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March 1990

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Henry H. Perritt Jr.

IIT Chicago-Kent College of Law, hperritt@kentlaw.iit.edu

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Recommended Citation

Henry H. Perritt Jr., *Health Care Plans and ERISA*, 6 Lab. Law. 949 (1990).

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Health Care Plans and ERISA

Henry H. Perritt, Jr.*

*Professor of Law
Villanova University Law School*

I. Introduction

Employers pay for most Americans' health care through health care employee benefit plans. Despite the variety of benefits and the different labels that may be used for various structural arrangements, analysis of the legal relationships involved is straightforward. This article provides an overview of the legal framework for employee health benefit plans, addressed in greater detail in the author's book, *Employee Benefits Claims Law and Practice*.¹

The complexity of employee benefits law and its heritage in the tax code unfortunately have intimidated many labor lawyers and general practitioners who perceive employee benefits law as something beyond their competence and within the exclusive province of tax lawyers or other employee benefits specialists. But while specialized expertise may be necessary to *develop* benefit plans, it is not necessary to *litigate* claims for employee benefits.

Employee benefit claims raise legal issues susceptible to conventional legal analysis. The principles of contract formation; statutory, contract and trust interpretation; remedies; and equity apply to employee benefit claims just as they apply to wrongful dismissal cases, labor injunction controversies, or personal injury claims.

This article concentrates on health benefit plans for three reasons. First, less has been written about health benefit plans than pension plans. Second, the Employee Retirement Income Security Act's (ERISA) role in regulating health benefit plans may surprise lawyers who would not be surprised that ERISA pervasively regulates pension plans. Third, ERISA constrains employers less in defining and modifying health benefits than pension benefits; and it also constrains insurance carriers less than state common law, which is preempted by ERISA.

*Professor of Law, Villanova University Law School. Member of the bar, Virginia, Pennsylvania, District of Columbia, and United States Supreme Court. Professor Perritt is vice chairman of the Coal Commission, appointed by Secretary of Labor Elizabeth Dole to develop long-term solutions to funding and delivery of health care in the coal industry. Copyright 1990 Henry H. Perritt, Jr.

1. John Wiley & Sons, 1990 (hereinafter EBCLP).

II. A Simplified Overview

Several rules of thumb are useful for thinking about employee health benefits claims:

1. A right to receive benefits must derive from a contract or trust.²
2. Claims for employee benefits are likely to be covered by federal law under ERISA, which preempts state law broadly.³
3. Welfare benefits like health care insurance as well as pension claims are covered by ERISA.⁴ ERISA defines welfare plans explicitly to include plans that provide benefits through "the purchase of insurance or otherwise."⁵
4. Claims must be filed initially under the plan before an employee has the right to sue on the claim.⁶
5. ERISA requires the existence of certain formal plan documents which must identify the plan administrator and describe the claims and appeals procedure.⁷
6. Failure by plan administrators to provide required information is an independent statutory violation under ERISA entitling participants to liquidated damages.⁸
7. ERISA imposes on plan administrators and other plan fiduciaries a set of fiduciary duties, including the obligation to administer the plan strictly for the benefit of plan participants. Breach of these fiduciary obligations entitles injured participants to be made whole.⁹
8. State and federal courts have concurrent jurisdiction over claims to enforce plan terms; federal courts have exclusive jurisdiction over claims of statutory violations, including fiduciary duty breaches¹⁰
9. Punitive and emotional distress damages probably are not

2. EBCLP Ch 3 addresses contract concepts. EBCLP Ch 4 addresses trust concepts.

3. EBCLP Ch 6 considers preemption.

4. 29 USC § 1003 (1988) says that ERISA covers employee benefit plans established or maintained by employers or employee organizations. Employee benefit plan is defined by 29 USC § 1002(3) to cover *employee welfare benefit* plans and pension benefit plans. Employee welfare benefit plan is defined by 29 USC § 1002(1) to include "any plan, fund, or program" established or maintained for the purpose of providing through the purchase of insurance or otherwise "medical, surgical or hospital care or benefits." EBCLP §§ 5.4 considers ERISA coverage.

5. 29 USC § 1002(a) (Supp V 1987).

6. EBCLP §§ 7.8–7.9 consider exhaustion of plan remedies.

7. EBCLP § 5.3 describes ERISA's structural requirements and EBCLP § 1.33 discusses the different types of plan decisionmakers.

8. See EBCLP § 5.26.

9. EBCLP §§ 4.10–4.13 and sections 4.28–4.31 explain fiduciary obligations and remedies.

10. See EBCLP §§ 7.2–7.11 (forums).

available even for bad faith administration *claims*.¹¹

10. ERISA's plan termination provisions apply only to pension plans, although the state mandates health insurance conversion rights for terminated employees.¹²
11. Persons entitled to receive benefits under ERISA plans are called "participants." Their survivors succeeding to their employee benefit rights are called "beneficiaries."

