the cost of retirees benefits was $20/month until 65, and no cost after that.

- Several years later, Unisys terminated that plan and replaced it with another plan under which retirees were responsible for an increasing amount of the benefit cost for several years and then responsible for the full cost of coverage.

- Plaintiffs claimed breach of fiduciary duty based on manager statements that benefits were available for $20 per month/no charge. Unisys argued that this was a true statement because, at the time, it was not considering changes to the plan.
• Court determined that the statement was a “half truth” because there was no mention of the right to amend or terminate the plan in the future. Thus, the managers misrepresented the cost and duration of the benefits.

• Court rejected Unisys’ arguments that oral statements do not constitute affirmative misrepresentations that could be actionable.

• Court also rejected Unisys' reliance on the unambiguous statement in the SPD that Unisys retained the right to amend the plan under which the retiree health benefits were being provided. This argument failed since the SPD had not been provided at the time the statements in question had been made and after employees actually retired.

• Court found the misrepresentation to be material since there was a substantial likelihood it would mislead a reasonable employee when making an adequately informed decision about health benefits.
• Each plaintiff had to show detrimental reliance. Two could not -- one had been fired and other had settled with the company.
• Court held that Unisys was a fiduciary when making the statements in question through its managers.

**TAKE AWAYS**

• To preserve a right to amend, modify or terminate retiree health benefits, employer must give employees full and accurate documents, including clear ROR provisions and other information BEFORE retirement.
• Consider obtaining a signed acknowledgement of receipt of the materials.
• Train supervisory employees to be careful about what they say, and limit those individuals who are authorized to talk to employees about employee benefits
Ladouceur v. Credit Lyonnais, 584 F. 3d 510 (2d Cir. 2009) (9/30/09), citing its earlier case of Perreca v. Gluck, 295 F.3d 215, 225 (2d Cir. 2002) – held that oral promises are unenforceable under ERISA and therefore cannot vary the terms of an ERISA plan. Thus, an oral statement purporting to alter the terms of an ERISA benefit plan was insufficient to give rise to a claim for promissory estoppel or breach of fiduciary duty.

• If there is nothing in writing, employers should be able to refute a claim, based on promissory estoppel or breach of fiduciary duty, that retiree health benefits were promised.

• Retirees alleged that Deere had made repeated promises of lifetime health benefits while they were still employed. Deere denied that its managers made promises of lifetime medical benefits, and emphasized that the applicable plan documents unambiguously reserved the right to change the benefits as it deemed appropriate.

• One plan stated: “Deere & Company reserves the right to suspend or terminate the plan; to modify the Plan to provide different cost sharing between the Company and participants; or to amend the plan in any respect. Changes may occur at any time.

• Court found this was an unambiguous reservation of rights clauses that negated what Deere might have otherwise have promised.
Reese v. CNH America LLC, 574 F.3d 315 (6th Cir. 2009) (7/27/09) -- retirees sued for lifetime health benefits under a 1998 CBA, and for a declaration that the employer had to maintain the level of retiree health benefits then in effect.

- CBA language indicated an entitlement to retiree health benefits at no cost. CBA also tied eligibility for the health benefits to eligibility for pension benefits. While CBA limited duration of time of other benefits, it was silent as to duration of retiree benefits – i.e. whether the promise of the benefits extended beyond the term of the CBA.

- The court restated its familiar Yard-Man rule -- while there is no presumption that health benefits negotiated by the employer and union vest, there is an “inference” that it is unlikely that these benefits would be left to the contingencies of future negotiations (lasting beyond term of CBA) if there is either explicit language in the CBA indicating, or in the event of ambiguity, extrinsic evidence indicating, an intent to vest retiree health benefits.

- Using this presumption, the Sixth Circuit found that the language in the CBA in question was sufficient to vest the retiree health benefits.
• Using this presumption, the Sixth Circuit found that the language in the CBA in question was sufficient to vest the retiree health benefits.

