

Boston University School of Law

Scholarly Commons at Boston University School of Law

Faculty Scholarship

8-4-2015

After Tackett: Incomplete Contracts for Post-Employment Healthcare

Maria O'Brien

Boston University School of Law

Follow this and additional works at: https://scholarship.law.bu.edu/faculty_scholarship



Part of the [Contracts Commons](#), [Health Law and Policy Commons](#), [Insurance Law Commons](#), [Labor and Employment Law Commons](#), and the [Retirement Security Law Commons](#)

Recommended Citation

Maria O'Brien, *After Tackett: Incomplete Contracts for Post-Employment Healthcare*, No. 15-30 Boston University School of Law, Public Law Research Paper (2015).

Available at: https://scholarship.law.bu.edu/faculty_scholarship/198

This Article is brought to you for free and open access by Scholarly Commons at Boston University School of Law. It has been accepted for inclusion in Faculty Scholarship by an authorized administrator of Scholarly Commons at Boston University School of Law. For more information, please contact lawlessa@bu.edu.



**AFTER TACKETT: INCOMPLETE
CONTRACTS FOR POST-EMPLOYMENT
HEALTHCARE**

Boston University School of Law
Public Law & Legal Theory Working Paper No. 15-30
August 4, 2015

Maria O'Brien Hylton
Boston University School of Law

This paper can be downloaded without charge at:

<http://www.bu.edu/law/faculty/scholarship/workingpapers/2015.html>

After Tackett: Incomplete Contracts for Post-Employment Healthcare

Maria O'Brien Hylton*

Professor of Law, Boston University. I am indebted to Joseph Stuligross of the United Steelworkers General Counsel's Office, C. Michael Harper, Susan Cancelosi, and to members of the AALS Section on Employee Benefits and Executive Compensation and the American College of Employee Benefits Counsel for comments and suggestions at various stages of this project. Lisa Bothwell, Noel Chavez, Tyler Patterson and Christopher York provided research assistance for which I am very grateful.

I. Introduction

This is a story about a union and a private sector employer who repeatedly negotiated collective bargaining agreements which referenced side contracts which provided retirees with post-employment healthcare benefits. In the early decades of their relationship neither the union nor the employer appear to have given any thought to whether or not these retiree health benefits in fact vested—i.e. were promised to retirees at no cost for the remainder of their lives. By the 1980s¹ and certainly the 1990s² however, as health care costs soared and life expectancy expanded, both parties continued to regularly re-negotiate agreements that were silent as to this critical term.³ With time and, predictably enough, the employer decided to eliminate this increasingly expensive benefit; the union objected vigorously on the ground that the benefit was promised to current retirees “for life” and could not be unilaterally terminated. Recently, in *M & G Polymers v. Tackett*,⁴ the Supreme Court considered the effect of this

¹ In 1980, life expectancy was at 73.7 years. While in 1970, life expectancy at birth was at 70.8 years. CENTER FOR PREVENTION DISEASE CONTROL AND, <http://www.cdc.gov/nchs/data/hus/2010/022.pdf> (last visited July 6, 2015). While United States’ total health expenditures per capita tripled from \$356 in 1970 to \$1,091 in 1980. *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/> (last visited July 6, 2015).

² In 1990, life expectancy was at 75.4 years. CENTER FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/nchs/data/hus/2010/022.pdf> (last visited July 6, 2015). By 1990 total health expenditures in the United States per capita was at \$2,810. *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/> (last visited July 6, 2015). See also David P. Richardson, *Trends in Health Care Spending and Health Insurance*, TIAA-CREF INSTITUTE (December 2008), https://www.tiaa-cref.org/public/pdf/institute/research/trends_issues/tr120108c.pdf (“Over the past four decades, the growth of health care spending has outpaced overall growth in the economy, with health care spending rising from about 5 percent of GDP in 1960 to about 16 percent of GDP in 2006.”).

³ On July 20, 1994, a letter was circulated that claimed “[t]he Company shall provide health care benefits under the * the Comprehensive Medical Benefits Program, Exhibit B-1, the Dental Benefits for Employees and Dependents, Part V, Section E of the Pension, Insurance and Service Award Agreement dated July 20, 1994, to the extent that such benefits shall be subject to the following limitations: 1) The average annual company contributions to be paid for all health care benefits per retired employee (including their surviving spouse) who retires on or after May 1, 1994, shall not exceed \$11,700 for retirees (including surviving spouses) under age 65 and \$4,200 for retirees (including surviving spouse) over age 65.” Exhibit 13 continued: Letter G at 1, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK). No where in the limitations is there a reference to the vesting of these health care benefits.

⁴ *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2015) (holding that under ordinary contract principles a collective bargaining agreement was not shown to vest retirees with a right to lifetime contribution-free health

silence and unanimously concluded that courts should not construe ambiguous contract provisions in order to create lifetime promises especially in the context of labor contracts where obligations typically cease when the agreement terminates.

This paper attempts to assess the Court's decision and to understand why both parties, in the face of increasing cost pressure, came to the same strategic conclusion during the course of bargaining over many years—i.e. that silence was preferable to an explicit commitment. The union's strategy was clearly influenced by the Sixth Circuit's longstanding decision in *Yard-Man*⁵--a decision the Court essentially sidelines in *Tackett*. *Yard-Man* was never widely adopted outside of the Sixth Circuit and the employer in *Tackett* wisely gambled that silence as to a critical term would force the Court to choose between conventional and widely accepted rules of contract interpretation and the nearly unique *Yard-Man* approach which presumed that in the absence of other evidence, an agreement that provided for retiree healthcare itself indicated an intent to vest lifetime contribution-free benefits.

care benefits since there was no presumption in favor of vested retiree benefits in all collective bargaining agreements, there was no evidence indicating that employers and unions in the industry customarily vested retiree benefits, a limiting durational provision could not be disregarded, and silence concerning the duration of retiree benefits did not permit an inference that the parties intended the benefits to vest for life).

⁵ *Int'l Union v. Yard-Man, Inc.* 716 F. 2d 1476 (6th Cir. 1983). In Richard L. Kaplan's *Retirees at Risk, Yard-Man* is summarized:

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

Richard L. Kaplan, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 Yale J. Health Pol'y L. & Ethics 287, 306-07 (2009).

Tackett certainly can be understood as an instance in which traditional rules of contract interpretation triumph over special rules crafted for employee benefits negotiated in connection with labor agreements. *Tackett* is also an implicit endorsement of the anti-*Yard-Man* jurisprudence of most of the other federal circuits.⁶ But, most important, *Tackett* provides yet more evidence that as financial reporting requirements⁷ changed and increased pressure on employers (and their unions) to reveal the true costs associated with post-employment benefits, there were multiple efforts to avoid full disclosure

⁶ *Senior v. NSTAR Elec. & Gas Corp.*, 449 F.3d 206 (1st Cir. 2006) (claiming that all *Yard-Man* instructs is that the Court should apply ordinary principles of contract interpretation and that there is no presumption of vesting); *Am. Fed'n of Grain Millers v. Int'l Multifoods Corp.*, 116 F.3d 976 (2d Cir. 1997) (stating that retiree welfare benefits are generally not vested, and an employer can amend or terminate a plan providing such benefits at any time) (citing *Curtiss-Wright*, 514 U.S. at 75, 78); *Int'l Union, United Auto., Aero. & Agric. Implement Workers of America v. Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999) (claiming that the Court does not agree with *Yard-Man* and its progeny that there is a presumption of lifetime benefits in the context of employee welfare benefits); *Nichols v. Alcatel USA, Inc.*, 532 F.3d 364 (5th Cir. 2008) (“The *Yard-Man* inference has never been accepted by this Court”). In other cases, courts have followed reasoning similar to the Sixth Circuit’s but have reached different conclusions. *E.g.*, *Ryan v. Chromally Am. Corp.*, 877 F.2d 598, 603 (7th Cir. 1989) (holding that plaintiffs’ benefits did not vest under the accrual, vesting and funding provisions of ERISA, the governing plan documents, or the collective bargaining agreement between defendant and plaintiffs’ union, and that the governing plan documents unambiguously provided the right to terminate the plan); *Anderson v. Alpha Portland Indus., Inc.*, 836 F.2d 1512 (8th Cir. 1988) (ruling that welfare plans did not vest as a matter of law and that the former employees had the burden of proving that the parties intended that the duration of benefits was not tied to the agreement that created them. The former employees relied on a faulty summary plan description given them by the former employer pursuant to 29 U.S.C.S. § 1022; however, the court held that the former employees did not show significant reliance on the summary sufficient to secure relief); *Turner v. L.U No. 302, Int'l Bhd. of Teamsters*, 604 F.2d 1219 (9th Cir. 1979) (finding that the retired employee did not have a vested interest in the medical benefits provided by the bargaining agreement between the unions and employers because the benefits could be terminated, no representation was made as to the length of time the benefits would be paid, and the trustees had the power to decrease benefits to maintain the fund).

⁷ Financial Accounting Standards Board (“FASB”) No. 106 establishes accounting standards for employers’ accounting for postretirement benefits other than pensions, focusing principally on postretirement health care benefits. *Employers’ Accounting for Postretirement Benefits other than Pensions*, FASB—FINANCIAL ACCOUNTING STANDARDS BOARD (December 1990), <http://www.fasb.org/summary/stsum106.shtml>. The Board’s conclusions in this Statement result from the view that a defined postretirement benefit plan sets forth the terms of an exchange between the employer and the employee. *Id.* In exchange for the current services provided by the employee, the employer promises to provide, in addition to current wages and other benefits, health and other welfare benefits after the employee retires. *Id.* It follows from that view that postretirement benefits are not gratuities but are part of an employee’s compensation for services rendered. *Id.* Since payment is deferred, the benefits are a type of deferred compensation. *Id.* The employer’s obligation for that compensation is incurred as employees render the services necessary to earn their postretirement benefits. *Id.* 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. KAPLAN, *supra* note 5, at 297. 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. *Id.*

and the expected backlash from shareholders. Only when rising costs and longevity simply made retiree healthcare an unaffordable luxury did employer ambiguity evaporate leaving retirees with few protections.

Thus far, the *Tackett* story has not ended happily for plaintiffs-retirees. This is by no means the first time however that plaintiffs seeking to enforce claims for post-employment health benefits have found themselves unable to do so.⁸ On the contrary, the result in *Tackett* is consistent with a growing line of cases that refuses to put much legal weight on oral and written promises⁹, employer custom and practice¹⁰ and even arguments about reliance¹¹ in light of the enormous (and sometimes unexpected burden) retiree healthcare costs present for employers.

One might ask why retiree health insurance matters much at all. The simplest response is that, for those over age 65, it is often a nice add-on to Medicare coverage. But, for retirees under the age of 65, alternative sources of health insurance are often expensive if available at all. When retiree health

⁸ See generally, Richard L. Kaplan et.al., “Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits”, 9 YALE J. HEALTH POL’Y L. & ETHICS, 286 (2009), available at

<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1162&context=yjhple>.

⁹ *Hughes v. 3M Retiree Medical Plan*, 281 F. 3d 786 (8th Cir. 2002) (finding 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 plaintiff’s plan and contained no language even remotely suggestive of vesting. Furthermore, both documents contained reservation clauses reserving the right to amend or discontinue benefits); *UAW v. Rockford Powertrain, Inc.* (2003) (finding that although the SPD purportedly conferred lifetime benefits on its employees, the employer’s right to modify and its explicit affirmation of such ability in the reservation-of-rights clause could not be read as promising vested healthcare benefits); *Cherry v. Auburn Gear, Inc.* (2006) (finding that “lifetime” benefits extended only so long as the collectively bargained insurance agreement remained in effect).

¹⁰ *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996) (holding that lying to employees in the context of benefits administration violates the fiduciary obligation); see *Vallone*, 375 F.3d at 626 (holding that, under *Varity* 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).

¹¹ *In re Unisys Corp. Retiree Medical Benefit “ERISA” Litig.*, 57 F.3d 1255 (3d Cir. 1995) (finding that 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); *Frahm v. Equitable Life Assurance Soc’y of the United States*, 137 F.3d 955 (7th Cir. 1997) (claiming “in federal law, a person cannot rely on an oral statement, when he has in hand written materials disclosing the truth”); *UAW v. Rockford Powertrain, Inc.*, 350 F.3d 698 (7th Cir. 2003) (claiming that it was impossible for the plaintiffs to have relied on their employer’s statements in making their retirement decisions, because “plaintiffs admitted in their brief that the statements at issue were made during exit interviews after the retirees made their decisions to retire”).

coverage is eliminated for a current retiree, the retiree must consider his options. “Depending on the reasons for retirement, an individual may not be willing or able to return to full-time employment to obtain active employee coverage. Even if someone is both willing and able, an older person’s chances of returning to a comparable position are limited. Employment-based coverage, once lost, may well be gone forever.”¹²

As others have noted,¹³*Tackett* can easily be described as a “win” for traditional rules of contract interpretation. Indeed, as Justice Scalia pointed out during oral argument: “[y]ou know, the nice thing about a contract case of this sort is you can’t feel bad about it. Whoever loses deserves to lose. [Laughter] I mean, the thing is obviously an important feature. Both sides knew it [the issue of vesting] was left unaddressed, so, you know, whoever loses deserves to lose for casting this upon us when it could have been said very clearly in the contract. Such an important feature. So I hope we’ll get it right,

¹² Susan Cancelosi, *Symposium: Under The Knife: Health Law, Health Care Reform and Beyond: The Shifting Focus of Federal Intervention in Retiree Health Benefits*, 13 NEV. L. J. 759, 763 (Spring 2013) (cites omitted). Cancelosi goes on to state:

Without employer-provided insurance, early retirees find themselves in a particularly difficult position. Adults who are neither age sixty-five nor disabled currently do not enjoy good alternatives to employer-provided health benefits. Group health insurance through one's work does not discriminate on the basis of health status; all similarly situated employees are similarly eligible for coverage. The same applies to retiree health plans sponsored by an employer. Eligibility for coverage under such plans depends on retiree status, not health conditions. Individual insurance, on the other hand, historically has come with no such protections, and insurers have routinely denied applications by those whom the companies perceive as poor risks. Because health declines with age, those old enough to qualify for retirement - early or normal - often fall into the poor risk category. Even if an early retiree can find an insurer willing to issue individual coverage, the cost may outstrip what the individual can afford. [] The only remaining alternative is government-provided or government-paid care, such as that available through Medicare and Medicaid for certain parts of the population. But healthy, early retirees historically have not qualified for either of the safety net programs.

Id. at 763-66.