III. Benefit Plan Structures: Three-Party Versus Two-Party Structures

Lawyers and clients easily can lose their bearings in the jargon of "first dollar coverage," "Medicare wraparound," "cost containment," "HMOs" and "PPOs." However, these distinctions do not matter much in terms of claims administration and litigation. What matters is who has an obligation and who has a correlative right in a particular two-party legal relation. A useful framework for evaluating rights, duties, and privileges in the employment torts context is that offered by Wesley N. Hohfeld¹³ and clarified by Arthur Corbin.¹⁴ The Hohfeldian framework classifies legal relations involving only two parties according to six concepts: privilege, immunity, right, duty, power, and disability. These six concepts can be paired as opposites: duty v. privilege, right v. no-right, power v. disability, and liability v. immunity. The six also can be paired as correlatives, signifying that each member of a correlative pair exists on the opposite side of the same relationship from the other: right and duty, privilege and no-right, power and liability, and immunity and disability.¹⁵

The most general type of distinction can be drawn between benefit plans involving a third party and those that involve only the employer and employee.¹⁶ In health plans involving a third party, the third party is most likely to be a trustee or an insurance carrier contracting to provide for insurance benefits. Most pension plans involve trustees and most health care plans involve insurance carriers, although some multiemployer health care plans involve trustees. A relatively pure example of a plan not involving a third party, but simply involving legal relationships between employer and em-

11. See EBCLP §§ 3.37, 4.28, and 5.26.

12. See EBCLP § 5.10 (discussing COBRA conversion requirement).

13. Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 Yale L J 16 (1913-14).

14. See Corbin, *Legal Analysis and Terminology*, 29 Yale L J 163 (1919-1920).

15. See Corbin, 29 Yale L J at 166.

16. ERISA requires trusts only over plan assets. Since the Internal Revenue Code does not permit employers to deduct contributions to prefund health care benefits, few health care plans accumulate assets beyond what is necessary to pay benefits as they are due, meaning that few health care plans are covered by the trust requirement.

ployee, is a hospitalization plan established by a hospital-employer, in which the employer promises to provide inpatient care to employees who require it. In some cases, plans provide services directly,¹⁷ but most employers contract with a third-party provider or reimburse for participant-purchased services. It should be obvious that two-party arrangements involve contractual obligations by the employer.¹⁸ In three-party arrangements, the employee-participant's claim for benefits most likely involves legal obligations of the third party, a trustee based on the trust instrument,¹⁹ or an insurance carrier on the insurance contract.²⁰ Sometimes an employer also may serve as trustee. In such cases, it is appropriate to distinguish the two roles of trustee and employer because they are likely to be associated with different legal obligations. There also frequently may be other actors: individuals serving as trustees or other fiduciaries; and individuals or institutions serving ministerial functions without being trustees or fiduciaries, or being fiduciaries without being plan administrators.²¹

All employee benefit plans involve some degree of risk sharing or insurance.²² Three basic types of insurance are involved in providing employer-sponsored health care benefits. The employer may be the insurer. A traditional insurance carrier may be the insurer. A medical care provider like a health maintenance organization may be the insurer. Employers have an incentive to self-insure for health care because, by self-insuring, they enjoy ERISA's preemption of state insurance regulation which may require coverage for certain types of health care services.²³ Insurers and employers both have an incentive to shift some of the insurance risk to health care providers. Unless providers share some of the risk for overuse of health care benefits, they have an economic incentive to overprescribe and encourage employee-participants and beneficiaries to overuse health care. Either traditional insurance carriers or health care providers playing an insurance role are subject to state insurance regulation

17. See *McLaughlin v Bendersky*, 705 F Supp 417, 418 (ND Ill 1989) (enforcing DOL subpoena against dental services contractor to compel release of cost and profits data in connection with contract with union health and welfare fund).

18. See generally EBCLP Ch 3.

19. See EBCLP Ch 4.

20. See EBCLP Ch 3 (contract enforcement) and EBCLP Ch 6 (role of state law in regulating insurance).

21. See EBCLP §§ 4.9, 5.3 (explaining where fiduciary duties lie); § 1.33 (decisionmakers).

22. *Allied Structural Steel Co. v Spannaus*, 438 US 234, 246 (1978) (likening pension plans to other types of insurance).

23. *Metropolitan Life Insurance v Massachusetts*, 471 US 724, 728 (1985) (prevalence of state mandated benefits statutes).

under the savings clause²⁴ of ERISA section 1134. It is a matter of state law whether and how these insuring entities are regulated.

A. Types of Plans: Structural Variations in Health Care Plans

It is increasingly common in managed care health insurance arrangements for the insurer to contract with health care entities to perform obligations under the insurance contract. One common arrangement involves a contract between a health care insurer and a physicians' group to provide all outpatient and inpatient services covered in the group insurance policy.²⁵ The physicians' group typically is compensated on a capitation basis (a flat payment per subscriber regardless of the level of services consumed by that particular subscriber). Any payments to subordinate care providers like hospitals are the legal responsibilities of the physicians' group.²⁶ Separate insurer-physician group contracts may be involved for specialized types of services such as psychiatric treatment.

Such an arrangement obviously puts the physicians' group in a risk management activity strongly resembling insurance. In many cases, however, only the insurer itself is subject to state insurance regulation. In any event, the participants' legal rights are defined by the group insurance policy and are enforceable against the insurer, without regard to the insurer's subcontracting arrangements.²⁷ Of course, the responsibility to pay premiums is, as explained above, a matter of a separate contract between employer and insurer or between employer and individual employee.

The insurer is obligated to provide health care or to pay for it. The employer is obligated to pay premiums. The physicians' group is obligated to provide health care. The employee may have a right to performance of all three obligations but privity of contract with at most two (the employer and the insurer) and maybe with only one (the employer). The employee's rights are those of a third-party beneficiary with respect to the physicians' group and maybe with respect to the insurer.²⁸

24. 29 USC § 1144(b)(2)(A) "saves" state insurance regulation from preemption.