• Interestingly, the applicable SPD had an ROR clause, but it also expressly stated that the CBA provisions controlled in the event of a conflict. The CBA was silent as to changes that could be made to the health benefits. The CBA itself and extrinsic evidence indicated that changes were permitted. Therefore, the court ruled that the employer could make reasonable changes to the health benefits, and remanded the case to the district court to determine the scope of these changes.
- **Schreiber v. Philips Display Components Co.**, 580 F. 3d 355 (6th Cir. 2009) (9/2/09) --CBA providing that retirees are entitled to health insurance coverage on same terms and same employee contribution level in effect for active employees and that insurance effective on signature date of CBA will remain in effect until a certain date. Court held provision ambiguous as to whether benefits were limited to the duration of the CBA, or were intended to last beyond the CBA and therefore vest. Court remanded and ordered lower court to review plan document and extrinsic evidence to determine parties’ intent.

- **Schreiber and Reese** indicate that employers need to insist on specific language in the CBA about retiree health benefits. They also raise interesting questions about the extent to which SPDs and other plan documents may establish vesting or the right to change/terminate the retiree health benefits, when the CBA is ambiguous.
• *Harps v. TRW Automotive U.S., LLC*, No. 09-3124 (6th Cir. 2009) (11/3/09). The court held that the following provision unambiguously disclaimed the employer’s obligation to provide retiree health benefits beyond the term of the CBA (so that there is no vesting): “This clause [the one establishing the health benefits] shall not be construed to convey any rights to those beyond the term of this agreement.”

• Every CBA should have a statement like this.
**Legislative Proposals**

- Health care reform bill passed by the House of Representatives on November 7, 2009, the "Affordable Health Care for America Act", contains a provision (Section 110) that limits the ability of a group health plan sponsor to reduce retiree medical benefits.

- Group health plans would be required to have a provision that "expressly" bars such plan (and any fiduciary thereof) from reducing health benefits to retirees (or beneficiaries) if the reduction affects the benefits provided as of the date of the individual’s retirement—*unless* the reduction is also made with respect to active participants under the group health plan. This statutory prohibition would override any ROR clause.

- Any employer thinking about revising/eliminating retiree health benefits might wish to act before this or any similar rule is enacted.
Voluntary Employees’ Beneficiary Association (VEBA)

An entity, normally a trust, established and maintained under Section 501(c)(9) of the Internal Revenue Code used by employers to pay for health, medical and life insurance benefits. It a tax-exempt entity (see UBTI exception below), so it is not taxed on its income and employer contributions grow tax-free.

VEBA subject to ERISA so there must be a plan document, a trust to hold assets and annual returns must be filed.
Requirements:

- No part of the VEBA’s earnings may be applied to the private benefit of any person --- must use funds to provide the benefits.

- Cannot use VEBA assets to pay unreasonable compensation for services or allow a reversion of assets to employer (e.g. cannot transfer amounts in VEBA to 401(h) account).

- Cannot provide a benefit to a member that is disproportionate to benefits provided to other members (unless provided pursuant to objective, nondiscriminatory standards).
• Beneficiaries must generally be employees with an employment-related common bond.
  – e.g., same employer, same union, same CBA, same line business
  – Must be an “employee” for purposes of employment taxes, a CBA or within meaning of LMRA

• Retirees can be covered if they were once an active employee.

• VEBA can consist entirely of retirees.

• 90% of members must be employees.
• VEBA cannot discriminate in favor of officers, shareholders or highly compensated individuals (HCIs)
  – Each class of benefits is provided under a classification of employees which does not discriminate in favor of HCIs (no discrimination as to eligibility) AND
  – Benefits in each class of benefits do not discriminate in favor of HCIs (no discrimination as to benefit types and amounts)
• Nondiscrimination requirement does not apply if VEBA maintained pursuant to a CBA.
• If VEBA is self-funded, nondiscrimination requirements of IRS section 105(h) will apply instead.
• Benefits must be limited to life, health, accident or similar benefits (must protect health or earning power, not pension/like benefits) in cash or noncash form.