¹³ *Bd. of Trs. v. Caddo Sheet Metal, LLC* 2015 U.S. Dist. LEXIS 85442 *5 (E.D. Va. June 30, 2015) (citing to *Tackett* which required it to interpret the CBA “according to ordinary principles of contract law”); *Gray v. Levi Strauss & Co.*, 2015 U.S. Dist. LEXIS 21178, *13 (S.D. Miss. Feb. 23, 2015) (quoting *Tackett*: “[Courts] interpret collective-bargaining agreements . . . according to ordinary principles of contract law. . . .”); *Bd. of Trs. of the Plumbers, Pipefitters & Mechanical Equip. Serv. v. R. & T. Schneider Plumbing Co.*, 2015 U.S. Dist. LEXIS 89917, *26 (S.D. Ohio July 10, 2015) (quoting *Tackett* in order to establish that interpreting collective-bargaining agreements must be done according to ordinary principles of contract law); *Cincinnati v. Cincinnati Shaper Indep. Union*, 2015 U.S. Dist. LEXIS 40681, *7 (S.D. Ohio Mar. 30, 2015) (quoting relevant language to establish that collective-bargaining agreements should be interpreted using ordinary principles of contract law).

but, you know, I can't feel bad about it."¹⁴ The union, in briefs filed since *Tackett* was remanded to the Sixth Circuit insists that the decision stands for nothing more than the position that courts should not grant judgment for retirees on the basis of ambiguous contract language alone.¹⁵

The longstanding relationship between the parties here may help explain the peculiar silence. In 2000 M & G Polymers purchased the Point Pleasant Polyester Plant in Apple Grove, West Virginia. M & G was a party to both a collective bargaining agreement and a related pension and insurance agreement which provided for retiree health coverage.¹⁶ Certain employees were eligible for employer paid retiree health

¹⁴ Transcript of Oral argument at 21-22, *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2014)(No. 13-1010). Justice Breyer responded by noting that “[w]ell, you know, the workers who discover they’ve been retired for five years and don’t have any health benefits might feel a little bad about it.” *Id.* at 22.

¹⁵ “*Tackett* cites *Litton* which holds that post-expiration obligations may arise from “express or implied” CBA terms. Nor does *Tackett* hold that general duration clauses automatically trump specific promises of post-expiration retiree healthcare. *Tackett* rejects presumptions and holds that CBAs are subject to the “ordinary principles of contract law” and “the parties’ intentions control.” Brief of Plaintiffs-Appellees, Case No. 12-3329, 2015 WL 2453261, *20, filed May 22, 2015.

¹⁶ Cancelosi encapsulates the fragile position of pre-65 year old retirees:

Employment-based health plans for retirees and their dependents cover at least fifteen million individuals in the United States. Retiree health insurance includes plans for both early retirees and Medicare-eligible retirees. Plans for early retirees - in general, those at least age fifty-five but not yet sixty-five- typically provide primary health insurance, often simply a continuation of active employee coverage; plans for Medicare-eligible retirees are secondary to Medicare and provide wrap-around coverage. For both groups, employment-based coverage is important. For early retirees, it is critical because they typically have few, if any, alternatives to employer-sponsored plans. In fact, individuals with a choice rarely retire before Medicare eligibility unless they qualify for retiree health benefits. For Medicare-eligible retirees, the supplemental insurance available through employers often is both less expensive and more comprehensive than what private Medicare supplemental policies (often referred to as "Medigap" plans) offer. When an employer reduces or terminates that supplemental coverage, the costs shift to retirees, who may not have the resources to adapt easily to new financial demands.

CANCELOSI, *supra* note 12 at 759-61. Kaplan explains the options that retirees possess when they are not eligible for Medicare due to being under 65 years of age. Kaplan claims:

One [] option is health insurance through a working spouse. A second option is obtaining Medicare as a disabled person prior to reaching age sixty-five. Someone who receives Social Security disability payments for twenty-four months is eligible for Medicare, regardless of age. 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), 2) purchase health insurance in the individual market , or 3) utilize a health savings account after retirement. [] None of these three options adequately addresses the problem of early retirees who have lost their employer-sponsored retiree health benefits.

KAPLAN, *supra* note 8 at 334-35.

Currently, Medicare is the source of health insurance for nearly 45 million Americans—mainly seniors ages 65 and older, but also 7 million younger adults with permanent disabilities. *Medicare Now and in the Future*, THE HENRY J. KAISER FAMILY FOUNDATION, (Oct. 1, 2008), <http://kff.org/health-reform/issue-brief/medicare-now-and-in-the->

coverage, subject to certain caps. The trial court found (and this issue was not before the Supreme Court) that the M & G retirees were not subject to caps as they were never adopted at the location owned by M & G Polymers.¹⁷ The collective bargaining agreement was silent as to the ability of the employer to make changes to retiree health care coverage; however, the labor agreement was subject to renegotiation every three years as was typical in the industry.¹⁸ The *Tackett* litigation began when the

future/. Before Medicare was signed into law in 1965, about half of all seniors lacked hospital insurance. *Id.* Today, virtually all people ages 65 and over are covered by Medicare. *Id.* In 1966, enrollment in the Medicare program was less than half of what it is today, at 19.1 million and none enrolled through permanent disabilities. STATISTA, <http://www.statista.com/statistics/237045/us-medicare-enrollment-figures/>. In 1970, some 7.1 billion U.S. dollars were spent on the Medicare program in the United States. STATISTA, <http://www.statista.com/statistics/248073/distribution-of-medicare-spending-by-service-type/>. While in 2013, that figure had risen to 581.7 billion U.S. dollars. *Id.* Cancelosi puts these figures into perspective, claiming that, the cost of retiree health benefits weights the scale against their maintenance. One study concluded that the cost of providing employment-based health benefits to retirees in 2010 would increase six percent for pre-sixty-five retirees and four percent for Medicare-eligible retirees, matching prior years' increases. That translates to a per-person cost of \$ 7,596 per early retiree and \$ 3,840 for the Medicare-eligible retiree, as compared to \$ 5,184 per active employee for single coverage. Even though employers have largely dealt with this problem by shifting costs to retirees, 10% of large employers surveyed in 2006 predicted that they were "very" or "somewhat" likely to terminate coverage altogether for future retirees, with another 2% predicting that they were "very" or "somewhat" likely to terminate coverage for current retirees. A 2010 survey similarly found that ten percent of companies with existing retiree health plans were "planning to exit, and 20% are seriously considering this option for the future." An early 2011 study reported that almost 60% of surveyed large employers currently offering retiree plans were "rethinking" their programs for 2012 or 2013.

Cancelosi, *supra* at 768-69.

¹⁷ The plaintiff employees were divided into five different sub-classes. The District Court ruled that cap letter applicability was only directed at future employees, and not directly beneficial to sub-classes one through four. "...[T]he trial evidence places the previously ambiguous Letter of Understanding 2003-6 into its proper context as a going-forward document applicable to individuals in Subclass Five and not a document that also speaks to and clarifies the meaning of prior agreements governing Subclasses One through Four." *Tackett v. M & G Polymers USA, LLC*, 853 F. Supp. 2d 697, 717 (S.D. Ohio 2012). Further, "... the document's context teaches this Court that application of Letter of Understanding 2003-6 to the plaintiffs in the first four subclasses was a unilateral move by M & G to unlawfully circumvent binding agreements to obtain economic advantages." *Id.*

¹⁸ Founded in 1942, the United Steelworkers union is North America's largest industrial union with 1.2 million members and retirees. *About Us*, UNITED STEELWORKERS—USW, <http://www.usw.org/union/mission> (last visited July 6, 2015). There are more than 1,800 local unions throughout Canada, the United States and the Caribbean. *One Member, One Vote*, UNITED STEELWORKERS—USW, <http://www.usw.org/union/mission/one-member-one-vote> (last visited July 6, 2015). The United Steelworkers represent workers in a diverse range of industries, including atomic, chemical, education, energy and utilities, health care, manufacturing, metals (steel, aluminum, etc.), mining, oil, paper and forestry, pharmacies and pharmaceuticals, public employees, rubber (tires, etc.), transportation, and varied work places. *Our Industries and Work Place*, UNITED STEELWORKERS—USW, <http://www.usw.org/union/mission/industries> (last visited July 6, 2015).

From the Court record, it is clear that the United Steelworkers union had a practice of re-negotiating contracts every three years. The first "Insurance, Medical, Pension Disability Income and Supplemental Unemployment Benefits for Hourly Rated Employees" packet was effective beginning May 15, 1991. Defendant's Exhibit 1 at 2-3,

employer notified the union in December 2006 that it intended to begin charging retirees for a portion of their health care and the employees responded by arguing they had a vested right to free retiree health care for life. The U.S. District Court for the Southern District of Ohio dismissed the employees' complaint for failure to state a claim¹⁹ but the Sixth Circuit reversed and in so doing relied heavily on its own precedent in *International Union, United Auto, Aerospace & Agricultural Implement Workers of America v. Yard-Man, Inc.*²⁰. While *Yard-Man* guided decision making in these kinds of cases in the Sixth Circuit since 1983, very different approaches to dealing with contracts that lacked "important feature[s]"²¹ developed in the other federal circuits. Indeed, outside of the Sixth Circuit, most courts

Tackett v. M&G Polymers USA, LLC, 523 F. Supp. 2d 684 (S.D. Ohio 2007). The next claims that effective July 20, 1994 the new terms of the benefits would begin. Defendant's Exhibit 3 at 2, *Tackett*, 523 F. Supp. 2d 684 (S.D. Ohio 2007). Then again on May 9, 1997, the Company issued a letter claiming that it would provide health care benefits under the Comprehensive Medical Benefits Program [. . .] with the aforesaid limitations would become effective that day. Defendant's Exhibit 4 at 2, *Tackett*, 523 F. Supp. 2d 684 (S.D. Ohio 2007). Following that agreement, there was another on November 6, 2000 to last until November 6, 2003 between M&G Polymers USA, LLC and United Steelworkers union to continue the benefits. Defendant's Exhibit 7 at 2, *Tackett*, 523 F. Supp. 2d 684 (S.D. Ohio 2007).

¹⁹ *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684, 691 (S.D. Ohio 2007) ("Count I of the amended complaint targets 'specified lifetime health care benefits,' and the specified benefits include sharing costs. The retirees are entitled to an employer contribution toward health benefits, but they must pay premium contributions; there is simply no contractual right to contribution-free health benefits [...]. The company's right to terminate benefits for retiree's failure to contribute is implicit. Therefore, the evidence before this Court indicates that because the caps scheme has continued to apply, Defendants are correct in asserting that there is no breach of the CBA").

²⁰ *Int'l Union v. Yard-Man*, 716 F.2d 1476 (6th Cir. 1983) (affirming the district court's holding that the retirees were entitled to continued benefits, but reversed the holding that appellant could not substitute cash value for the annuities) *Yard-Man* urges that

a general durational clause which provided that the collective bargaining agreement should remain in force until June 1, 1977 demonstrates an intent that all benefits described in the agreement also terminate at that date. We do not agree. The clause does not specifically refer to the duration of benefits. The persuasive considerations we have discussed demonstrate that retiree benefits were intended to outlive the collective bargaining agreement's life and outweigh any contrary implications derived from a routine duration clause terminating the agreement generally. Such an intent takes precedence over a non-specific, general clause.

Id.

²¹ Transcript of Oral Argument, *Tackett*, 135 S. Ct. 926 (No. 13-1010). The oral argument reflects this frustration of leaving vesting silent:

Justice Alito: This certainly can't be something that didn't occur to the employer or to the union. Why did they choose to leave it silent? Why did they choose not to address it expressly?

Ms. Ho: I think there—one could consider that they didn't express it directly or one could read the contract as saying there simply is no—silence says there is no promise of vesting here, because that is an extraordinary obligation for a company to take on.

Justice Ginsburg: How about “Retirees will receive health benefits as long as they are eligible for an receiving a monthly pension”? Doesn’t that sound like as long as they’re getting the pension, they will get health benefits?

Ms. Ho: No, Your Honor. Again, read in conjunction with either the express clause in this case or the background rule that the terms expire with the agreement, that doesn’t indicate that those—those extend. And I think what—what the Sixth Circuit has done, and it did in this case, it instructed this Court that the mere fact that the retiree healthcare benefits were tied to receipt of a pension was sufficient to indicate vesting. I think that essentially undoes what Congress did in saying you—you have to vest in pension; you don’t have to vest in the welfare context. The Sixth Circuit essentially puts those things—

Justice Scalia: Well, I don’t think it’s reversing that. I think it’s—it’s an argument of—of contractual expression, contractual intent. It says if you tie the continuing receipt of health benefits to the continuing receipt of retirement benefits, and if you know that retirement benefits survive the termination of the contract, right? You acknowledge that.

Ms. Ho: The vesting.

Justice Scalia: It seems to suggest that—that health benefits continue as long as retirement benefits do. Now, I mean, maybe there are other indications, but that one certainly seems to—seems to tie health benefits to retirement benefits.

Ms. Ho: I don’t think so, Your Honor. Because I think one con—one consequence of that is essentially no matter what the parties contract or agree to, you’re always going to have vesting, even though it’s the exception and not the rule, simply by tying the healthcare benefits to—to retirement status.

Justice Ginsburg: Why do you have to—why do you have to do that? If you want to treat them as separate, treat them as separate. Don’t tie them together. There was nothing that required these two to be tied together.

Ms. Ho: Well, Your Honor, I think the practical reason for—for linking those two is not to indicate vesting, but to ensure that the recipient is—is actually retired for purposes of receiving the benefits.

Justice Kennedy: Well, I thought it was your position that whatever might be the outcome of these questions, the Sixth Circuit didn’t think that that was the right analysis, that the Sixth Circuit didn’t think the result could be reached without imposing the presumption of your argument, and so instructed the district court. And that’s the issue before us.

Ms. Ho: That’s correct, Your Honor. And the district court—and the district court made clear on remand, and the Sixth Circuit in the second appeal, in Tackett II, explicitly approved, and the word the Sixth Circuit used was “presumption,” that the district court decided correctly in applying the presumption to this case.

Justice Ginsburg: I thought that the district court on remand said it would have come out the same way anyway. They said there are no facts that would defeat this same conclusion.

Ms. Ho: Correct, Your Honor. And I—and I think that’s an important response to what Justice Sotomayor was pointing out earlier about the fact that there was a trial here. I think that—that language makes clear that the trial here was about what—what vested, and that’s the district judge making clear that whatever facts there had been, it would have reached the same conclusion about vesting, which is the only issue before this Court based on the Sixth Circuit’s directive, as Justice Kennedy was pointing out, to apply Yard-Man and to apply the Yard-Man presumption.