25. See *Adnan Varol, M.D., P.C. v Blue Cross & Blue Shield*, 708 F Supp 826, 828-30 (ED Mich 1989) (describing General Motors cost containment pilot program).

26. See generally Rank, *Capitated Health Delivery Systems*, 6 Whittier L Rev 649 (1984) (discussing capitation arrangements in California).

27. See EBCLP § 8.22 for a discussion of liabilities in the event of insolvency of a physicians' group playing this role.

28. There is conflicting authority as to whether the insured under a group insurance policy is best treated as a third-party beneficiary to a contract between the insurance carrier and the employer-purchaser of the group policy or as a party to a contract with the insurance carrier. In the latter view, the employer-purchaser can be viewed as the agent of the employer-beneficiary-contract party. 19 G. Couch, *Cyclopedia of Insurance Law* § 82.2 at 708 (1983) (primary contract is group master

B. *Benefit Plan Decisionmakers*

Employee benefits cases can be confusing because of the many different roles and labels assumed by various decisionmakers.²⁹ ERISA requires that every plan have at least one named *fiduciary* as the *plan administrator*.³⁰ Generally, someone is a fiduciary under ERISA when the person exercises discretion with respect to plan interpretation or asset management.³¹ The Labor Department regulations make it clear that the legal obligations under ERISA are to be determined by functions performed and obligations voluntarily undertaken rather than by labels applied.³² For example, even if no fiduciary is named explicitly, a *plan committee* may be a fiduciary, based on its degree of discretionary responsibility. Conversely, an *advisor*, *attorney*, or *accountant* for a plan may not be a fiduciary, and a *benefits supervisor* may not be a fiduciary to the extent that ministerial functions are performed. On the other hand, some titles such as *administrator* and *trustee* presumptively, and perhaps irrebuttably, establish fiduciary status. Fiduciaries may have fiduciary responsibility only for those functions they actually perform and not for functions they have delegated to others, and certainly not for functions never given to them in the first place.³³ The Labor Department regulations also make it clear that an entity such as a corporation may be a fiduciary or administrator.³⁴

A fiduciary has obligations to comply with the terms of the plan, whether the plan is a trust or a contract, and to satisfy fiduciary obligations imposed by ERISA and the common law of trusts. Fidu-

policy issued to employer); § 710 (certificate of insurance under group policy is merely evidence of insurance and not the insurance contract, citing *Blue Cross v Ayotte*, 35 AD2d 258, 315 NYS2d 998 (1970)); § 82.1 at 32 (1990 Supp) (citing *Rhodes v Aetna Life Insurance Co.*, 135 Mich App 735, 356 NW2d 247 (1984) (employee not primary party to group insurance contract; employee rights derived from contracts among insurer, employer, and union) and *Paul v Insurance Co. of N. America*, 675 SW2d 481 (Tenn App 1984) (primary group insurance contract is between employer and insurer; if employees contribute part of premium, there is also a contractual relationship between employee and insurer)).

29. See *Musto v American General Corp.*, 861 F2d 897, 910 (6th Cir 1988) (employer, plan administrator, and insurance carrier roles all played by same insurance company that was also plan sponsor); *Anoka Orthopaedic Associates v Mutschler*, 709 F Supp 1475, 1476 (D Minn 1989) (employer-medical practice was plan administrator; shareholders and employees of employer-medical practice were plan participants and also plan trustees).

30. See EBCLP § 5.6.

31. See EBCLP § 4.9.

32. 29 CFR § 2509.75-7 FR-3 (1987); 29 CFR § 2509.75-7 FR-1; 29 CFR § 2509.75-8 FR-12 (1987) (questions and answers by Labor Department on interpretation of fiduciary definition). The Labor Department regulations are reviewed in EBCLP §§ 5.6-5.8.

33. See EBCLP § 4.9 (explaining who has fiduciary responsibility); §§ 5.6 (explaining statutory delegation sections).

34. See EBCLP §§ 5.6-5.8 (reviewing Labor Department regulation).

ciary capacity, therefore, has the broadest range of responsibility associated with it. Frequently, the employer acts as the administrator for a group insurance policy by collecting premiums, notifying the insurer of changes in participant status, and possibly handling claims.³⁵ In such circumstances, both insurance company and employer may be fiduciaries if both exercise significant discretion. In addition, employer personnel play dual roles, sometimes acting for the employer, sometimes acting as fiduciaries of the benefit plan.³⁶

Nonfiduciary contract obligors are people or entities with obligations imposed by contract that do not involve significant discretion and therefore fail to qualify the actors as fiduciaries.³⁷ For example, an insurance company performing purely administrative functions under contract to an employer who serves as plan administrator would fall into this category,³⁸ as would an individual hired by a trustee to keep records and process claims in a routine way.

A benefit claimant is likely to have legal rights against fiduciaries under ERISA but is not likely to have direct contract rights against persons playing purely administrative roles. However, the benefit claimants may be third-party beneficiaries to contracts delegating the administrative responsibilities.