  – Must be provided to members, spouses and dependents. A “dependent” is either
    • a child of a member or spouse who is a minor or a student, or who resides with the member, or
    • an individual that the VEBA believes is a dependent for federal tax purposes.
    • de minimis amounts (2% to 3% of assets) may be expended for other benefits or other persons.
• Membership must be voluntary-- that is, becoming a member
  – requires an affirmative voluntary act
  – involves a designation as a member without incurring a detriment (pay deduction) or
  – is required under a CBA.

• VEBA must be controlled by an independent trustee or the members (who may elect a COO, administrator or trustee).
Tax Implications

- A member is taxed on coverage and benefits from the VEBA unless there is an express exception in the Code. For retiree health benefits, the coverage and benefits provided by the VEBA are exempt from tax under sections 105 and 106 of the Code.
• The deductibility of employer contributions to the VEBA are limited by Code Sections 419 and 419A as follows:
  - excess contributions may be carried over.
  - contributions are deductible only when paid.
  - amount of deduction is limited for each year to “qualified cost” that is the
    • qualified direct costs, plus
    • additions to the qualified asset account minus
    • the VEBA’s after-tax income.
-- qualified direct costs are benefits paid out of VEBA plus administrative costs;

-- after-tax income is GI (includes employee contributions but not employer contributions) minus directly connected deductions minus any tax imposed such as UBTI (discussed below); and

-- additions to the qualified asset account are contributions to an account from which the VEBA’s benefits will be paid, up to the “account limit”

  • account limit is the amount reasonably and actuarially necessary to fund the VEBA’s health benefit claims incurred but not paid by year-end, plus admin costs, plus an additional reserve for post-retirement health benefits. The reserve is funded over the working lives of the covered employees and actuarially determined on a level basis using reasonable actuarial assumptions; but if you cannot get an actuary to certify the account limit for a year, you must use a safe harbor account limit, which is 35 percent of the qualified direct costs for the immediately preceding year.

  • the account limit does not apply to a VEBA maintained pursuant to a CBA.
• Account limit is the amount reasonably and actuarially necessary to fund the VEBA’s health benefit claims incurred but not paid by year end, plus admin costs, plus an additional reserve for post-retirement Health benefits. The reserve is funded over the working lives of the covered employees and actuarially determined on a level basis using reasonable actuarial assumptions; but if you cannot get an actuary to certify the account limit for a year, you must use a safe harbor account limit, which is 35 percent of the qualified direct costs for the immediately preceding year.

• The account limit does not apply to a VEBA maintained pursuant to a CBA.
Note that, to have the reserve for the post-retirement health benefits:

- you need a separate account for the post-retirement health benefits of each key employee, and the key employee’s post-retirement health benefits can be paid only from that account and
- amounts allocated to those accounts are annual additions, which have to be taken into account when computing the section 415(c) dollar limit ($49,000 for 2010) (but not the 100% of comp limit) on any qualified defined contribution plan the employer maintains
Despite the VEBA’s tax-exempt status, a VEBA must still pay tax on its unrelated business taxable income (UBTI)
• UBTI equals gross income, other than exempt function income, less tax deductions directly connected to the gross income.
-- “exempt function income” (EFI) is not included in the VEBA’s gross income. It is, for each year:
  • gross income from dues, fees, charges or similar amounts paid by members (and by employers of those members) in exchange for the membership; and
  • all income (except if derived by an active trade or business) which is “set aside” to pay for the VEBA’s benefits, including the retiree health benefits, plus administrative costs.
The “set aside” is limited: an amount may be treated as set aside only to the extent that it does not cause the total of the VEBA’s assets set aside at year end to exceed the “account limit” for the year. The account limit is determined without the reserve for retiree benefits.