Justice Scalia: You know, the nice thing about a contract case of this sort is you can’t feel bad about it. Whoever loses deserves to lose.

(Laughter.)

Justice Scalia: I mean, this thing is obviously an important feature. Both sides knew it was left unaddressed, so, you know, whoever loses deserves to lose for casting this upon us when it could have been said very clearly in the contract. Such an important feature. So I hope we’ll get it right, but, you know, I can’t feel bad about it.

(Laughter.)

Justice Breyer: Well, you know, the workers who don’t discover they’ve been retired for five years and don’t have any health benefits might feel a little bad about it.

rejected *Yard-Man* and its emphasis on the context in which labor negotiations took place in favor of the more conventional contract analysis of the sort Justice Scalia other members of the Court focused on in *Tackett*.²²

This paper seeks to explain the odd silence in both the collective bargaining agreements and the pension and insurance agreements about whether or not free-to-retirees retiree health benefits were vested.

The parties' long shared history makes impossible a conclusion that it was simply a mistake that this important issue was never addressed. On the contrary, a detailed review of the relationship between M & G Polymers and the Steelworkers Union suggests that for a long time both parties believed they were both better off leaving the issue unaddressed. Both the union and M & G were able to avoid the reckoning that FAS 106²³ would have required of them. Both gambled that when push came to shove and they could no longer avoid confronting the enormous cost free retiree health care represented, their "silence" could be used advantageously.

Ms. Ho: And—and Your Honor, I—I agree.

Justice Breyer: I'm taking sides, but I want to—

(Laughter.)

Justice Breyer: I mean, what I've listened to sort of drives me to the conclusion where you started, decide these things without any presumption, period. Ordinary contract. Go read the contract. Where it's ambiguous, Judge, ask them for extrinsic evidence if they want to present it. Decide it like any other case. I started there. Maybe I've heard something that should change my mind. I often do change it in oral argument, but I haven't yet.

Id. at 18-23.

²² The Sixth Circuit approached the issue of whether retiree insurance benefits continue beyond the expiration of the collective bargaining agreement by looking at the intent of the parties. *Yard-Man*, 716 F.2d at 1479. The court then looked to the explicit language of the collective bargaining agreement for clear manifestations of intent. *Id.* at 1479. The Court then analyzed the collective bargaining agreement using "basic rules of [contract] construction" to determine that since "[t]he [duration] clause does not specifically refer to the duration of benefits [. . .] retiree benefits were intended to outline the collective bargaining agreement's life and outweigh any contrary implications derived from a routine duration clause terminating the agreement generally. Such an intent takes precedence over a non-specific, general clause." *Id.* at 1482-83.

²³ Financial Accounting Statement No. 106 (FAS 106) requires companies to accrue the cost of retiree health benefits and to record a liability for unfunded retiree medical costs explicitly on their financial statements, effective beginning for fiscal years beginning after December 15, 1992. *Fundamentals of Employee Benefit Programs*, EBRI—EMPLOYEE BENEFIT RESEARCH INSTITUTE (2005), <http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp26.pdf>. FAS 106 applies to current and future retirees, their beneficiaries, and qualified dependents. *Id.*

II. The Mysterious Silence in Tackett

A. Tackett—Years of Strategic Silence

Before M & G Polymers employees were represented by the Steelworkers, the International Union of the United Rubber, Cork, Linoleum and Plastic Workers of America, AFL-CIO-CLC (the “URW”) represented M & G workers and employees of its corporate predecessors for decades.²⁴ The URW merged with the Steelworkers in 1995.²⁵ It appears as though free retiree health benefits were first offered to employees/union members in ____.²⁶ Following years of relatively stable cost and mortality experience, the cost of retiree health care began to increase in the 1980s.²⁷ As others have noted,²⁸ the

²⁴ The United Rubber, Cork, Linoleum Plastic Workers of America was founded on September 12, 1935, in Akron Ohio, the then “Rubber Capital of the World” and former home base for most of the major tire and rubber companies. *The History of the United Rubber, Cork, Linoleum Plastic Workers Union of America, AFL-CIO, CLC*, <http://uswlocal878l.com/page4.html>. In 1960, the URW, at its peak, had close to 200,000 members. Kenneth N Gilpin, *Rubber Workers’ Union Acts To Merge With Steelworkers*, N.Y TIMES (May 13, 1995). By 1995, at the time the URW merged with the United Steelworkers of America, membership had shrunk to 94,000 members. *Id.*

²⁵ *Rubber and Steel Workers Consolidate Union*, WARDAUTO (Aug. 1, 1995), <http://wardsauto.com/news-amp-analysis/rubber-and-steel-workers-consolidate-unions>; *Our History*, UNITED STEELWORKERS—USW, LOCAL 2003, <http://www.usw2003.org/history.html>.

²⁶ It appears that the “1950 Pension Plan of the Company,” as continually referenced in Exhibit K, began the company’s practice of providing welfare benefits. The company and the union would negotiate a new collective bargaining agreement approximately every three years. They also negotiated a series of Master Pension, Insurance and Service Award Agreements with every CBA negotiation. Individual plants could adopt the agreement in one of three possible ways: first, some plants directly participated in the “master bargaining” with the employer and became a party to the Master Agreement itself. Second, some plants separately adopted “me to” agreements that were identical to the Master Agreement. And, third, some plants adopted “me too with exceptions” agreements. Basically the governing insurance agreements created a point system for employees based on age and years of service requirements. Exhibit A at 3-4, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK). Employees whose age and years of continuous service at the time of retirement equaled ninety-five or more points received a full company contribution toward the cost of benefits. *Id.* Employees with less than 95 points at the time of retirement received reduced benefits. Retiree spouses and surviving spouses were entitled to the same benefits until death or remarriage. *Id.*

²⁷ *Cause for Concern*, NEW REPUBLIC (Apr. 21, 2014) <http://www.newrepublic.com/article/117452/rising-health-care-costs-what-it-means-economy-obamacare> (noting a quick increase in healthcare costs in the 1980s and in the early 2000s); *Snapshots: Health Care Spending in the United States & Selected OECD Countries*, THE HENRY J. KAISER FAMILY FOUNDATION, <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected->

increases in the cost of healthcare, especially for retirees, created several problems for old line manufacturing employers who often had more retirees than active workers.²⁹

As the cost pressures mounted on employers the Financial Accounting Standards Board acted in 1992 and again in 2006 to increase transparency about the true cost of retiree health care and other post-employment benefits. First, in 1992, the FASB began requiring private sector employers to disclose the projected cost of future retiree health care benefits. Rule 106 represented a dramatic departure from prior accounting practices. As the Board explained shortly before Rule 106 went into effect:

The Board's conclusions in this Statement result from the view that a defined postretirement benefit plan sets forth the terms of an exchange between the employer and the employee. In exchange for the current services provided by the employee, the employer promises to provide,

oecd-countries/ (last visited July 6, 2015) (contributing the spike in healthcare costs in the late 1980s to the United States' accelerated growth rate); David Blumenthal, Kristof Stremikis, and David Cutler, *Health Care Spending—A Giant Slain or Sleeping*, NEW ENGLAND J. MED. 2551, 2552 (Dec. 26, 2013), <http://scholar.harvard.edu/files/cutler/files/nejmhpr1310415.pdf> (claiming that real per capita increases in health costs averaged 5.5% in the 1980s).

²⁸ Philip Klein, *Health care spending spikes at fastest rate since 1980 in first quarter of Obamacare*, WASHINGTON EXAMINER (Apr. 30, 2014, 12:00 AM), <http://www.washingtonexaminer.com/health-care-spending-spikes-at-fastest-rate-since-1980-in-first-quarter-of-obamacare/article/2547891> (referencing the fact that health care spending grew at a ten percent rate in the third quarter of 1980). James Lubitz, *Three Decades Of Health Care Use By The Elderly, 1965-1998*, HEALTH AFFAIRS, <http://content.healthaffairs.org/content/20/2/19.full> (last visited July 6, 2015) (detailing the spike in the oldest old).

²⁹ See, e.g., General Motors, Ford, and Chrysler. GM could not survive with continuing losses and associated loss of liquidity, and without the governmental funding it had been receiving. *In re GMC*, 407 B.R. 463, 474 (Bankr. S.D.N.Y. 2009). Historically, GM was one of the best performing Original Equipment Manufacturers ("OEM") in the U.S. market. *Id.* at 476. But with the growth of competitors with far lower cost structures and dramatically lower benefit obligations, GM's leadership position in the U.S. began to decline. *Id.* At least as a result of that lower cost competition and market forces in the U.S. and abroad (including jumps in the price of gasoline; a massive recession (with global dislocation not seen since the 1930s); a dramatic decline in U.S. domestic auto sales; and a freeze-up in consumer and commercial credit markets), GM suffered a major drop in new vehicle sales and in market share—from 45% in 1980 to a forecast 19.5% in 2009. *Id.* Another factor that contributed to GM's bankruptcy was the fact that the company had obligations to an estimated 500,000 retirees. *Id.* at 474. As of March 31, 2009, GM employed approximately 235,000 employees worldwide, that is less than half of the amount of retirees. *Id.* at 475. Likewise, Ford was in a similar position reporting that they were "hemorrhage[ing] cash in the the third quarter." Dan Carney, *Ford better positioned to ride out recession*, NBC News (Nov. 17, 2008, 10:14am), <http://www.nbcnews.com/id/27723139/ns/business-autos/t/ford-better-positioned-ride-out-recession/#.VafuWu3BzGc>. Ford posted a \$129 million loss in the third quarter and said it would eliminate another 2,260 jobs. *Id.* Ford, though, did not receive assistance through T.A.R.P. and sold off its Jaguar and Land Rover operations in order to gain cash during the recession. Meanwhile, both GM and Chrysler accepted T.A.R.P. assistance.

in addition to current wages and other benefits, health and other welfare benefits after the employee retires. It follows from that view that postretirement benefits are not gratuities but are part of an employee's compensation for services rendered. Since payment is deferred, the benefits are a type of deferred compensation. The employer's obligation for that compensation is incurred as employees render services necessary to earn their postretirement benefits.³⁰

FAS 106 essentially required non-governmental employers to incorporate into current financial statements the future costs associated with providing retiree health care. The result was a dramatic increase in *reported* costs.³¹ It is important to note that the real, out of pocket costs to employers were also increasing at this time as retirees benefited from often costly improvements in medical technology that led to longer lifespans and greater demand for medical care in retirement.³²

³⁰ *Summary of Statement No. 106*, FASB—FINANCIAL ACCOUNTING STANDARDS BOARD (Dec. 1990), <http://www.fasb.org/summary/stsum106.shtml>.

³¹ See, e.g., Anna M. Rappaport & Carol H. Malone, *Adequacy of Employer-Sponsored Retiree Health Benefit Programs*, in *Providing Health Care Benefits in Retirement at 72-74* (1994). See also *Fundamentals of Employee Benefit Programs*, EMPLOYEE BENEFIT RESEARCH INSTITUTE 69 (2005), <http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp26.pdf> (noting that “[a]s a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs”); Kaplan, *supra* note 5 at 297-98 (“Faced with [FASB No. 106] 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. 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. Even larger employers - namely, those with at least 1000 employees - have diminished their offerings of retiree health benefits steadily”).

³² 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), <http://www.nybooks.com/articles/18802> (agreeing that “new medical technology” is the principal factor driving health care costs higher); see also *Snapshots: How Changes in Medical Technology Affect Health Care Costs*, THE HENRY J. KAISER FAMILY FOUNDATION (Mar. 2, 2007), <http://kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/> (“Health care experts point to the development and diffusion of medical technology as primary factors in explaining the persistent difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.”); see also Jonathan S. Skinner, *The Cost Paradox of Health-Care Technology*, MIT TECHNOLOGY REVIEW (Sept. 5, 2013), <http://www.technologyreview.com/news/518876/the-costly-paradox-of-health-care-technology/> (discussing why

B. Cap Letters

So, employers and their unions—already scrambling to survive in the increasingly difficult manufacturing sector in the United States—faced real cost increases and were required to incorporate a new accounting approach that made those increases appear even larger. Not surprisingly, many employers began to limit and/or eliminate retiree health care benefits.³³ These adjustments were easier in non-unionized sectors where employers simply amended existing plans without any organized objection from current or retired workers.³⁴In the unionized world of *Tackett* the parties appear to have decided

it is that health care technology contributes to rising health care costs); see also Daniel Callahan, *Health Care Costs and Medical Technology*, THE HASTINGS CENTER 79-82 (2008), <http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2178> (“New or increased use of medical technology contributes 40-50% to annual cost increases, and controlling this technology is the most important factor in reducing them”).

³³ 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. Posner, *supra* note 5 at 294-95 (citing 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); Employers have responded by placing caps on what they were previously willing to spend on retiree health benefits. *Fundamentals of Employee Benefit Programs*, EBRI—Employee Benefit Research Institute at 69, available at <http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp26.pdf>. “Others added age and service requirements; moved to some type of ‘defined contribution’ health benefit; completely dropped retiree health benefits for future retirees; or dropped benefits for current retirees [...].” *Id.*

³⁴ This did not prevent private, non-unionized workers from suing in an effort to maintain these benefits. In *Abbruscato v. Empire Blue Cross & Blue Shield*, 274 F.3d 90 (2d Cir. 2001) and *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76 (2d Cir. 2001)

plaintiff-retirees left employment through the ordinary course of business or through early retirement severance packages, between 1989 and 1998,. 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. 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. The Second Circuit deemed the eligibility formulas to conflict with the generalized reservation-of-rights clause found elsewhere in the plans. 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. 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.” Since the pre-1987 SPDs lacked a reservation-of-rights clause, and certain other sentences read that “retired employees, after [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. Therefore, the Empire retirees require 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, standing alone, is apparently sufficient to sustain an employer’s motion for summary judgment.

Richard L. Kaplan, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL’Y L. & ETHICS 287, 316-18 (2009). See also *Stearns v. NCR Corp.*, 297 F.3d 706 (8th Cir. 2002), [a] group of early retirees brought suit against their former employer for reducing health benefits granted to them in their severance package. 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. 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. Plaintiff Stearns represented the retiree class, arguing that NCR’s purported reservation-of-rights provision in the Plan Amendments 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* that an unambiguous reservation-of-rights provision is sufficient to defeat a claim that retirement welfare plan benefits are vested. 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 plans provisions. Finding neither situation, the Eighth Circuit held that NCR could terminate benefits according to the reservation-of-rights clause.

Kaplan, *supra* at 318. In *Bland v. Fiatallis North America, Inc.*, 401 F.3d 779 (7th Cir. 2005), 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. 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. 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.” 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.” 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.