IV. Legal Overview

ERISA has federalized and integrated the law of employee benefits. ERISA preempts state law except in a few areas and requires certain structural features of all benefit plans, including disclosing the plan terms to participants, naming fiduciaries and administrators, specifying benefit claim and appeal procedures, and establishing a trust to hold any segregated plan assets. ERISA also imposes minimum vesting, accrual, and distribution requirements, but only on pension plans.³⁹

Except for these specific statutory requirements, however, all other plan terms, including benefit levels and preconditions for benefits, are defined by private documents negotiated between employer and employee or unilaterally established by employers. Benefit plan rights and obligations not directly involving trusts are defined by

35. R. Keeton & A. Widiss, *Insurance Law* § 2.6(c), at 107–10 (1988).

36. See *Donovan v Bierwirth*, 680 F2d 263, 267 (2d Cir 1982) (senior executives of employer served as trustees of pension plan as permitted by 29 USC § 1108 (c)(3)).

37. See *Dzingslky v Weirton Steel Corp.*, 875 F2d 1075, 1077–79 (4th Cir 1989) (plan entitled only employees not dismissed to early retirement benefits; trustees have no discretion regarding dismissal; employer not a fiduciary when it decides to dismiss).

38. See *Dozza v Crum & Forster Insurance Co.*, 716 F Supp 131 (D NJ 1989) (sponsoring employer was administrator of health plan but delegated to insurance carrier administrative functions and pretreatment determinations of plan coverage; successful suit to compel coverage of cancer treatment).

39. See EBCLP §§ 5.11–5.17.

contract—between employers and unions obligating employers to contribute to pension or welfare plans, between insurance carriers and employers obligating the insurance carrier to pay benefits to individual employees, and between employers and individual employees obligating the employer to pay benefits directly. The usual common-law requirements for contract formation—offer and acceptance—apply.⁴⁰ Typically, employee benefit contracts are unilateral contracts consisting of a promise or offer made by the employer and accepted by employee conduct, which usually consists of performing employment services after knowing of the benefit plan. Employee benefit contracts can, like other contracts, reserve the right of one party, usually the plan sponsor, to modify the contract, to terminate it, or to interpret its provisions subject only to limited judicial oversight. Damages are the usual benefit of the bargain damages. ERISA modifies traditional contract analysis in that it imposes fiduciary obligations on contract promisors exercising discretion in connection with the plan.⁴¹

Trust documents are the other major source of employee benefit rights and obligations. ERISA requires that benefit plan assets be held in trust unless the plan is funded through the purchase of insurance.⁴² Because most health insurance plans are funded through insurance or are unfunded, trust principles are less important for health benefit plan analysis than for pension plan analysis.

ERISA broadly preempts state law. Accordingly, claims of breach of contract or breach of trust involving benefit claims almost always involve application of federal common law under ERISA rather than state law. State courts have concurrent jurisdiction with federal courts to adjudicate claims based on benefit plans; but federal courts have exclusive jurisdiction to adjudicate claims of violation of the statutory provisions of ERISA, particularly the fiduciary duties imposed by ERISA. ERISA, however, preserves state authority to regulate insurance. Therefore, states retain broad authority to prescribe the terms of insurance policies involving employee benefits, although enforcement of the policies is a matter of federal law under ERISA. States also retain authority over state and local government employee benefits and over public benefit programs like workers' compensation and unemployment compensation, which may have important interrelationships with private employee benefit programs.

40. See EBCLP §§ 3.13–3.17.

41. See EBCLP § 3.21.

42. See EBCLP §§ 5.2, 5.6.

A. *Insurance and Other Methods of Providing Employee Health Care Benefits*

Group insurance is a common mechanism for providing insurance to a number of employees under a contract between the employer and the insurer. Most single-employer health insurance plans fund benefits through the purchase of insurance. The terms of the insurance contract for group insurance usually are contained in a "master agreement" and issued by the insurer to a representative of the group (e.g., the employer). Insured employees may be described as participants or subscribers.⁴³

Breach of contract claims against insurers are routine ERISA matters. This circumstance is conceptually distinct from the circumstances in which the employer is the contract promisor or the trustee and hires an insurance company to administer the plan. When the insurance company is the administrator only, it simply acts as the agent of the employer, not as an independent promisor on an insurance contract. This is because there is no insurance contract in the usual sense.

The most appropriate analytical framework for evaluating all types of claims to employee benefits not involving trusts is to apply common-law contract principles, reach a tentative conclusion as to entitlement, and then superimpose the handful of ERISA doctrines that alter traditional common-law analysis.

B. *Relationship Between ERISA and Common-Law Contract Doctrines*

ERISA provides a federal civil action to enforce benefit obligations established by contract. ERISA establishes two different kinds of federal rights. The first kind of right is statutory, relating to fiduciary obligations and obligations to provide accountings, furnish summary plan descriptions, establish trusts, and distribute assets of terminated plans in particular ways. The second type of right relates to obligations created under the common law of trusts or the common law of contracts.⁴⁴

The right under ERISA to enforce obligations created by contract is centered in section 502.⁴⁵ Section 502 provides an exclusive federal cause of action to enforce substantive provisions of the statute and confers concurrent jurisdiction on United States district courts and on state courts to award benefits due or otherwise to enforce the terms of a particular plan.⁴⁶ Section 502(a)(1)(B) provides:

43. R. Keeton & A. Widiss, *Insurance Law*, at 104 (cited in note 35).

44. See *Barrowclough v Kidder, Peabody, and Co.*, 752 F2d 923, 929-35 (3d Cir 1985) (suit involving deferred income plan).

45. 29 USC § 1132 (1982 & Supp V 1987).