What is a “set aside”? Not totally clear, but adequate records of the trustee, administrator or employer describing the amount set aside, and indicating that such amount is to be used only for the payment of VEBAs benefits, should be o.k. One issue, if the set aside grows too large, that is an indication that the amounts will be used for a non-permitted purpose, jeopardizing the characterization of amounts as EFI.
IRS formulation: Treasury regulation section 1.512(a)-5T states that UBTI, for any year, equals the lesser of:

- income of the VEBA, including investment income but excluding member and employer contributions (prong 1); or
- the excess of the amounts set aside at year-end over the account limit for that year (prong 2).

If the VEBA goes back to July 18, 1984, certain rules for existing reserves to pay retiree health benefits may increase the tax deduction for contributions and reduce the UBTI.
**CNG Transmission Management VEBA v. U.S.** (1st Circuit, 12/14/09)

- VEBA argued that the account limit did not apply so that more of its income was EFI and thus not taxable as UBTI because its investment income was used to pay VEBA benefits. That is, even though its year-end assets set aside exceeded the account limit since the VEBA used its investment income to pay VEBA benefits, the investment income does not factor into the amount set aside, and should simply be treated as EFI.

- The court rejected that argument, saying that the test is the amount of the assets set aside, at year end, over the account limit, without regard to the source of those assets. Further, the Court said that the IRS formulation should be used to determine UBTI, and that the VEBA hadn’t even established the amounts for prong 2, with the result that all of its income was taxable under prong 1.
Voluntary Employee Benefit Associations (VEBAs)

Presented by:
James P. McElligott, Jr.
Richmond, Virginia
804-775-4329 jmcelligott@mcguirewoods.com
www.mcguirewoods.com
What is a VEBA?

• Voluntary Employee Benefit Associations (“VEBAs”) are tax-favored vehicles for funding employee and retiree health and welfare care.
• Ford, General Motors and Chrysler established VEBAs to assume liability for union retirees’ medical care, allowing removal more than $100 billion in liabilities from their balance sheets under FASB 106.
• State and local governments also consider VEBAs (or Section 115 trusts) in response to GASB 45, which requires public employers to report their retiree health liabilities to taxpayers.
• IRS reports that more than 12,000 VEBAs exist today.
Why VEBAs?

VEBAs properly designed and administered under Section 501(c)(9) of the Internal Revenue Code have several tax advantages:

• Contributions are generally not taxable to employees.
• Investments in the VEBA accumulate tax-free (but some UBIT issues).
• Payments from the VEBA are tax-free so long as they are used for qualified welfare benefits, such as health benefits.
• Under Code Section 419A(f)(5)(A), there is no “account limit” on the deductibility of employer contributions to VEBAs maintained under collective bargaining agreements.
What Makes a VEBA?

- An employee association, consisting of two or more employee members with an objective common bond, such as a common or affiliated employer.
- Membership must be voluntary. Membership is deemed voluntary if membership is a condition of employment, but there is no detriment to the employee (such as mandatory contributions).
- VEBA must provide life, sickness, accident, or other permissible benefits to its members and dependents (or designated beneficiaries). It cannot be used to provide deferred compensation. Benefits can be provided to non-dependent domestic partners of members. VEBA benefits are includible in gross income of beneficiaries unless specifically excluded by the Code.
- Benefits can include reimbursement of medical benefits qualifying under Internal Revenue Code §213: medical, dental, prescription drug, health benefits, and Medicare supplemental premiums.
- No part of the net earnings or reversion of a VEBA may inure to the benefit of an employer.
- VEBA cannot discriminate in favor of officers, shareholders, or highly compensated employees. These rules do not apply if the employees/retirees are collectively-bargained.
- Contributions to welfare plans benefiting retirees are generally deductible in the year paid or incurred, subject to the limitations of IRS Sections 419 and 419A. Active employees may also make tax-deductible contributions to the VEBA trust fund, but only with after-tax dollars.
VEBA Plan Design

• The VEBA may be designed as an individual account fund (like a defined contribution plan) or as a pooled fund available to pay medical expenses, including Medicare premiums, deductibles, and co-pays.