Kaplan, *supra* at 319. And lastly, in *Boubolis v. Transport Workers Union of America*, 442 F.3d 55 (2d Cir. 2006), an employee union was the benefits-slashing employer. Plaintiff-retirees, former New York City Transit Authority workers, alleged that they were given assurances at various junctures during their employment with Local 100, of the Transport Workers Union of America that they would have “lifetime health insurance coverage” under Local 100’s plan. When new union leadership of Local 100 terminated 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.

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. Because they were already retired, plaintiffs reasoned that they could lose their benefits only upon death; i.e., the end of their lifetime. Unfortunately for the retirees, the Second Circuit rejected this argument based on the widely held rule that the absence of vesting language does not

to rely on the cost containment device known as cap letters and to silently wait and see if either the upward trajectory of health care costs and/or the regulatory environment might improve.³⁵

A cap letter refers to a written summary of caps the employer and union agreed would govern maximum employer contributions to retiree health costs. The caps in *Tackett* were explicitly established to comply with FAS 106. At the 2011 bench trial Ron Hoover who worked for the international union, testified to the effect that:

[T]he 1991 cap letter as a union compromise to help [the employer] control or minimize its liabilities; he explained that the letter was a way to avoid showing the extent of projected liability for retiree medical benefits due to FASB considerations. In other words, Hoover noted, the cap letter was a mechanism by which a company could minimize cost numbers to attract investors. He explained how the letter worked and the importance of what he called the “bite date”, or the date on which retirees would have to actually begin contributions toward their medical insurance. Hoover emphasized the importance of always moving the bite date out so that it could always be subject to further movement by negotiation.

In addition Hoover noted that there was a general understanding between the employer and the union that the “bite date” would always be moved up as “the union never intended to have retirees pay a premium and that he understood that the company representatives could not say publically that there would never be retiree contributions because the accountants would then not certify the FASB statements.” Exhibit A: Excerpt of Ron Hoover Deposition Transcript at 72, *Tackett v. M&G Polymers USA, LLC*, 742 F. Supp. 2d 901 (S.D. Ohio 2010) (No. 2:07-cv-00126-GLF-NMK).

create a promise to vest by the employer. The SPD therefore did not, on its own, vest lifetime health care benefits in the retirees.

Kaplan, *supra* at 319-20.

³⁵ I am indebted to Joe Stuligross, Esq. of the United Steelworkers for explaining to me the form and function of cap letters in connection with both the negotiation of collective bargaining agreements and the management of retiree health care cost containment.

Apparently the caps in place always distinguished between maximums for retirees over the age of 65 (i.e. those who were Medicare³⁶ eligible) and those under 65 who had no other source of health insurance.

In 1994 for example, the cap at Goodyear master agreement facilities (which were not part of this litigation) was \$11,700 for those under 65 and \$4200 for those over 65.³⁷ The Medicare program was clearly an important backdrop to the M & G Polymers retiree healthcare benefit.³⁸ For retirees too

³⁶ Medicare is the largest health insurance program offered by the United States government, serving more than 49 million people. It is run by The Centers for Medicare and Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. *What is Medicare*, MYMEDICAREANSWERS.COM, available at <https://www.mymedicareanswers.com/docs/DOC-1016>. Medicare covers Americans 65 and older and those who qualify due to a disability. While being “eligible” means you may enroll in Medicare, there are strict rules regarding when you can enroll. *Id.* At age 65, an individual is eligible for Parts A and B, even if they still work, though, some individuals may have to pay premiums for Part A and most have to pay premiums for Part B. *Id.* Medicare is divided into four parts: A, B, C, and D. *Id.* Parts A and B are considered “Original Medicare.” *Id.* Part A, or hospital insurance, helps cover an individual’s care when they are admitted to a hospital or skilled nursing facility, which also includes hospice care and home healthcare. *The Parts and Plans of Medicare*, MYMEDICAREANSWERS.COM, available at <https://www.mymedicareanswers.com/docs/DOC-1014>. Part B, or medical insurance, helps cover doctor’s visits and outpatient care. *Id.* Part B also assists in paying for some services that Part A does not cover, such as physical therapy, some home healthcare, and some preventive services. *Id.* Part C, or Medicare Advantage (MA), is not offered by the federal government as Parts A and B are, but instead offered by health insurance companies. *Id.* Part C covers everything Parts A and B cover and often covers other services such as wellness programs. *Id.* Part D, or the Medicare Prescription Drug Plan, is provided by insurance companies and other private companies, and is an optional prescription drug coverage plan. *Id.*

³⁷ Defendant’s Exhibit 3 at 2, *M&G Polymers USA, Inc. v. Tackett*, 523 F. Supp. 2d 684 (2007) (claiming that beginning on July 20, 1994, “[t]he average annual Company contributions to be paid for all health care benefits per retired employee (including their surviving spouse) who retires on or after May 1, 1994, shall not exceed \$11,700 for retirees (including surviving spouses) under age 65 and \$4,200 for retirees (including surviving spouses) over age 65”).

³⁸ Medicare, as has been noted by others, is generally only available to those age 65 and older. For retirees who lose employer sponsored health insurance, [t]he only remaining alternative is government-provided or government-paid care, such as that available through Medicare and Medicaid for certain parts of the population. But healthy, early retirees historically have not qualified for either of the safety net programs. Except for those with serious disabilities or certain terminal conditions, Medicare eligibility begins at age sixty-five. Medicaid eligibility traditionally has required not only that a person fit into specified categories—none of which has been likely for someone age fifty-five plus who is not disabled—but also that the person be impoverished. Cancelosi, *supra* note 12 at 765. Cancelosi also notes: “[o]n the other hand, retirees age sixty-five and older start out reasonably well thanks to Medicare’s safety net. They still need and use employment-based coverage however, because gaps in Medicare coverage make the safety net far less solid than many realize. Thus, for example, annual out-of-pocket health care spending by Medicare beneficiaries averaged \$4241 per beneficiary in 2006, with younger beneficiaries spending far less on average than older ones. The vast majority of Medicare beneficiaries—eighty-nine percent in 2007—therefore obtain some form of secondary insurance to offset these costs. About a third have access to such insurance through a former employer. This remained true even after the Medicare

young for Medicare the only likely source of health insurance was the employer's coverage; for those 65 and above the expectation was that Medicare would function as the main source of coverage. This accounts for the wide variation in cap amounts. The cap letter arrangement also explains the essence of the mysterious silence about a crucial aspect of the retiree health benefit—why neither party had an incentive to formalize its views about vesting and the source of external pressures that encouraged both the union and the employer to behave in a way that presented the best possible picture of the company's health to outsiders.

C. *Yard-Man* and Sixth Circuit Jurisprudence

The behavior of the parties in *Tackett* and their mutual confidence in the cap letter device can only be fully understood in light of the somewhat unique approach the Sixth Circuit had taken decades earlier in an effort to deal with labor agreements and ancillary contracts that were silent or ambiguous on some critical issue. In its landmark decision in *Yard-Man*, the appeals court, ostensibly relying on ordinary principles of contract law, held that an employer whose collective bargaining agreement did not specifically address the duration of retiree health benefits must have intended those benefits to vest for life. The *Yard-Man* decision emphasized the role of context and, as the Supreme Court noted in *Tackett* “[t]he Court of Appeals has continued to extend the reasoning of *Yard-Man*. Relying on *Yard-Man*'s statement that context considerations outweigh the effect of a general termination clause, it has concluded that, “[a]bsent specific durational language referring to retiree benefits themselves,” a general durational clause says nothing about the vesting of retiree benefits.”³⁹

Prescription Drug, Improvement and Modernization Act (MMA) added Part D prescription drug coverage, closing what had been one of the most glaring benefit holes.” *Id* at 765-766.

³⁹ *Tackett*, 135 S. Ct. at 935 (“We disagree with the Court of Appeals’ assessment that the inference applied in *Yard-Man* and its progeny represent ordinary principles of contract law. As an initial matter, *Yard-Man* violates ordinary contract principles by placing a thumb on the scale in favor of vested retiree benefits in all collective-bargaining agreements. That rule has no basis in ordinary principles of contract law. And it distorts the attempt ‘ascertain the intention of the parties.’ *Yard-Man*’s assessment of likely behavior in collective bargaining is too

Justice Thomas, writing for a unanimous court, expresses unmistakable frustration with *Yard-Man* and its ostensibly contextual approach to discerning the intent of the parties in the face of silence about the duration of retiree health benefits. He asserts: “[a]s an initial matter, Yard-Man violates ordinary contract principles by placing a thumb on the scale in favor of vested retiree benefits in all collective bargaining agreements. That rule has no basis in ordinary principles of contract law.”⁴⁰ Thomas suggests that *Yard-Man* consists of one inference after another and results in a conclusion that is directly at odds with traditional principles.

The Court of Appeals also failed even to consider the traditional principle that courts should not construe ambiguous writings to create lifetime promises. ...Similarly the Court of Appeals failed to consider the traditional principle that “contractual obligations will cease, in the ordinary course, upon termination of the bargaining agreement.” [citation omitted] That principle does not preclude the conclusion that the parties intended to vest lifetime benefits for retirees. Indeed, we have already recognized that “a collective bargaining agreement [may] provid[e] in explicit terms that certain benefits continue after the agreement’s expiration [citation omitted]. But when a contract is silent as to the duration of retiree benefits, a court may not infer that the parties intended those benefits to vest for life.”⁴¹

Although the trial record is replete with suggestions that the ambiguity in *Tackett* was strategic or “conscious” as Professor Duhl has suggested⁴² Thomas does not distinguish between ambiguity that

speculative and too far removed from the context of any particular contract to be useful in discerning the parties’ intention”).

⁴⁰ *Id.*

⁴¹ *Id.* at 936-37.

⁴² See Gregory M. Duhl, *Conscious Ambiguity: Slaying Cerberus in the Interpretation of Contractual Inconsistencies*, 71 U. PITT. L. REV. 71 (2009). In Duhl’s article he discusses this intentional ambiguity:

Scholars have previously given attention to the benefits (especially economic) of lawyers intentionally drafting open, incomplete, and vague contracts, but *Cerberus* illustrated that lawyers also deliberately

arises from a simple failure of drafting and the strategic approach that both M & G Polymers and the union both found so useful for so many years. The core question raised by *Tackett* is what is the proper rule of interpretation when both parties found it advantageous to leave a critical term out of a contract?

The problem in *Tackett* is by no means unique to labor contracts or employee benefits plans for active or retired employees. As Judge Posner has observed:

Even in a setting of perfect foresight an interpretive problem may arise. Parties may rationally decide not to provide for a contingency, preferring to economize on negotiation costs by delegating completion of the contract, should the contingency materialize, to the courts. This is especially likely if they think that the likelihood that the contingency will materialize is slight. But even if they think the likelihood is significant they may prefer to leave the contingency unprovided for. **Deliberate ambiguity may be a necessary condition of making the contract; the parties may be unable to agree on certain points yet be content to take their chances on being able to resolve them, with**

draft contracts that are inconsistent. Although open, incomplete, and vague terms should be encouraged in the drafting of contracts in certain circumstances, we should discourage rather than encourage ambiguity. Alan Schwartz and Robert Scott do not believe that the goal in contract interpretation is to help courts get at the “correct answer,” but rather to get parties to write in “the court’s language.” But Schwartz and Scott miss the mark in not accounting for deliberate ambiguity in addressing what is the majoritarian default rule that courts should use to interpret contracts that are silent as to “judicial interpretive style.” They suggest that the default should be the Willistonian four-corners rule, which bars parties from introducing extrinsic evidence to show that the contract is ambiguous. The Willistonian approach enables parties to include ambiguous language in contract when it suits their interests, at the expense of courts having to make an imprecise judgment about whether the contract is ambiguous, which risks getting the result wrong.

. . . [C]ourts should discourage lawyers from drafting intentionally ambiguous contracts in the rush to get a deal done. Part of lawyers’ professional obligation is to draft clear contractual language for their clients. Furthermore, lawyers have an ethical obligation to reveal known inconsistencies that exist in the agreements that they are drafting, and not to contribute to such inconsistencies. Where the language of the agreement is ambiguous, there is a risk—especially from application of the four-corners rule—of courts not enforcing the obligations to which the parties consented. This risk poses a challenge to consent and other autonomy-based theories of contract.

Id. at 76-77 (cites omitted).

or without judicial intervention, should the need arise. It is a form of compromise, like “agreeing to disagree.”⁴³

Professor Duhl argues that intentionally vague contracts are inconsistent with a lawyer’s ethical duty to be forthright and to respect the ethical obligation to draft contracts clearly—even when the lawyer believes that without ambiguity the deal may not get done.⁴⁴ He urges courts to rely explicitly on the “forthright negotiator” principle in order to discourage drafters from doing precisely what the parties in *Tackett* both felt obliged to do.

It is hard to see how the forthright negotiator could have solved the core problem in *Yard-Man* or in *Tackett*. The hard reality of retiree health benefits is that they began as a relatively inexpensive way to continue health benefits for a small group of formerly active employees who needed a bridge to Medicare.⁴⁵ Retirees who had spent twenty or thirty years working in heavy manufacturing jobs often

⁴³ Richard A. Posner, *The Law and Economics of Contract Interpretation* 3 (John M. Olin Law & Economics Working Paper No. 229, 2004), available at <http://www.law.uchicago.edu/files/files/229-rap-contracts.pdf>. Judge Posner proceeds to say:

The goal of a system, methodology, or doctrine for contractual interpretation is to minimize contractual transaction costs, broadly understood as obstacles to efforts voluntarily to shift resources to their most valuable use. Those costs can be very great when by inducing parties not to contract they prevent resources from being allocated efficiently. Because methods of reducing contractual transaction costs, such as litigation, are themselves costly, careful tradeoffs are required. But it would be a serious mistake for courts to take the position that any ambiguity in a contract must be the product of a culpable mistake by one or both of the parties; that the judicial function in contract law is to punish parties who do not make their agreement clear. Sometimes it is, but more often it is not.

Id. at 3-4 (cites omitted). Judge Posner concludes his paper with, “[t]he more carefully drafted the contract is, the easier it will be for the parties to resolve a dispute over its meaning when the dispute first arises, in other words at the prelitigation stage.” *Id.* at 42. Thus, lowering the transactional costs that could potentially be incurred.

⁴⁴ Duhl, *supra* note 40 at 115.