46. See *Barrowclough*, 752 F2d at 935, 936 n 12.

A civil action may be brought—by a participant or beneficiary . . . —to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

Section 1144 preempts state law relating to plans covered by ERISA.⁴⁷ Accordingly, ERISA contemplates the evolution of a federal common law of employee benefit plans.⁴⁸ The courts of appeals uniformly have held that section 502(a)'s grant of jurisdiction to enforce rights created through contracts or trusts is modeled on section 301 of the Labor Management Relations Act (LMRA),⁴⁹ governing suits arising under a collective bargaining agreement.⁵⁰ The analogy between section 502 federal common law and section 301 federal common law requires courts considering section 502 common-law claims to borrow traditional state common-law principles, modifying them only when necessary to serve some identified policy interest of ERISA.⁵¹

A benefit obligation is not enforceable under section 502(a) unless common-law contract or trust principles make it enforceable.⁵² Employee contractual rights to benefits are determined by federal common law.⁵³ Federal courts look to state common law of contracts as an initial source of federal common law under ERISA.⁵⁴ Once a common-law contract right exists, ERISA may dictate contract terms or standards for determining breach and affording remedies different from those applicable under common-law contract doctrines.

Common-law contract doctrines have been substantially modified in virtually every state as they pertain to contracts of insurance, but these special insurance contract doctrines have been almost en-

47. Presumption is explored fully in EBCLP §§ 6.2–6.18.

48. *Scott v Gulf Oil Corp.*, 754 F2d 1499, 1502 (9th Cir 1985); *Barrowclough*, 752 F2d at 936; *Amato v Bernard*, 618 F2d 559, 567 (9th Cir 1980); *Musto*, 861 F2d at 900–01, 907 (although welfare benefit plans are not subject to ERISA vesting requirements, an employee nevertheless may acquire a contractual interest in such benefits, enforceable under federal common law).

49. 29 USC § 185 (1982) (providing for enforcement of collective bargaining agreements).

50. *Barrowclough*, 752 F2d at 936; *Amato*, 618 F2d at 567 (noting explicit link between ERISA and section 301).

51. See *Firestone Tire & Rubber Co. v Bruch*, 109 S Ct 948, 954 (1989) (reference to state common law of trusts and contracts as guidance in formulating federal common-law rule for standard of reviewing plan administrator decision).

52. *Mead Corp. v Tilley*, 109 S Ct 2156 (1989).

53. See *Pilot Life Insurance Co v Dedeaux*, 481 US 41, 48 (1987) (quoting legislative history and observing that ERISA section 502 claims are to be resolved by federal common law); (state common-law tort and contract claims preempted); *Musto*, 861 F2d at 910 (determining federal common-law standard varying from state standard by referring to federal statutory policy in favor of written plan adherence).

54. See *Firestone*, 109 S Ct at 954–55 (reference to state common law of trusts and contracts as guidance in formulating federal common-law rule for standard of reviewing plan administrator decision). See also Brennan, J., concurrence in *Mass Mutual Life Insurance Co. v Russell*, 473 US 134, 148, 153, 155 n 18 (1985).

tirely preempted by ERISA.⁵⁵ ERISA adds the following to traditional common-law analysis of employee benefit rights:

- It provides a federal judicial forum for litigating contract rights.
- It requires that benefit promises be communicated in a particular way to persons entitled to receive the benefits.
- It requires that certain contractual terms be provided, including conversion rights for group health insurance⁵⁶ and some form of claims appeal procedure.
- It imposes fiduciary duties on contract promisors.
- It limits damages to those provided under ERISA, which are essentially benefit of the bargain common-law contract damages.

ERISA has revolutionized the legal doctrines and procedures that otherwise would be applicable to insurance contracts associated with employee benefit plans. ERISA governs employee benefits provided through insurance contracts. ERISA defines welfare plans explicitly to include plans that provide benefits through “the purchase of insurance or otherwise.”⁵⁷ The reporting and disclosure provisions require that insurance carriers providing ERISA-covered benefits through insurance contracts transmit and certify to plan administrators information sufficient to permit the plan administrator to comply with the reporting and disclosure requirements of ERISA.⁵⁸ As to benefits “purchased from and guaranteed by” an insurance carrier, the annual report required by ERISA must include the premium rate and the total premiums⁵⁹ and the number of subscribers for each class.

ERISA directly regulates fiduciary responsibility for administering plan assets for funded plans. But certain responsibilities of plan fiduciaries which are insurance companies are ensured mostly through state insurance regulation. State insurance regulation rather than ERISA⁶⁰ governs reserves and assets levels, usually by regulating the relationship among premium levels and assets and claims payouts. Similarly, auditing of recordkeeping and reporting by insurers performing responsibilities in connection with employee benefit plans is a matter for state insurance regulation.

Therefore, if an insurer were to conduct its business so as to jeopardize its ability to meet employee benefit obligations provided

55. See EBCLP §§ 6.2–6.18.

56. See 29 USC §§ 1161–1162 (Supp V 1987) (continuation coverage).

57. 29 USC § 1002(1) (Supp V 1987).

58. ERISA § 103(a)(2)(A); 29 USC § 1023(a)(2)(A) (1982).

59. 29 USC § 1023(e) (1982).