• VEBAs that are individual account plans are generally set up as Health Reimbursement Arrangements (HRAs). If so, only employer contributions can be made into the HRA accounts, not employee contributions.
Establishing and Administering a VEBA.

- VEBA is established through a trust agreement and plan document. Medical plan VEBA (non-public) trustees are ERISA fiduciaries.
- VEBAs must apply to the IRS for a determination letter using Form 1024 in order to obtain recognition of tax-exempt status. Annual VEBA/health plan administration includes filing annual Form 5500s, and, if applicable Form 990 and/or Form 990-T.
- VEBA providing medical benefits would usually have a third-party administrator or insurer providing the benefits, handling claims, etc., subject to ERISA claims procedure rules. Trustees of the VEBA invest plan assets with guidance of investment managers, depending on the manner in which the VEBA received contributions.
Use of VEBA to Fund Retiree Health

- VEBA trust funds (with restricted funds to provide benefits solely to retirees, their dependents and beneficiaries) can offset FAS 106 accounting liabilities. Fund assets include amounts contributed by the employer (and by employees for a contributory plan), plus earnings, less benefits paid and administrative expenses paid from the trust fund.

- General Motors, Ford, Goodyear and Chrysler have agreed with their unions to fund VEBAs to pay retiree medical benefits in lieu of the employer.

- VEBA can be started as an entirely free-standing entity, such as a multi-employer plan with union and employer trustees. Those VEBAs have separate legal counsel, actuaries, consultants, investment advisors, auditors, service providers, etc.

- VEBAs can also be structured with the employer retaining authority to replace plan administrators and some power over plan design, investments, and recordkeeping. For example, the VEBA could simply be used to fund the retirees' benefits under the employer's medical plan.
VEBAs of Non-union, Non-public Employers Face UBTI.

• Under the “account limit” rules of Code Section 419 and 419A, non-union employers may only deduct a year’s worth of employee benefit claims and expenses.
• Congress added these restrictions in the mid 1980s to prevent abuse of VEBAs as tax shelters.
• These limits on annual deductions can create “unrelated business taxable income” (“UBTI”) for VEBAs and have made prefunding of medical expenses through VEBAs less attractive for non-union employers.
Design Decisions for VEBA

- How will the VEBA be funded? One large contribution? Contributions over time? IRC 419 and 419A limitations are important with respect to tax deductions.
- Will advance contributions be sufficiently large at the outset to generate substantial investment income? If so, an investment adviser and investor will be needed to advise concerning investment of plan assets.
- Will the VEBA simply pay benefits through the employer's existing health plan? This will greatly simplify administration, and avoid the need for the VEBA to have separate health plan documents, summary plan descriptions, open enrollment period, COBRA administrator, planning benefit manager, claims administrator, etc.
- Ford and other companies have funded VEBAs with company stock. See Private Letter Ruling.
Funding VEBAs with Company Stock

- DOL has issued notices of proposed individual exemption (Application Nos. No. L-11566, L-11575), requested by New Chrysler Corp. and Ford Motor Co. to permit those companies to contribute company securities to their respective VEBAs negotiated with the UAW for Chrysler and Ford retirees.

- ERISA Section 408(a) prohibits VEBAs from holding employer securities as a large percentage of plan assets, but ERISA also gives DOL authority to grant exemptions.

- Ford seeks to use Ford common stock for 50 percent of its payment obligations, subject to protections negotiated with UAW and Ford retirees. Proposed exemption would require conditions, such as: establishing an independent committee with fiduciary authority to act on behalf of the VEBA in all transactions involving the transfer of securities to the VEBA; appointing a separate monitor to identify potential conflicts of interest and regularly review committee reports, investment banker reports, and public information about the companies.
UBTI of VEBAs

- VEBAs established under § 501(c)(9) are tax-exempt, but must pay tax on UBTI. Under Code § 512(a)(3)(A), UBTI is gross income that is not “exempt function” income. Exempt function income includes income from dues, fees, charges or similar amounts contributed by VEBA members “in furtherance of the purposes constituting the basis for” the VEBA’s tax-exempt status. § 512(a)(3)(A). Exempt function income also includes income set aside “to provide for the payment of life, sick, accident, or other benefits.” § 512 (a)(3)(B).