⁴⁵ “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 II and was later canonized by a tax law provision that excluded such insurance from employees’ taxable income. The pervasiveness of industrial unions during this period further contributed to the expansion of various employer-provided job benefits, most especially health insurance. As an outgrowth of this 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. Employers were generally amenable to providing these benefits, because health care costs were not expensive, life expectancy was rather limited, and no actual

needed to leave the workforce well before the age of 65. And, if they made it to 65, anything else the employer offered functioned as a supplement to Medicare.⁴⁶

If the forthright negotiator understands both the pressures imposed on the employer by FAS 106 and has paid attention to the rapidly escalating cost of health insurance, she will recognize immediately the advantage of forestalling for as long as possible the inevitable. Whether her client is the union or M & G Polymers she will understand that the *best possible outcome* is to push forward the date on which the employer can no longer afford to cover the entire cost of retiree healthcare. If, relying on the cap letter device, this result can be postponed for three more years, that is an unambiguous win for both parties. The union understands that FAS 106 makes it entirely unreasonable to demand explicit language about vesting; the employer likewise wants to present the most attractive financial picture possible. The union and the employer both also know that, increasingly, the cap amounts are failing to keep up with healthcare inflation. The only end to this story is a bad one. These parties aren't lacking information or suffering from the failure of a legal representative who is insufficiently aggressive or honest. What they both lack is the ability to navigate the twin demands of increased transparency and rapidly escalating health care costs.

expenditures were required until many years into the future. 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." Posner, *supra* note 5 at 293-94; see *History of Health Insurance Benefits, Facts from EBRI*, EMPLOYEE BENEFIT RESEARCH INST. 1 (Mar. 2002), <http://www.ebri.org/publications/facts/index.cfm?fa=0302fact> (detailing the history of employer-based health benefits in the United States).

⁴⁶ "For those with employer sponsored retiree health insurance, the cost of coverage varies significantly between the pre-65 and the Medicare-eligible populations. The reason is that employer sponsored retiree health insurance is the primary source of coverage for the pre-65 group, whereas employer sponsored insurance is the supplemental payer for the Medicare eligible population." David P. Richardson, *Trends in Health Care Spending and Health Insurance*, TIAAA-CREF INSTITUTE (Dec. 2008) https://www.tiaa-cref.org/public/pdf/institute/research/trends_issues/tr120108c.pdf. "There are two basic designs for retiree health benefit plans: one for plans covering retirees under age 65 and one covering retirees age 65 and older. The reason for this age distinction is that eligibility for the Medicare program begins at age 65. For retirees under age 65, the benefit plan is usually based on the coverage they received while working, although, in recent years, programs for early retirees have increasingly featured different premium sharing than programs for active employees." *Fundamentals of Employee Benefit Programs*, EMPLOYEE BENEFIT RESEARCH INST. (2005), <http://www.ebri.org/pdf/publications/books/fundamentals/Fnd05.Prt03.Chp26.pdf>.

Under these circumstances the Sixth Circuit’s “thumb on the scale” in *Yard-Man*, while inconsistent with basic contract principles as Scalia pointed out in oral argument and Thomas notes in *Tackett* represents an understandable albeit flawed approach to an otherwise impossible predicament for the parties. It was entirely reasonable for retirees to assume that their benefits were available to them for life at no cost. The entire course of conduct between the parties supported this understanding.⁴⁷ At the same

⁴⁷ From the beginning in 1991 the Company expressed this view:

For purposes of conforming with the new Financial Accounting Standards Board (FASB) accounting requirements and rising health care costs, the Company has established a required maximum average annual company cost per retiree for medical coverage.

These limits are presently \$10,500 per year for each retired employee (including surviving spouse) under age 65 and \$4,200 for each retired employee (including surviving spouse) over age 65, with those ages being determined as of January 1 of each year. These limits equal the average cost for the over 65 and under 65 age groups. The limits should not be confused with the claim payments for an individual retiree. If the average for either group in the future exceeds the present averages, then the cost of that excess will be allocated among all members of the group evenly. No retired employee or surviving spouse shall be obligated to contribute for their health care costs that exceed the above maximum average cost limits . . .

Exhibit 1 at 6, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK).

This was true even during times of negotiation where it would have seemed likely that the company would begin requiring retirees to pay. This is shown in a letter dated November 23, 2003:

During 2003 negotiations between M&G Polymers U.S.A. LLC (the “Company”) and the United Steelworkers and its Local 644L (collectively the “Union”), the Company and the Union discussed the costs and burdens associated with various benefits, including medical benefits for active employees and retirees. The parties recognize there are many challenges associated with maintenance of these benefits, which include unique issues resulting from the large number of retirees in comparison to the employees actively working for the Company. At the same time, the Union emphasized the importance of these benefits for active employees, future retirees, and preexisting retirees. The parties during negotiations agreed to certain modifications of the health care benefits available to active employees and retirees, including modifications in plan design and provisions regarding premium cost sharing for these benefits. The Company and the Union have mutually agreed, during the 2003 negotiations, to make the same health care benefits as will be provided to active employees available to retirees. Except as set forth below, these benefits will be provided to active employees available to retirees. Except as set forth below, these benefits will be made available to retirees on the same terms and conditions as for active employees, except that premium cost sharing charged to retirees will be based on the amount by which total cost for all retiree insurances (medical, life, etc.) exceed the caps set forth in Letter H dated January 1, 2001. In addition, *retirees will not be required to make contribution toward the cost of health care benefit premiums* until January 1, 2006.

Exhibit 8: Letter of Understanding 2003-6—Retiree Health Care Benefits at 6, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK).

In addition, letters from May 15, 1991, July 20, 1994, May 9, 1997, January 1, 2001, all claim that there will be a cap on health care coverage, but all letters claim that “no retired employee or surviving spouse shall be obligated to contribute for such excess health care cost.” See Defendants’ Exhibit 2 at 8, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK); Defendants’ Exhibit 3 at 2, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK); Defendants’ Exhibit 4 at 2,

time, representatives of both the employer and the employees must have understood the risk associated with their strategy of silence and postponement. One day, unless the cost of healthcare dropped dramatically, the employer would no longer be able to afford to offer retirees cost free health insurance. The outcome in *Tackett* is not surprising, nor is the high court's repudiation of *Yard-Man* which never enjoyed much support outside the Sixth Circuit. The only remarkable feature of *Tackett* is that the parties, relying on strategic silence made an essentially unworkable arrangement last as long as they did.

III. Alternative Approaches and the Limited Applicability of *Yard-Man*

Much of Justice Thomas' opinion in *Tackett* is devoted to critiquing the Sixth Circuit's longstanding precedent for dealing with labor contracts that reference benefits provisions but fail to speak explicitly to the vesting question. Thomas may have felt empowered to reject *Yard-Man* in part because so many other circuit courts did so first. The fact is *Yard-Man* never gained much traction outside of the Sixth Circuit much to the dismay of some.⁴⁸ It is a measure of how widespread the retreat from retiree health care has been over the past few decades that every single circuit court of appeals has had several occasions upon which to evaluate the *Yard Man* approach. And, in most instances outside of the Sixth

Tackett v. M&G Polymers USA, LLC, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK); Exhibit H at 28, *Tackett v. M&G Polymers USA, LLC*, 523 F. Supp. 2d 684 (S.D. Ohio 2007) (No. 2:07-cv-00126-GLF-NMK).

⁴⁸ David L. Gregory, *COBRA: Congress Provides Partial Protection against Employer Termination of Retiree Health Insurance*, 24 SAN DIEGO L. REV. 77, 90 (Jan.-Feb. 1987) ("*Yard-Man* is an obviously significant case, seriously dealing with the difficult conceptual analysis of whether benefits are vested and interminable, supplemented by the "status" benefit analysis. This case encapsulates the pivotal conceptual inquiry that the courts must conduct in all such cases, and helpfully suggests appropriate general guidelines to structure this analysis"); Joan Vogel, *Until Death Do Us Part: Vesting of Retiree Insurance*, 9 INDUS. REL. L.J. 183, 207 (1987) ("*Yard-Man* [. . .] stand[s] for the proposition that when the language of the agreement is ambiguous and when the company's statements and actions indicate that it did not consider the benefits to be limited to the duration of the collective bargaining agreement, then courts will treat the benefits as lifetime benefits. This is a reasonable result; in the absence of clear language indicating that benefits last only for the duration of the collective bargaining agreement, retirees are likely to believe they have lifetime benefits and will plan accordingly").

Circuit, these courts have declined to presume that the parties intended for retiree health benefits to vest absent clear language to the contrary.

For example, in *Anderson v. Alpha Portland Industries*⁴⁹ the Eighth Circuit explicitly rejected the retirees' attempt to invoke a *Yard-Man* inference. "[W]e disagree with *Yard-Man* to the extent that it recognizes an inference of intent to vest. Congress explicitly exempted welfare benefits from ERISA's vesting requirements.....Proper allocation of the burden of proof in this case leads to the conclusion that the district court correctly held that retiree welfare benefits were intended to last only for the duration of the CBA [collective bargaining agreement]."⁵⁰ In the Seventh Circuit, Judge Posner authored the majority opinion in the well known case of *Bidlack v. Wheelabrator Corp.*⁵¹ While declining to follow the Sixth Circuit's inference in *Yard-Man* the court noted that a contract can "create[] entitlements that outlast it."⁵² Specifically, "[e]mployers adamant against assuming perpetual obligations can eliminate all doubt

⁴⁹ 836 F.2d 1512 (8th Cir. 1988) (ruling that welfare plans did not vest as a matter of law and that the former employees had the burden of proving that the parties intended that the duration of benefits was not tied to the agreement that created them. The former employees relied on a faulty summary plan description given to them by the former employer. The court held that the former employees did not show significant reliance on the summary sufficient to secure relief).

⁵⁰ *Id.* at 1517. (explaining briefly, but accurately, that, in general, ERISA provides fewer protections for welfare plan benefits such as healthcare than for pensions). *See, e.g.*, *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (claiming that "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits. Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify or terminate welfare plans."); *Inter-Modal Rail Empl. Ass'n v. Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 513-14 (1997) (explaining that Congress purposely chose the word "plan" as opposed to "pension plan" as it could have easily done to exempt welfare benefits to vest automatically); *Diehl v. Twin Disc*, 102 F.3d 301, 305 (7th Cir. Ill. 1996) ("[T]he insurance benefits at issue here are 'welfare' benefits, which, unlike pension benefits under ERISA, do not automatically vest in the absence of an agreement providing for lifetime entitlement.") (cites omitted); *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 604-605 ("ERISA does not require the vesting of health or other 'welfare' benefits, as it does pension benefits []") (cites omitted).

⁵¹ 993 F.2d 603 (1993). The lead opinion specifically adopts "the weak no-vest rule. First, it rejects the strong no-vest rule (the *Senn* rule) because its rigidity may frustrate the actual intent of the parties, and it is in tension with the Seventh Amendment right to a jury trial. *Ante* at 6, 11. The lead opinion likewise rejects [the parol substitution rule] because that rule would resort to extrinsic evidence even when the agreement is silent about retiree benefits, thus 'depriving parties of the protection of a written contract.' *Id.* at 7. Having rejected both of these 'extreme' options, the lead opinion falls back on the one remaining option, the weak no-vest rule, and finds that it comports with settled principles of contract law." *Id.* at 611.

⁵² *Bidlack* at 606. The court goes on to state:

At argument the plaintiff's counsel gave the example of wages due under a contract of employment at will, a contract terminable at the whim of either party. Suppose the employer's practice is to pay

by insisting on a clause that makes any entitlement to health benefits granted by the agreement expire on the date the agreement expires. Employers don't even have to bargain over health benefits of retired employees. [cite omitted] They certainly don't have to grant such benefits *in perpetuo*. If they did so in the past, not anticipating the recent rise in health care costs, they should not expect the courts to bail them out by undoing the contractually determined allocation of risk on the question.⁵³

In the First Circuit, a reservation of rights (ROR) clause was sufficient to defeat employee claims that a collection of welfare plan benefits had vested.⁵⁴ Although the plaintiffs raised *Yard-Man* and

employees at the end of each week for the work they have done during the week. Jones, an employee at will, is fired at noon on Wednesday, having worked 20 hours that week. The contract is at an end as of noon that day, and yet, quite apart from any statutory entitlement that employees may have to be paid at the agreed rate for work actually done (*National Metalcrafters v. McNeil*, 784 F.2d 817 (7th Cir. 1986)), the employee would have a compelling argument that the employer's promise to pay for work actually done had survived the expiration of the contract. This is not the best example for the plaintiffs' point, however, because an alternative conceptualization of employment at will treats it as a unilateral contract that is accepted by the employee's working at the agreed wage. 1A Arthur Linton Corbin, *Corbin on Contracts* § 152 at 13-14 (1963). So understood, a contract of employment at will does not end until the employee is paid. But there are plenty of better examples—examples of bilateral contracts that create obligations that outline the term of the contract because the parties wanted them to do so. A contract that contains a post-employment restrictive covenant is one, *Tower Oil & Technology Co. v. Buckley*, 99 Ill. App. 3d 637, 425 N.E.2d 1060, Ill. Dec. 843 (1981); *J.D. Marshall International, Inc. v. Fradkin*, 87 Ill. App. 3d 118, 409 N.E.2d 4, 42 Ill. Dec. 509 (1980), and there are others. *Litton Financial Printing Division v. NLRB*, 115 L. Ed. 2d 177, 111 S. Ct. 2215, 2226 (1991); *Ryan v. Chromalloy American Corp.*, 877 F.2d 598 (7th Cir. 1988); *In re White Farm Equipment Co.*, 788 F.2d 1186, 1193 (6th Cir. 1986). No doubt a court should cast a cold eye on contentions that a contract with a fixed term actually created a perpetual obligation, *William B. Tanner Co. v. Sparta-Tomah Broadcasting Co.*, 716 F.2d 1155, 1159 (7th Cir. 1983), and should, therefore, as *Senn* and many other cases hold (notably *Litton*), presume that a collective bargaining agreement ceases to obligate the employer when the agreement's term (invariably three years) is up. But it is not an irrebuttable presumption. 'Rights which accrued or vested under the [collective bargaining] agreement will, as a general rule, survive termination of the agreement.' *Litton Financial Printing Division v. NLRB*, *supra*, 111 S. Ct. at 2226. The question is what it takes to rebut the presumption. We add that the obligation for which the plaintiffs contend in this suit is not perpetual, because retired people and their widows (or widowers) do not live forever.

Id. at 606-607.

⁵³ *Id.* at 609. ("Employers don't even have to bargain over health benefits of retired employees. They certainly don't have to grant such benefits *in perpetuo*. If they did so in the past, not anticipating the recent rise in health costs, they should not expect the courts to bail them out by undoing the contractually determined allocation of risk on the question. Courts do not sit to relieve contract parties of their improvident commitments, except within the limited dispensation conferred by the doctrine of impossibility, not here invoked. Contracting parties who want to be spared the uncertainties of trial by jury have only themselves to blame if by failing to specify the limits of their undertakings they open the door to extrinsic evidence of contractual meaning") (cites omitted).