60. For example, 29 USC § 1081(a)(2) (1982) exempts insurance contract plans from its funding requirements.

for in an insurance policy, the remedies would lie under state insurance law rather than ERISA. This would include conflicts of interest, misinvestment of assets, and inappropriate relationships between premium levels and benefit levels.⁶¹

In contrast, the legal framework for *enforcing* insurance contracts providing for employee benefits has been altered sharply by ERISA which preempts state statutory and common law. Accordingly, a claim that an insurer has not met its obligations as defined by an insurance policy to pay benefits is a claim under ERISA section 502(a)(1)(B)⁶² within the concurrent jurisdiction of federal and state courts.

A claim that an employer has breached a contractual obligation to pay premiums is cognisable under ERISA to the extent that the contribution obligation arises from a plan (as it usually would) and also may be cognisable under section 301 of LMRA⁶³ if the contribution obligation is contained in a collective bargaining agreement. In terms of enforcing benefit claims, it does not make much difference under ERISA whether the plan fiduciary is an insurance company or an ordinary trustee. ERISA applies, and the same analytical approach to sorting out parties, rights, and duties and their sources works just as it would if no insurance was involved at all.

C. Preemption of State Law

Since ERISA was enacted in 1974, the role of states in regulating employee benefits has been sharply circumscribed by its preemption provisions.⁶⁴ Despite ERISA's broad preemption, however, states retain the power to regulate employee benefits in three major areas: They can directly regulate employee benefit plans not covered by ERISA; they can regulate employee benefits plans indirectly through state regulatory schemes directed primarily at regulating insurance; and they can regulate employee benefit plans indirectly through generally applicable statutes and common-law doctrines.

Insurance policies not funded through employer contributions and not administered by or on behalf of employers are not covered by ERISA.⁶⁵ A DOL regulation established four criteria for "group or group-type insurance programs" within this exclusion:

61. For example, excessive benefits and too-low premiums, just like insufficient employer contributions and too-high benefit payouts in a trust arrangement.

62. 29 USC § 1132(a)(1)(B) (1982).

63. 29 USC § 185 (1982).

64. See *Allied*, 438 US 234 (1978) (invalidating, under contract clause, pre-ERISA state statute requiring employer closing facility to fund pension plan).

65. See *Donovan*, 688 F2d at 1373 n 11 (employer facilitation of direct employee purchase of insurance not necessarily a "plan" under ERISA); *Plotkin v Association of Eye Care Centers, Inc.*, 710 F Supp 156, 161 (ED NC 1989) (health care plan not covered by ERISA; neither nonprofit marketing organization nor individual optometry practices exercised control; summary judgment for defendant on state law claims).

1. Neither the employer nor an employee organization makes contributions.
2. Employee participation is voluntary.
3. The employer or employee organization's role is limited to providing a conduit for insurer publicity and collecting premiums through payroll deduction and transfer to the insurer, without endorsement of the program.
4. No employer or employee organization receives consideration except for reimbursement of actual costs without a profit for collecting premiums.⁶⁶

ERISA preemption extends to state common-law claims for breach of contract and for negligent misrepresentation based on employee benefit plan obligations, as well as state statutory regulations directly aimed at benefit plans.⁶⁷

It is important to understand that insurance involvement makes no difference regarding the law to be applied to decide claims. Federal law applies to claims regardless of whether the obligor under the plan is an insurance carrier. Insurance makes a difference in the funding standards to be applied and in mandated benefits.

Suits for breach of health insurance contracts arguably involve both state insurance regulation and employee benefit plans. In *Metropolitan Life Insurance Co. v Massachusetts*⁶⁸ and *Pilot Life Insurance Co. v Dedeaux*,⁶⁹ reaching opposite results, the Supreme Court developed guidelines for determining when such suits are preempted by ERISA because they are covered by the "preemption clause"⁷⁰ and not covered by the "savings clause"⁷¹ of ERISA. "If a state law relates to employee benefit plans it is preempted [by the preemption clause]. The savings clause excepts from the preemption clause laws that regulate insurance."⁷²

In determining that an employee's action for reimbursement under a policy is not saved from preemption, the Supreme Court, in *Dedeaux*,⁷³ found that an action for punitive damages alleging bad faith on the part of the carrier did not regulate insurance and thus was not saved from preemption.⁷⁴ *Dedeaux* itself involved a state

66. 29 CFR § 2510.3-1(j) (1987).

67. See *Straub v Western Union Telegraph Co.*, 851 F2d 1262, 1263-64 (10th Cir 1988) (reviewing cases in other circuits).

68. 471 US at 732-47 (1985) (mandated benefit law regulates insurance, therefore not preempted by ERISA).

69. 481 US at 44-47 (1987) (state suite alleging improper processing of benefits claim preempted by ERISA).

70. 29 USC § 1144(a).

71. 29 USC § 1144(b)(2)(A).

72. *Dedeaux*, 481 US at 45.

73. *Id* at 41.

74. *Id* at 49.

common-law action against an insurance carrier seeking compensatory and punitive damages for tortious breach of contract, breach of fiduciary duties, and fraudulent misrepresentation based on the carrier's refusal to continue payments under a disability insurance policy purchased by the insured's employer. Much of the Supreme Court's preemption discussion focused on the inappropriateness of state law remedies beyond those provided under the ERISA plan enforcement provisions. Nevertheless, the Court's analysis leaves no doubt that any state common-law doctrine involving "suits brought by beneficiaries or participants asserting improper processing of claims"⁷⁵ is preempted. The Eleventh Circuit reached the same conclusion in a state law claim brought against an insurance company.⁷⁶

It can be difficult to separate the insurance from the noninsurance provisions of self-insured health care plans that purchase insurance to cover large claims⁷⁷ or that contract with insurance companies to administer the plans, especially when the insurance company formerly provided benefits through insurance and then became merely an administrator.⁷⁸ In deciding whether state law is preempted with respect to such plans, the critical question should be whether the plan in question is funded through insurance or is self-funded.⁷⁹ Only if the plan is funded through insurance is it within the savings clause. If it is self-funded, state law relating to it is preempted.⁸⁰ Different types of coverage under a plan must be con-

75. *Id.* at 56.