- The exemption for set-aside funds exists only to the extent that income does not exceed Section 419A account limit for the taxable year. The excess over the Section 419A “account limit” is not exempt function income and results in UBTI. Because VEBAs of non-union, private sector employers will have an “account limit.”

- Some Courts disagree with IRS’s interpretation of Code 419A account limit.
Calculating a VEBA’s UBTI

- Section 419A IRS “account limit” rules were rejected by Sherwin-Williams Co. Employee Health Plan Trust v. Commissioner, 330 F.3d 449 (6th Cir. 2003), which interpreted “account limit” as applying only to income that the VEBA accumulated during the taxable year and did not spend on qualified benefits and admin expenses. IRS will not follow this interpretation outside Sixth Circuit. 2005-35 I.R.B. 422.

- Federal Circuit rejected the Sixth Circuit’s interpretation of Section 419A in CNG Transmission Management VEBA v. United States (Fed. Cir. No. 2009-5025, December 14, 2009), in which the VEBA’s investment income exceeded its yearly account limit by $2.6 million, which excess was spent by the VEBA on health benefits during the same year. VEBA sought to deduct this excess amount, relying on Sherwin-Williams that amounts spent during year and not accumulated were not subject to Section 419A account limit. IRS argued that Section 419A account limit applies to all VEBA’s investment income, “even where VEBA spends more money on program benefits than the investment income it earns.”

- Federal Circuit agreed with the IRS interpretation, relying on Treasury Regulation § 1.512(a)-5T, which interpreted “exempt function income.” Under this interpretation, VEBA excludes investment income from UBTI only to extent that investment income does not exceed “account limit.” VEBA always pays tax on the lesser of its investment income or the excess of investment income over the VEBA’s account limit.
Settling Retiree Medical Claims with VEBAs

U.S. District Court approved Ford's 2008 settlement with its retirees, which created a multibillion dollar VEBA to be funded in part by Ford common stock (UAW v. Ford Motor Co., E.D. Mich., No. 07-CV-14845).

• The amendment allowed Ford to smooth out its payments to the VEBA and use Ford common stock for 50 percent of its payment obligations, subject to certain protections that Ford negotiated with the UAW and Ford retirees.
Use of Captive Insurer

- DOL released December 22, 2009 a notice of proposed prohibited transaction exemption to allow Coca-Cola to use “captive insurance” to pay for a portion of its retiree benefit liability.
- Coca-Cola proposes to use assets in its VEBA to purchase stop-loss insurance. The medical stop-loss insurance would pay claims that fall between an “attachment point” and an upper limit. For all retirees the attachment point would be $100. For retirees under age 65, the upper limit would be $5,800 and for retirees over 65 the upper limit would be $3,500.
- The insurer would reinsure its risks with Coca Cola’s captive insurer, who insures a wide range of risks for the company, including benefit coverage for employees outside the United States.
James P. McElligott, Jr.

Mr. McElligott is a partner in the Richmond, Virginia office of McGuireWoods LLP. He handles employee benefits, executive compensation, and labor relations matters for employers and fiduciaries, and has an active litigation and arbitration practice. He is a Fellow of the College of Labor and Employment Attorneys, and is listed in *Chambers USA, Best Lawyers in America*, and *SuperLawyers* under both Employee Benefits and Labor and Employment.

Mr. McElligott is a member of the Employee Benefits Committees of the ABA Sections of Labor and Employment Law and Taxation, a member of the US Chamber of Commerce Employee Benefits Committee, former President of the Federal Bar Association, Richmond Chapter, and former president of the Central Virginia Employee Benefits Council. Mr. McElligott is a Phi Beta Kappa graduate of the University of Illinois and received his law degree, *cum laude*, from Harvard Law School, where he served as Note Editor on the *Harvard Journal on Legislation*. 