⁵⁴ *Senior v. NSTAR Electric*, 449 F.3d 206 (2006). The court claims "[i]f the intent of the bargain contained in the ERP agreements was to remove the reservation of rights the company had always retained and to advantage

encouraged the First Circuit to adopt it, Judge Lynch noted, “[o]ur view is that in a claim for benefits based on a labor agreement under the LMRA federal labor law creates no presumption regarding vesting.”⁵⁵ Likewise, the Second Circuit declined to adopt the *Yard-Man* inference. In *Schonholz v. Long Island Jewish Medical Center*⁵⁶ the court noted that a party must “point to a written language capable of

plaintiffs over all other employees, one would expect the agreement, or some other relevant document, to say so. As we discuss, the bargaining history shows nothing of the sort.” *Id.* at 222. The court concludes that, after applying normal principles of contract interpretation and labor agreements, the health benefit summaries referenced the dental plan documents, which contained the reservation of rights language, and say these plan documents are governing. *Id.*

⁵⁵ *Id.* at 218. Judge Lynch goes on to list many reasons the court refuses to adopt any presumptions in favor of vesting:

We fear that the use of presumptions may interfere with the correct interpretation, under normal LMRA rules, of the understanding reach by the parties. Secondly, the use of presumptions may also be inconsistent with the dynamics of bargaining set up under the National Labor Relations Act, 29 U.S.C. §§ 151-169, and the LMRA. Third, Congress could easily have created interpretive presumptions by statute had it cared to do so. The text of the LMRA does not contain any statutory presumptions. Fourth, though the courts sometimes create judicial interpretive presumptions, there is no reason to craft judicial default rules here. See *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603, 604 (7th Cir. 1993) (en banc). The Supreme Court has crafted only one presumption under the LMRA: the presumption in favor of arbitrability in labor contracts, which applies when a CBA contains an arbitration clause. See *Local 285, Serv. Employees Int’l Union v. Nonotuck Res. Assocs. Inc.*, 64 F.3d 735, 738 (1st Cir. 1995). Fifth, in the end, the question will usually be one of the degree of clarity that benefits were or were not unalterably vested, and if vested, under what conditions. There are traditional rules of interpretation of labor agreements which have proven adequate to answer those questions as to non-ERISA benefits, and we do not see why those rules would not work when ERISA benefits are at stake. Those are the rules we use.

Id.

⁵⁶ 87 F.3d 72 (2d Cir. 1996). The court points to clarification provided by the Supreme Court, “ERISA . . . follows standard trust law principles in dictating only that whatever level of specificity a company ultimately chooses, in an amendment procedure or elsewhere, it is bound to that level.” *Curtiss-Wright Corp. v. Schoonejongen*, 131 L. Ed. 2d 94, 115 S. Ct. 1223, 1231 (1995). Therefore, any agreement to vest Schonholz’s benefits would only have to be memorialized at the same level of formality that LIJ chose in promulgating the Severance Plan in the first place. In this case, the alleged promise was memorialized not in a formal plan document, but in the 1991 memorandum that Match sent to senior employees. We easily conclude that the December 18 and December 22 letters are at least as formal as the 1991 memorandum and that, therefore, the district court erred in concluding that Schonholz’s claim is barred because ‘Match’s letter is not a formal plan document.’ *Schonholz II*, 889 F. Supp. At 614. We also disagree with the district court’s holding that LIJ’s commitment to vest Schonholz ‘must be in ‘precise language denying the right to withdraw benefits.’ *Id.* at 615 (quoting *Wise*, 986 F.2d at 938). We do not think, at least in this case, that Schonholz is required to point to unambiguous language to support her claim. See *Bidlack*, 993 F.2d at 608-09. It is enough if she can point to written language capable of reasonably being interpreted as creating a promise on the part of LIJ to vest her severance benefits. Because the December 18 letter may be so interpreted by a trier of fact, we remand the contractual vesting claim to the district court.” *Id.* at 78.

reasonably being interpreted as creating a promise” in order for vesting to occur. The Fifth Circuit⁵⁷ likewise shied away from *Yard-Man*.

Alone among the courts of appeal, the Eleventh Circuit and the Fourth Circuit explicitly followed *Yard-Man* albeit while noting that it simply instructs courts to apply ordinary rules of contract interpretation. *United Steelworkers v. Connors Steel Co.*,⁵⁸ and *Keffer v. Porter*⁵⁹ (but see *Dewhurst v. Century Aluminum Co.*,)⁶⁰ stand almost alone outside of the Sixth Circuit in support of the *Yard-Man* inference. These cases stand in sharp contrast with the lengthy list of cases in the Sixth Circuit which followed *Yard-Man*.⁶¹

The Supreme Court’s rejection of *Yard-Man* in *Tackett* certainly cannot be said to have unsettled the law to a significant degree outside of the Sixth Circuit. Even in that circuit the Court of Appeals had recognized in *Sprague v. General Motors*⁶² that the presence of a reservation of rights clause which

⁵⁷ See *Nichols v. Alcatel USA Inc.*, 532 F.3d 364, 378 (5th Cir. 2008) (noting the *Yard-Man* inferences were never accepted by this court).

⁵⁸ 855 F. 2d 1499 (11th Cir. 1988) (ruling that the expiration clause of the collective bargaining agreement did not demonstrate an intent that all benefits described in the agreement also terminated, and that the plan agreements and the labor agreement as a whole established that the benefits did not terminate as to retirees. The court also held that appellant exercised such domination of its subsidiary that it became responsible as the alter ego plan sponsor and administrator under ERISA).

⁵⁹ *Keffer v. H.K. Porter Co.*, 872 F. 2d 60 (1989) (noting that “The intended meaning of even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion”) (citing *UAW v. Yard-Man, Inc.*, 716 F. 2d 1467, 1479 (6th Cir. 1983)).

⁶⁰ 649 F. 3d 287 (4th Cir. 2011) (holding that the CBA language on the duration of the benefits at issue appeared direct and plain that such benefits would remain in effect for the term of the labor agreement. In the face of the durational language in the CBAs, appellants had not made a showing, much less a clear showing, of a likelihood of success on the merits so as to meet the *Winter* standard. The language of the relevant CBAs did not infer an intent for retiree health-care benefits to extend beyond expiration of the relevant CBA).

⁶¹ See, e.g., *Cole v. ArvinMeritor, Inc.*, 549 F. 3d 1064, 1069 (2008) (noting that *Yard-Man* creates no presumption that benefits are vested for life.); *Noe v. Polyone Corp.*, 520 F. 3d 548, 568 (2008) (“[u]nless a company can point to explicit language in the relevant agreement stating that “retirement benefits” terminate at a particular date or do not vest, the benefits seem to vest as a matter of law. What we continually disclaim presuming, we continually seem to presume.”); *Golden v. Kelsey-Hayes Co.*, 73 F. 3d 648, 656 (“*Yard-Man* is still good law and controls this case.”); *International Union, United Auto., Aerospace and Agr. Implement Workers of America v. BVR Liquidating, Inc.* 190 F. 3d 768 (affirming ongoing validity of *Yard-Man*).

⁶² 133 F. 3d 388 (6th Cir. 1988). Plaintiffs, retired employees of the defendant, General Motors Corporation, allege that GM violated the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* (“ERISA”), by denying them fully “paid-up” lifetime health care benefits. *Id.* 392. The main thrust of the plaintiff’s complaint was that GM had bound itself to provide salaried retirees and their spouses basic health coverage for life, entirely at

unambiguously guaranteed to the employer the right to amend the plan defeated any subsequent claims that healthcare benefits had vested. The near universal failure of the *Yard-Man* approach to attract adherents outside the Sixth Circuit no doubt made it an easy target for the Supreme Court.

IV. Contract Interpretation in Cases in Cases of Mutually Strategic Silence

Given the shaky foundation of *Yard-Man* upon which the Sixth Circuit rested its conclusion in *Tackett* that union members could establish their claim to lifetime, employer paid retiree health benefits, the Supreme Court's forceful conclusion that the *Yard-Man* approach was inconsistent with "ordinary principles of contract law"⁶³ is not especially surprising. Thomas' opinion for the entire Court, however, seems to leave no room for the possibility that, on remand, the Sixth Circuit could possibly conclude that the parties in fact agreed to free health care for life.⁶⁴ Four justices joined in a concurrence, though, that suggests this conclusion is possible.

GM's expense. The right to such coverage vested upon retirement, according to the plaintiffs, so the coverage could never be changed or revoked. *Id.* at 395. This complaint arose when GM announced in late 1987 that significant changes would be effective in health care coverage for both salaried employees and retirees the following year. *Id.* at 395. Ultimately, the court affirmed the order that the employer was entitled to summary judgment on the employees' claims of breach of plan documents because the plan reserved the right to amend the health care benefits. The court itself claims, "[n]either the GM plan itself nor any of the various summaries of the plan states or even implies that the plaintiffs' benefits were vested." *Id.* at 402.

⁶³ *M & G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 930, 933 (2015).

⁶⁴ Thomas enters into several reasons why the logic underpinning the *Yard-Man* decision was flawed, and therefore led the Court of Appeals to "further compound this error" of relying on *Yard-Man* when deciding *Tackett*. *Id.* at 936. First, Thomas criticizes the Court of Appeals for attempting to ascertain the intent of the parties during collective bargaining with likely behavior as "too speculative and too far removed from the context of any particular contract to be useful in discerning the parties' intention." Second, Thomas questions the ability of the Court of Appeals to accurately understand the customs and intentions of parties across diverse industries, which would be necessary in the collective bargaining process. *Id.* at 935. Third, Thomas states that *Yard-Man* was not based in "any record evidence," and therefore the inferences it created rest on a "shaky factual foundation." *Id.* Fourth, *Yard-Man* principles allowed retiree benefits to vest at a point in the future violates the basic contractual principle that a contract is designed to "encompass the whole agreement of the parties." *Id.* Finally, Thomas

The concurrence makes four simple points about contract interpretation in situations like those in *Tackett* : first, “the intention of the parties, to be gathered from the whole instrument, must prevail”⁶⁵. This is not especially helpful in *Tackett* given the lack of language dealing directly with vesting in the written instruments. (This, of course, is the predictably risky position the union finds itself in following years of “strategic silence.”) Second, a court “must examine the entire agreement in light of relevant industry-specific ‘customs, practices, usages and terminology’.”⁶⁶ Third, if the parties’ intent is clearly expressed in the contract then that expression must control; where, as in *Tackett*, the contract is ambiguous, “a court may consider extrinsic evidence to determine the intention of the parties.”⁶⁷ (This, as we shall see, may be the *Tackett* plaintiffs only hope going forward.) And, fourth, “implied terms” from the expired labor agreements may serve as a basis for concluding that the parties in fact intended retiree health benefits to vest.⁶⁸ (This fourth point is a clear rejection of the employer’s claim that there can be no vesting without “clear and express” language demonstrating intent to vest.⁶⁹) The concurrence concludes by noting that this entire inquiry must take place without *Yard-Man’s* “thumb on the scale” but may “for example, [focus on] the parties’ bargaining history.”⁷⁰ This is, for the *Tackett* plaintiffs, the only part of the opinion which offers any hope going forward. The agreement itself, as

criticizes the Appeals Court for misapplying other contractual principles because it was “tugged” at by the influences of *Yard-Man*. Id.

⁶⁵ Id. at 937 (J. Ginsburg, concurring) (citing 11 Williston on Contracts § 30:2, p. 27 (4th ed. 2012)).

⁶⁶ Id. at 938 (J. Ginsburg, concurring) (citing 11 Williston on Contracts § 30:4, pp. 55-58 (4th ed. 2012)).

⁶⁷ Id. (citing 11 Williston on Contracts § 30:6, p. 98-104 (4th ed. 2012)).

⁶⁸ Id. (citing *Litton Financial Printing Div., Litton Business Systems, Inc. v. NLRB*, 501 U.S. 190, 203, 207 (1997)). “A similar duty may arise as well from the express or implied terms of the expired agreement itself.” *Litton Financial Printing Div., a Div. of Litton Business Systems, Inc. v. NLRB*, 501 U.S. 190, 203 (1991).

⁶⁹ “To effectuate the intent of the parties to a collective bargaining agreement, and provide the uniformity needed in national labor law, any commitment to vest health-care benefits should be clear and express in the language of the agreement.” Reply Brief for Petitioners, *M & G Polymers v. Tackett* No. 13-1010 2014 WL 5299414, *1 (2014). Later in their brief, the employer continues to argue that the “clear statement rule” used by the Third and Fifth Circuits is the optimal solution to resolving silence in collective bargaining agreements “regarding the duration of retiree health-care benefits.” Id. at *9. Justice Ginsburg flatly refutes these arguments by stating, “Contrary to M & G’s assertion, Brief for Petitioner 25, no rule requires “clear and express” language in order to show that parties intended health-care benefits to vest.” *Tackett*, 135 S. Ct. at 938 (J. Ginsburg, concurring).

⁷⁰ “If, after considering all relevant contractual language in light of industry practices, the Court of Appeals concludes that the contract is ambiguous, it may turn to extrinsic evidence—for example, the parties’ bargaining history. The Court of Appeals, however, must conduct the foregoing inspection without *Yard-Man’s* ‘thumb on the scale in favor of vested retiree benefits.’” Id.

noted, is consciously unclear; it is only the long relationship between the parties, their shared concern about increasing demands for transparency from regulators, and the cap agreements which may suggest that union members' reliance on what was not said was both reasonable and worthy of legal recognition.

A. ERISA's Equitable Estoppel Jurisprudence

Tackett is certainly not the first instance in which the administration of an ERISA plan⁷¹ has given rise to claims from employees that written or oral communications, combined with a long relationship and course of conduct between the parties, created vested rights that are not clearly expressed in the written contract.⁷² Indeed, there is a substantial ERISA jurisprudence that attempts to apply common law principles of equitable estoppel to cases involving disputes about plan administration and interpretation.⁷³

One possible avenue of redress for retirees hoping to hold onto their health benefits is an estoppel claim based upon the federal common law that has developed in connection with ERISA welfare and pension plans.⁷⁴ As others have noted, retirees have met with limited success as they have struggled to prove material misrepresentation by employers in connection with changes to health care plans⁷⁵. For

⁷¹ Long note here on the regulation of these retiree health care plans by ERISA. Cite to statute and explain why ERISA regulation matters. Cite to earlier ERISA retiree health care cases.

⁷² Long cite here--there are lots of these cases. Divide them into "oral promises" and "written promises".