76. See *Farlow v Union Central Life Insurance Co.*, 874 F2d 791, 793 (11th Cir 1989) (affirming dismissal of state common-law and statutory claims for oral misrepresentations by health insurance carrier).

77. See *State Farm Mutual Auto Insurance Co. v American Community Mutual Insurance Co.*, 659 F Supp 635, 638 (ED Mich 1987) (multiemployer medical plan, self-administered and self-insured, but with excess loss insurance covering claims over \$5,000 subject to state insurance regulation; discussing conflict between Sixth and Ninth Circuits); *Drexelbrook Engineering Co. v Travelers Insurance Co.*, 710 F Supp 590, 596 (ED Pa 1989) (finding state law claims preempted because employer self-insured and insurance carrier only administered plan and provided "stop-loss" coverage).

78. See *Tumulty v Aetna Life Insurance Co.*, 659 F Supp 70, 73 (SD Fla 1987) (self-funded single-employer medical plan using insurance company as administrator within "deemer clause" and thus state law claims against administrator preempted by ERISA); *MacKey v Prudential Insurance Co.*, 666 F Supp 1447, 1450-51 (D Mont 1986) (self-funded disability plan within preemption though administered by insurance company; crucial question is whether plan is self-funded).

79. *MacKey*, 666 F Supp at 1450 (reciting issue).

80. See *United Food & Commercial Workers and Employers Arizona Health and Welfare Inst. v Pacyga*, 801 F2d 1157, 1159 (9th Cir 1986) (accident and health care plan self-funded, with reimbursement coverage only for catastrophic losses and therefore Arizona law prohibiting subrogation of claims was preempted); *Moore v Provident Life & Accident Insurance Co.*, 786 F2d 922, 926-27 (9th Cir 1986) (state claims for wrongful termination of health benefits preempted; insurance company acted as administrator, not insurer, for self-funded plan which adopted form and substance of insurance company's policy; power to review preliminary claim findings and to defend

sidered separately under this approach. A plan may be self-funded for one type of coverage, for example, and provide benefits through insurance for another type of coverage.⁸¹

A good example of the need to dissect the responsibilities carefully to determine the funding mechanism is *Insurance Bd. v Muir*.⁸² In that case, Blue Cross & Blue Shield of Pennsylvania contracted with the benefit plan of Bethlehem Steel to perform the following responsibilities:

- distribute Blue Cross & Blue Shield cards to beneficiaries,
- process claims submitted on Blue Cross & Blue Shield forms,
- determine coverage of claims, and
- pay beneficiaries directly.

Under the contract, Blue Cross & Blue Shield was reimbursed by the plan for claim payments, with approximately a two-month lag.⁸³ A fair characterization is that Blue Cross did everything usually associated with medical insurance except serve as the ultimate funding source for claims payments. The Pennsylvania Department of Insurance argued that the plan was subject to Pennsylvania insurance law and that it failed to offer certain benefits mandated under the law.⁸⁴ The State argued that the plan in effect had purchased an insurance policy to provide plan benefits and that the insurance savings clause applied.⁸⁵ The district court held that state law applied because of the role of the insurance company. The Third Circuit summarized the Supreme Court's standard from *Metropolitan Life* as follows: ERISA permits states to regulate insurance policies purchased by plans from insurance companies, though ERISA does not permit states to regulate the plans themselves.⁸⁶ The Third Circuit considered three factors in order to decide whether Blue Cross's sale of administrative services to the Bethlehem plan put Blue Cross in the "business of insurance." The first factor, risk shifting, suggested no business of insurance was involved⁸⁷ because the

and settle lawsuits did not change conclusion); *Powell v Chesapeake & Potomac Telephone Co. of Virginia*, 780 F2d 419, 423 (4th Cir 1985) (insurance company played only administrative role in self-funded disability plan; state law theories for mishandling claims preempted).

81. See *Pacyga*, 801 F2d at 1162 (payment of life insurance and accidental death and dismemberment benefits through life insurance does not change self-funded character of health care benefits; state regulation of health care benefits part of plan preempted).

82. 819 F2d 408 (3d Cir 1987).

83. *Id.* at 409 (role of Blue Cross). The two-month lag is significant because it put Blue Cross in the position of funding the plan to a limited extent.

84. *Id.* (describing position of state agency that benefits for newborn children, psychological testing services, maternity coverage, and coverage for certain health care providers were not offered).

85. *Id.* at 410 (describing district court decision, argument of state).

86. *Muir*, 819 F2d at 411.

87. *Id.* at 412.