⁷³ Long cite here on all the famous equitable estoppel ERISA cases—sort them by circuit court and describe each one. Cite also to law review articles written about equitable estoppel and ERISA and summarize each one.

⁷⁴ Long note here citing cases in Noel's memo about estoppel claims and making clear that standard is retirees have to prove material misrepresentation, detrimental reliance and extraordinary circumstances. Cite to misrepresentation cases, detrimental reliance cases and then extraordinary circumstances cases. General point is retirees rarely win these cases as burden of proof is substantial. The reason for high burden of proof is that ERISA plan sponsors are typically "free under ERISA, for any reason at any time, to adopt, modify or terminate welfare plans". Curtis-Wright Corp. v. Schoonejongen, 514 U.S. 73, 79 (1995). (describe facts and holding of Curtis-Wright here too.)

⁷⁵ Vallone v. CNA Financial, 375 F. 3d 623, 639-40 (7th Cir. 2004) (finding that the employees had not shown a knowing misrepresentation of fact because the employer could have had no actual intent of terminating the retirement benefit when it was offered, and second, that the employees unreasonably ignored the reservation of

example, in Moore v. Metropolitan Life⁷⁶ the Second Circuit emphasized the centrality of plan documents in these kinds of disputes. As Kaplan⁷⁷ and his co-authors have noted the Moore court pointed out 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.”⁷⁸

In addition, meeting the burden of proof with respect to detrimental reliance and extraordinary circumstances frequently proves difficult albeit not impossible. In a rare example of success, an employee demonstrated extraordinary circumstances to the satisfaction of the Third Circuit in Smith v. Hartford Ins. Group⁷⁹. Smith concerned an employee whose wife suffered a cerebral hemorrhage which required skilled nursing care and treatment. During this time the employer switched to a self-funded plan that limited skilled care to 180 days. However, the employer repeatedly assured the employee that the benefits under the new plan were identical to those of the previous plan. The court noted that a genuine issue of material fact prevented summary judgment as the employer’s oral and written

rights clauses in the retirement plan documents that “put them on notice that the HCA benefit could be terminated or modified); Moore v. Metropolitan Life Ins. Co., 856 F. 2d 488, 492 (2d Cir. 1988) (holding 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”); Hughes Aircraft v. Jacobson, 525 U.S. 432 (1999) (finding that misrepresentation of benefits to the employee may be incidental and thus legitimate); Pisciotta v. Teledyne Indus., 91 F.3d 1326, 1331 (9th Cir. 1996) (reiterating that the Ninth Circuit has two additional requirements for an ERISA beneficiary to establish material misrepresentation from an employer: 1) the provisions of the plan at issue must be ambiguous such that a reasonable person could disagree as to their meaning or effect, and 2) oral representations must be made to the employee involving an oral interpretation of the plan); In Re Unisys Corp., 58 F. 3d 896, 907 (3d Cir. 1995) (holding that the employees could not establish “reasonable detrimental reliance” on the employer’s claims).

⁷⁶ “Congress intended that plan documents and the SPDs [summary plan descriptions] exclusively govern an employer’s obligations under ERISA plans.” Moore, 856 F. 2d at 493.

⁷⁷ Kaplan, Powers, Zucker, “Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits,” 9 Yale J. Health Pol., Law and Ethics 287 (2009).

⁷⁸ Moore at 492, cited by Kaplan et. al. at 328.

⁷⁹ Smith v. Hartford Ins. Group, 6 F. 3d 131, 134-35 (3rd Cir. 1993) (holding that summary judgment against the plaintiff’s estoppel claim was inappropriate due to the repeated oral and written misrepresentations by the defendant, the plaintiff’s diligent attempts to obtain answers about coverage, and the large costs of the care).

communications were ambiguous and that, taken together, the employee had satisfied the requirement for demonstrating “extraordinary circumstances.”⁸⁰

With respect to allegedly oral modifications to plan terms the circuit courts are nearly unanimous in their refusal to permit oral promises to trump written plan language.⁸¹ For retirees such as those in *Tackett* this generally difficult legal standard, combined with the absence of the *Yard-Man* inference, means written contracts and ancillary documents will surely control the outcome of retiree health litigation.

B. Lifetime Benefits Not Uncommon

One of the curious features of the *Tackett* arrangement—a long term practice of providing retiree health benefits for life in the absence of explicit language enshrining the practice—is that a review of recent Sixth Circuit cases makes it clear that what would seem unthinkable now for economic reasons⁸² was

⁸⁰ See also, *Abbruscato v. Empire Blue Cross & Shield*, 274 F.3d 90 (2nd Cir. 2001) (remanding the estoppel claim back to the District Court to determine if the employer held the retirement programs out as an incentive to retire, if it had then this would be considered extraordinary circumstances); See *Bloemker v. Laborers Local 265 Pension Fund*, 605 F. 3d 436 (6th Cir. 2010)(plaintiffs, an ERISA plan participant and his wife sued defendants alleging that the plan breached an agreement with him, that he detrimentally relied on defendants’ misrepresentations and that they also breached fiduciary duties owed to him under the plan. The court concluded that extraordinary circumstances existed where the plan administrator certified erroneous early retirement pension amounts as correct and paid the incorrect amount for 22 months.)

⁸¹ See, e.g., *Perreca v. Gluck*, 295 F. 3d 215 (2d Cir. 2002) (holding that oral promises made by an employer are “unenforceable under ERISA and therefore cannot vary the terms of the employer’s pension plan”) (citing *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6, 7, 10 (2d Cir. 1992); *Ladouceur v. Credit Lyonnais*, 584 F. 3d 510 (2d Cir. 2009) (citing the language of *Perreca*, 295 F. 3d at 225); *Slice v. Sons of Norway*, 34 F. 3d 630 (8th Cir. 1994) (finding that failure to notify the employee of a rollover option for his benefits constituted extra-contractual damages and was non recoverable under ERISA); *Smith v. Dunham-Bush Inc.*, 959 F.2d 6 (2d Cir. 1992) (describing how the employee conceded that the oral promise was unenforceable under ERISA); *Frahm v. Equitable Life Assurance Society*, 137 F.3d 955 (7th Cir. 1998) (discussing that oral promises combined with a written plan could lead to a worker getting twice the benefits as established, something contrary to ERISA interpretation and contract law); *Bowerman v. Wal-Mart Stores, Inc.*, 226 F. 3d 574 (7th Cir. 2000) (reiterating that the Court has repeatedly stressed that equitable estoppel “cannot dilute the rule forbidding oral modifications to an ERISA plan); *de Nobel v. Vitro Corp.*, 885 F.2d 1180 (4th Cir. 1989) (holding that the plan itself is the defining source of a plaintiff’s claim, not material representations that items such as plan summaries might include).

⁸² It is probably impossible to overstate the role of economic forces in these retiree health cases. From the mid-1980s onward, as the cost of health care escalated and the pressure to account for post-employment benefits

apparently quite common in many heavy manufacturing industries up until recently. For example, shortly after the Supreme Court issued its opinion in *Tackett*, Whirlpool Corp. very publicly moved to reverse an adverse ruling in the Sixth Circuit on facts almost identical to those in *Tackett*. The Sixth Circuit, in *Moen v. Whirlpool Corp.*⁸³ had concluded that Whirlpool owed a group of retirees lifetime health care benefits.⁸⁴ The Sixth Circuit determined that this was clearly the intent of the parties⁸⁵ and that the absence of clear and express language did not forestall this conclusion.

increased, both the bargaining process itself and the administration and structure of these expensive ERISA plans were affected in a singular manner by costs. As Joe Stuligross of the United Steelworkers noted (phone interview May 7, 2015 on file with author) all of these cases including *Tackett* really boil down to an “offer and ask” problem. He described the years leading up to the litigation as “a problem [the cost of retiree health] that neither side really wants to talk about.” He pointed out that both the “employer and union clearly understood that this benefit was for life...even when employees went on strike retirees continued to get their free healthcare. This was clearly the intent and the plan was to control for costs via the cap letters.”

⁸³ *Zino v. Whirlpool Corp.*, 47 F. Supp. 3d 561 (N.D. 2014).

⁸⁴ The District Circuit provides a brief summary of the facts of the case, but directs the reader to the summary judgment action brought by cross-motions from both parties. *Zino v. Whirlpool Corp.*, 2013 WL 4544518 (2013). The retirees in this case were ones that retired between 1980 and 2007 and were represented by the International Brotherhood of Electrical Workers Local No. 1985 (“the Union”). *Id.* at *1. Since 1971, the Union and Whirlpool entered into a series of CBAs in two, three, or five year intervals. Prior to 1992, “each Welfare Plan explicitly provided that company-sponsored healthcare benefits will end upon retirement” and that the retirees “may continue medical coverage ‘at their own expense.’” *Id.* In 1992, “a new Welfare Plan extended qualifying retiring employees the ‘opportunity’ to receive company-paid healthcare after retirement.” *Id.* Every subsequent Welfare Plan until 2007 recognized this opportunity. Every retiree in the Zino lawsuit “has continued to receive company-sponsored healthcare benefits.” *Id.* Changes in corporate structure occurred during the negotiation of these CBAs, with many of the now Whirlpool retirees originally working for Hoover, but Whirlpool sold Hoover to a Hong Kong company, keeping the liabilities for the employee retirement plans as a part of the deal. *Id.* at 2. In 2011, Whirlpool informed the retirees that it would reduce their health care benefits in January 2013, and later extended it to January 2014. *Id.* “Specifically, Whirlpool notified Medicare-eligible retirees that company-paid supplemental health coverage will have to be individually purchased from private insurance companies. Whirlpool also informed retirees who were not Medicare-eligible that their health coverage will ‘transition’ to the same plan as that provided to the majority of Whirlpool retirees who are not eligible for Medicare.” *Id.* With these planned reductions in coverage, Whirlpool declared, “the right, at its discretion, to change or terminate all or any part of the benefits offered at any time and in any manner.” *Id.* “Whirlpool does not deny that these reductions will result in “an approximately 75% decrease” in estimated present value of the retiree’s benefit plans. *Id.*

⁸⁵ *Zino v. Whirlpool Corp.*, 47 F. Supp. 3d 561 (N.D. Ohio 2014). According to the provision of the 1992 agreement, “the eligibility of retirees to receive company-paid health benefits was unequivocally tied to their receipt of pension benefits. In order to continue company insurance coverage during retirement, these retirees must have retired ‘under the terms of the Pension Plan’ and have had ‘at least ten years of pension credit accumulated after attaining the age of 45 (or [have been] born prior to December 31, 1937)....’” The Court relies on *Yard-Man* principles to emphasize that under the Sixth Circuit vesting rules, this “demonstrat[es] the parties’ intent to create vested healthcare benefits.” *Id.* Testimony of various parties also indicated that, “the intent of the Company and the Union was to negotiate an agreement that provided health benefits to retirees *for life.*” *Id.* at 571 (emphasis in original). Finally, the Court focuses on the fact that these benefits would continue after the expiration of the CBA,

Likewise in *USW v. Kelsey-Hayes*,⁸⁶ a case in which the employer Kelsey-Hayes (later TRW) sent a letter to employees informing them that it would discontinue group health care coverage and instead provide Health Reimbursement Accounts (HRAs)⁸⁷, the same court noted that this change was essentially a mechanism by which risk shifted from the employer to the employees. “The HRAs differed from the prior group coverages in that they shifted risk—and potentially costs—off of the defendants and onto plaintiffs. At the deposition of TRW Benefit Director [...] it was established that, under the HRAs, plaintiffs ‘bear [] the risk of expenses that exceed the company contribution [.]’ For example, as [...] confirmed, if a retiree spent \$20,000 in 2012, the retiree would be responsible for the \$5000 spent in excess of the \$15,000 in his or her HRA.”⁸⁸

Noting that it found the employer’s assertion that the HRAs would provide better coverage than the prior group coverage “dubious”⁸⁹ the Court noted that HRAs are simply not what the parties bargained for.⁹⁰ “In sum”, the Sixth Circuit noted, “we conclude that the [collective bargaining agreements]

which both *Yard-Man* and *Wieimer v. Kurz-Kasch, Inc.* support. *Id.* at 578 citing *Weimer v. Kurz-Kasch, Inc.*, 773 F. 2d 669, 676 n. 6 (6th Cir. 1985) (“the fact that retirees’ insurance benefits initially were continued after the collective bargaining agreements expired ... would be some evidence of the parties’ intent”); *UAW v. Yard-Man*, 716 F. 2d 1476, 1481 (1983) (“[company’s] own course of conduct in continuing retiree insurance benefits after plant closure beyond the point as which insurance benefits could have been terminated for active employees indicates that it did not consider retiree benefits to be tied to the durational limitations of that active group”).

⁸⁶ *USW v. Kelsey-Hayes Co.*, 750 F. 3d 546 (2014).

⁸⁷ In 2012, Kelsey-Hayes switched its group coverages plans to “Health Reimbursement Accounts” (HRAs). *Id.* at 550. “The HRAs were designed to function, essentially as a health care voucher system” that TRW (the company at the time) would make “a one-time contribution” of “\$15,000 for each eligible retiree and his or her spouse.” *Id.* Then, as of 2013, “TRW would provide a \$4,800 credit into the HRAs . . . for each eligible retiree and eligible spouse.” *Id.* “The notion was that [employees] would then use these funds to purchase their own insurance from among a variety of providers.” *Id.* The benefit of this system was to “shift risk - and potentially costs - off of [TRW] and onto the [employees].” *Id.* The benefit of this fixed system of payments was that the employer would not be responsible for health care costs that went above the fixed cost that went above the one time payment. *Id.* See *infra* notes 88-89. Additionally, TRW would be able to predict and fix its costs related to these retiree benefits.

⁸⁸ *Id.* at 550. This statement was made by the TRW Benefit Director, and she admitted that this process shifted excess costs of healthcare to the retirees, “as ‘that risk used to be borne by the insurance company’ under prior group coverages.”

⁸⁹ *Id.* at 557.

⁹⁰ “As described above, the HRAs were simply not what was collectively bargained. The parties agreed in the CBAs that the retirees would get the same type of coverage they had upon retirement, which in the case of these retirees was group coverages with the full premium paid by the company.” *Id.*

established a vested right to lifetime health care benefits, and that⁹¹ the unilateral implementation of the HRAs breached [those contracts].”

The prevalence of lifetime benefits in unionized, manufacturing sectors of the economy⁹² would seem to support the main contention of the plaintiffs in *Tackett*: that the benefits were so pervasive and so deeply ingrained that, combined with past practice and the growing need to be careful about the requirements of FAS 106, the lack of explicit language about vesting is understandable. These facts, taken in light of the four factors identified by the justices who signed onto the concurring opinion in *Tackett*, are essentially all that the plaintiffs can point to in support of their position. The explicit reliance though in both the *Whirlpool* and *Kelsey-Hayes* cases on the now disfavored *Yard-Man* inference will make it difficult to overcome the new skepticism about vested retiree health care benefits after *Tackett*.⁹³

⁹¹ Id. at 556. Note that Judge Merritt, in concurrence, pointed out that this case is not about requiring the employer to provide health care benefits in the same way forever; instead it is about an “employer [that] clearly violated its legal obligations and should be required to pay the price of its recalcitrance.” Id. at 561 (J. Merritt, concurring).

⁹² Data here on how many of these plans existed and in what sectors of the economy. Did these benefits ever exist outside of unionized workplaces? Data?

⁹³ Both the *Whirlpool* and *Kelsey-Hayes* Courts rely on the *Yard-Man* decision potentially to their detriment. *Yard-Man* explained that “retiree benefits are in a sense ‘status’ benefits which, as such carry with them an inference . . . that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree.” Zino v. Whirlpool Corp., 47 F. Supp. 3d 561, 566 (N.D. Ohio 2014) (citing UAW v. Yard-Man, 716 F. 2d 1476, 1479) (internal quotations omitted). However, *Yard-Man* is “properly understood as creating an inference only if the context and other available evidence indicate an intent to vest.” Id. The burden of proof does not shift to the employer, and there is no requirement that employers use anti-vesting language. USW v. Kelsey-Hayes Co., 750 F.2d 546, 552 (6th Cir. 2014) (citing Mauer v. Joy Tech., Inc., 212 F. 3d 907, 915 (6th Cir. 2000)). *Yard-Man* is also influential “for its instruction to ‘look to other provisions of the agreement for guidance’ when the explicit language is ambiguous” to the parties’ intent. *Whirlpool*, 47 F. Supp. 3d at 566. *Yard-Man* and its subsequent cases instruct Courts to simply “apply ordinary principles of contract interpretation.” *Kelsey-Hayes*, 750 F. 3d at 554. The *Whirlpool* Court focuses on the fact that the retirees from the 1980-1983 have continued to receive their benefits after the CBA expired. Id. This factor leads the Court to believe the *Yard-Man* presumption should act “like a thumb on the scales” for the employees. Id. Similarly, in the Court in *Kelsey-Hayes* cites that *Kelsey-Hayes* had promised the retirees “the continuance of the healthcare coverages that he or she had . . . at the time of retirement.” *Kelsey-Hayes*, 750 F. 3d at 554. Further, *Kelsey-Hayes* had agreed to pay “the full premium or subscription charge for health care coverages continued in accordance” with other sections of the CBA. Id. The Court found this language unambiguous, and under the *Yard-Man* presumption, there was a vested lifetime right to health care benefits. Id. Indeed, the *Yard-Man* principles have caused the 6th Circuit to vacate and remand the *Kelsey-Hayes* case to the District Court. *USW v. Kelsey-Hayes Co.*, 2015 WL 4538811 (2015). However, Judge Merritt dissented with this

C. Regulatory Distortion and FAS 106

The behavior of plan sponsors in the private sector in anticipation of and following the implementation of FAS 106 is well documented.⁹⁴ Thousands of employers modified existing plans in order to provide for an acceptable balance sheet that would take into account the cost of promises made for future payments as required. Likewise an argument could be made that the changes in the public sector which were triggered by GASB 45⁹⁵ were even more dramatic. Numerous state and local government employers have been forced to reckon with the size and scope of benefits that had been promised to public employees—often without much thought to the future cost to taxpayers.⁹⁶ Indeed, some states are still trying, very publicly, to come to terms with the cost of post-employment benefits that threaten to crowd out all other spending.⁹⁷ In the private sector, especially in workplaces without unions, reductions in retiree healthcare were swift and often unchallenged.⁹⁸ Many employers simply eliminated retiree health coverage altogether.⁹⁹

decision, stating that “Kelsey-Hayes employees who are retired are entitled to vested health care benefits under the collective bargaining agreements.” Id. (J. Merritt, dissenting).

⁹⁴ Financial Accounting Standards Board, Statement of Financial Accounting Standards No. 106 (1990), *available at* http://www.fasb.org/jsp/FASB/Document_C/DocumentPage?cid=1218220123671&acceptedDisclaimer=true.

⁹⁵ Governmental Accounting Standards Board, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions (June 2004), *available at* http://www.gasb.org/jsp/GASB/Document_C/GASBDocumentPage?cid=1176159988899&acceptedDisclaimer=true.

⁹⁶ “[P]olitical actors, often in exchange for promises of support at the polls, commit to more generous benefits than the taxpayers can realistically afford.” Legislators generally realize they have various other commitments in addition to pensions, and these “generally require immediate spending in order to satisfy the public’s demand for services.” Maria O’Brien Hylton, *The Case for Public Pension Reform: Early Evidence from Kentucky*, 47 *Creighton L. Rev.* 585, 596 (2014).

⁹⁷ Long note here about saga in Illinois—state is basically bankrupt and just lost Illinois Sup. Ct. case that says it cannot reduce promised benefits to its public employees. Cite to lots of data; cite to Illinois Sup Ct. case and also to WSJ and NYT articles on this and include quotes.

⁹⁸

⁹⁹ From 1993 to 1994, the percentage of large companies “offering benefits to retirees eligible for Medicare fell from 40% to 21%.” David A. Pratt, *The Past, Present and Future of Retiree Health Benefits*, 3 *J. HEALTH & BIOMEDICAL LAW* 103, 121-122 (2007).

If the explanation provided by the *Tackett* plaintiffs is accurate, their story is essentially one of a different, but understandable response. While the public sector continues to grapple with the fallout from GASB 45 and its implications for municipal bankruptcy,¹⁰⁰ and non-unionized employers made fairly nimble adjustments as required by FAS 106 to their benefit plans¹⁰¹, the *Tackett* story (and that of the plaintiffs in the *Whirlpool* and *Kelsey-Hayes* cases) is likewise a slightly modified tale of adjustment. Lacking the ability to make unilateral changes to benefit plans that characterizes the unorganized private sector and also the messy political process that has at times paralyzed the public sector¹⁰², unionized workplaces, as they so often do, settled on repeated, short term fixes that would appear to satisfy shareholders, keep the company profitable and provide retirees with benefits they had every reason to believe they were entitled to.

The cap letters and the inexplicable silence about vesting make the most sense when understood as a response to a painful move toward more transparency that made lifetime promises of any sort seem ridiculously expensive. Many of the modern changes to post-employment benefits are rightly attributed to employers reacting to GASB 45 or to FAS 106. It makes sense to view the relationship between the parties in *Tackett* through the same lens—indeed, it would be peculiar to think that the widespread changes buffeting all employers as they struggle with rising health care costs somehow were irrelevant to unionized manufacturers like M & G Polymers.¹⁰³

¹⁰⁰ See Maria O’Brien Hylton, *Central Falls Retirees v. Bondholders: Assessing Fear of Contagion* in Chapter 9 Proceedings, 59 Wayne L. Rev. 525 (2013).

¹⁰¹

¹⁰² Detailed examples from California, Illinois, Rhode Island and other states here. Cites and quotes.

¹⁰³ The growth of healthcare expenses has risen across the world, but the United States has grown far more rapidly than similar countries around the world. Kaiser Family Foundation, “Snapshots: Health Care Spending in the United States & Selected OECD Countries,” <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/> (last visited July 28, 2015). In 1980, the United States was roughly equivalent to Sweden in healthcare costs per capita, but now spends more than \$3,000 more per capita on healthcare expenses. *Id.* at Exhibit 3. Interestingly, this is also \$3,000 greater than the United States was spending per capita in 2008, and roughly twice as much per capita as the global average. *Id.* at Exhibit 4B. Additionally, the growth of United States healthcare spending is a “clear outlier” to many other highly developed countries. Dept. of

That an employer and a union with a long relationship and a shared goal of presenting to shareholders the best possible balance sheet would opt for strategic silence seems entirely reasonable. Silence was completely unnecessary in the non-unionized private sector where employers could generally implement the changes they sought with little or no consultation with employees; in the public sector, whose unions vigorously opposed GASB 45¹⁰⁴ silence was impossible once the public learned of the extraordinarily generous benefits that its tax dollars were supporting.¹⁰⁵

In the shrinking private and organized part of the economy though, strategic silence was a perfectly reasonable response, albeit a risky one for retirees. If the Sixth Circuit on remand focuses carefully on the four factors identified by the Justices who wrote in concurrence, there is a reasonable likelihood that the *Tackett* plaintiffs (the current retirees) will hold onto their free health care benefits.

Health and Human Servs. “The Effect of Health Care Cost Growth on the U.S. Economy,” 2-3, *available at* <http://aspe.hhs.gov/health/reports/08/healthcarecost/report.pdf>. See also “The History of Health Care Spending in 7 Graphs,” WASH. POST. http://www.washingtonpost.com/business/economy/the-history-of-health-care-spending-in-7-graphs/2012/01/09/gIQAfICcmP_gallery.html (last visited July 28, 2015).

¹⁰⁴ “The unions said that if governments were forced to disclose the cost of their plans, they would probably cut or drop them, just as companies have done.” *The Next Retirement Time Bomb*, N. Y. TIMES, Dec., 11, 2005, <http://www.nytimes.com/2005/12/11/business/yourmoney/the-next-retirement-time-bomb.html>. Forcing governments to confront the amount promised to future retirees is a process that will help them ascertain costs for programs promised but not accounted for. *Id.* Some unions have taken the position that the financial accounting rules are “being used to promote and enforce a corporate political agenda, the ending of retiree benefits.” *The Attack on Pensions and Retirees Heats Up: GASB*, UNION ELECT. WORKERS, (last visited July 30, 2015), http://www.ueunion.org/stwd_gasbfasb.html. In 2005, the president of the American Federation of State, County and Municipal Employees “promised a fight if GASB is used to eliminate retiree health care.” Ronald A. Wirtz, *Gaspings over GASB*, Fed. Reserve Bank of Minneapolis, (May 1, 2006), <https://www.minneapolisfed.org/publications/fedgazette/gaspings-over-gasb>. In Costa County, California, the International Federation of Professional and Technical Engineers has sued the county for capping its current county healthcare limits has resulted in going “against the spirit of the negotiated language” because the county is worried about their “bond rating” and the “appear[ance] of hav[ing] greater liabilities on their books.” Mark Seville, *Unions Seek Creatively, Financially Sound Solutions to Protect Retiree Healthcare*, Twenty One, Winter 2014, *available at* <http://www.ifpte21.org/sites/local21.huang.radicaldesigns.org/files/winter2014-final.pdf> (Twenty One is the quarterly publication of IFPTE Local 21).

¹⁰⁵ While there is difficulty computing the exact value of government employee pensions, “the average public pension is several times more generous than 401(k)-style plans in the private sector.” Jason Richwine, *The Real Cost of Public Pensions*, THE HERITAGE FOUND. (May 31, 2014), *available at* <http://www.heritage.org/research/reports/2012/05/the-real-cost-of-public-pensions>.

The parties' long history of bargaining, combined with the industry specific practice of cap letters and side agreements¹⁰⁶ and other extrinsic evidence that suggests the retirees' reliance was not misplaced and that both parties almost certainly understood what was really going on. The major obstacle to a "win" for the *Tackett* retirees is not common and widely accepted rules of contract interpretation, *Yard-Man* notwithstanding. The central problem is that employers like M & G Polymers simply cannot afford to honor the promises they made implicitly and which they did honor for a long time.

Justice Thomas' opinion in *Tackett* is not so much a rejection of *Yard-Man* (although it certainly sidelines that decision) as it is a practical way out of a problem that threatens to overwhelm many employers.

The obvious solution for retirees in non-physically demanding industries is to remain employed until at least age 65 when Medicare eligibility is triggered.¹⁰⁷ For those who simply cannot continue to work past age 50 or 55 (a not uncommon reality in mining, steel, auto and other manufacturing jobs)¹⁰⁸ some sort of legislative solution is required to fill the new gap. The catch of course is that the Medicare program's finances are already shaky¹⁰⁹ and the political will needed to expand the program is not certain.¹¹⁰

V. Conclusion

¹⁰⁶

¹⁰⁷ "Every individual who-- has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, is eligible to enroll in the insurance program established by this part." 42 U.S.C.A § 1395o(2) (2015).

¹⁰⁸ Injuries present in these professions similar to the steel and mining industry could lead to necessary retirement due to workplace related injuries, disabilities, and even death. See Dept. of Labor, Bureau of Labor Statistics, Industry Injury and Illness Data (2013), *available at* <http://www.bls.gov/iif/oshwc/osh/os/ostb3962.pdf> (referencing Table SNR01, titled Highest Incident Rates of Total Nonfatal Occupational Injury and Illness Cases); Dept. of Labor, Bureau of Labor Statistics, National Census of Fatal Occupational Injuries in 2013 (Preliminary Results) (Sept. 11, 2014), *available at* <http://www.bls.gov/news.release/pdf/cfoi.pdf> (referencing Chart 2, showing that while the mining industry had decreased in number of fatal workplace incidents, it still reported one of the highest rates of employee death on the job).

¹⁰⁹ Long note here on out of control Medicare costs; high cost of insuring older people; cite to NYT, LATimes, WSJ as well as law review articles and numerous research articles in the health law field.

¹¹⁰

The Supreme Court’s recent unanimous decision in *Tackett* rejects the *Yard-Man* inference which only ever enjoyed limited support outside of the Sixth Circuit. The central contribution of the opinion is its clear reaffirmation that traditional principles of contract interpretation—the primacy of unambiguous language, the role of industry specific customs and the availability of extrinsic evidence in light of ambiguity—apply in cases where the parties have failed to be explicit and, in doing so, essentially gambled about future litigation. For the *Tackett* plaintiffs—current retirees who are, by definition not well suited to obtaining new employment and/or alternate sources of employer-based health insurance—the only moderately optimistic way forward requires a coherent explanation of the years of silence surrounding an important and increasingly expensive benefit.

The story needs to include an explanation of the years long practice of not talking about the unacknowledged but well understood expectation of retirees that their benefits would always be free and would last for life. The role of the cap letters as a mechanism for controlling risk will be critical to this process. If the retirees can characterize their own strategic behavior as a calculated response to the post FAS 106 world—a world that was materially different from the experience of unorganized workers in the private sector—they will maximize the chances of holding on to their employer sponsored health care.

PRELIMINARY DRAFT: PLEASE DO NOT CITE OR QUOTE