Bethlehem plan, and not Blue Cross, remained ultimately responsible for payment of benefits. The second factor, with appropriate modification, also suggested that the business of insurance was not involved because the nature of the services provided by Blue Cross was purely administrative and not central to the claims payment role traditionally associated with the services insurers provided beneficiaries.⁸⁸ The third criterion was not met because many entities other than insurance companies provide employee benefit plans with administrative services.⁸⁹ The court concluded that ERISA's savings clause did not protect the Pennsylvania-mandated benefit statute from preemption as applied to the Bethlehem plan.⁹⁰

In *Metropolitan Life Insurance v Massachusetts*,⁹¹ the Supreme Court held that a Massachusetts statute requiring mental health care benefits as a part of employee health care plans was not preempted. The Court characterized mandated benefits statutes as a relatively recent phenomenon, but one which had become commonplace in all fifty states.⁹² It noted that a majority of states require that health care coverage for mentally or physically handicapped dependents continue beyond contractually imposed age limitations, require coverage of infants beginning at birth, and require optional coverage for certain services like those of optometrists.⁹³ The Massachusetts statute at issue was typical. It required that any health insurance policy provide sixty days of mental health benefits.⁹⁴

The Court rejected the argument that mandated benefit laws are innovations which ought to be treated as health laws rather than insurance laws and therefore not saved by ERISA section 514(B)(2)(A).⁹⁵ It concluded that mandated benefit laws are well within the scope of traditional insurance laws.⁹⁶

D. *Retiree Health Care Benefits*

The obligation of an employer to provide postretirement pension and health benefits largely turns on whether those benefits are vested at the time of retirement. An employer is contractually obligated to

88. *Id.*

89. *Id.*

90. *Muir*, 819 F2d at 408.

91. 471 US 724 (1985).

92. *Id.* at 728.

93. *Id.* at 729.

94. The Court noted without approval or disapproval *Wadsworth v Whaland*, 562 F2d 70 (1st Cir 1977) (ERISA savings clause saved a New Hampshire-mandated benefit statute). Its decision in the Massachusetts case, however, obviously endorses the *Wadsworth* decision.

95. *Metropolitan Life*, 471 US at 741.

96. *Id.* at 742. The Court also rejected the argument that state-mandated benefits legislation is preempted by the NLRA because it may specify the terms of plans arrived at through collective bargaining. 471 US at 756.

continue to provide all vested benefits even after retirement.⁹⁷ However, the obligation to provide postretirement health benefits depends upon whether the employer has a contractual duty to pay such benefits,⁹⁸ because ERISA's preretirement vesting requirements are not applicable to retiree health insurance plans.⁹⁹ Retiree suits to compel continuation of those postretirement benefits can be divided into two categories: (1) suits for benefits previously provided pursuant to a collective bargaining agreement which has subsequently lapsed, and (2) suits by former salaried employees seeking to challenge cutbacks in benefits.

The policy of ERISA is served by treating benefit rights, whenever possible, as vested before an employee leaves service. While employed, an employee has a certain amount of bargaining power that derives from his right to quit. After he leaves, through retirement for example, he has virtually no leverage to resist employer modification or termination.¹⁰⁰

Retirees seeking to prolong benefits provided pursuant to a lapsed collective bargaining agreement usually sue under section 301(a) of the LMRA.¹⁰¹ In *Allied Chemical Workers Local No. 1 v Pittsburgh Plate Glass Co., Chemical Div.*,¹⁰² the Supreme Court held that retiree benefits are not mandatory subjects of bargaining covered by section 8(a)(5) of the National Labor Relations Act (NLRA). Accordingly, an employer may change such benefits unilaterally without bargaining with the union representing its employees. On the other hand, such benefits may be vested. This subjects the employer to an obligation to bargain with the retirees individually before changing the benefits or to liability for breach of contract if it changes the benefits unilaterally.¹⁰³

97. See EBCLP § 3.12.

98. *Mioni v Bessemer Cement Co.*, 6 Empl Ben Cases (BNA) 2677, 2680 (1985).

99. See 29 USC § 1051 (1982); See also *Mioni*, 6 Empl Ben Cases (BNA) at 2680 (employer could not unilaterally deny benefits to retiree because of contracts and past performance even though there was no explicit language in trust).

100. *Musto*, 615 F Supp at 1496-97 (enjoining termination or modification of health insurance coverage), rev'd in material part, 861 F2d 897, 900-01, 907 (6th Cir 1988).

101. 29 USC § 185(a) (1982).

102. 404 US 157 (1971).

103. *Id* at 181 n 20. See also *Anderson v Alpha Portland Industries, Inc.*, 752 F2d 1293, 1300 (8th Cir 1985) (en banc) (retirees may sue directly to enforce collectively bargained benefit rights without exhausting grievance and arbitration procedures under collective agreement), appeal after remand, 836 F2d 1512 (8th Cir 1988); *Bower v Bunker Hill Co.*, 725 F2d 1221, 1223-25 (9th Cir 1984) (reversing summary judgment for employer; payment of medical benefits during strike and other evidence could support finding that benefits were vested, despite expiration of collective agreement when company ceased operations), on remand, 675 F Supp 1263 (ED Wash 1986) (judgment on jury verdict finding retirees entitled to lifetime medical benefits); *UAW v Yard-Man, Inc.*, 716 F2d 1476, 1480-83 (6th Cir 1983) (construing expired collective

In cases involving the reduction or termination of retiree welfare benefits brought under section 502(a)(1)(B) of ERISA,¹⁰⁴ the analysis is similar to that of the collective bargaining cases.¹⁰⁵

The first step is to determine whether under the terms of the plan the employer had reserved the right to modify or terminate the benefits in question.¹⁰⁶ If the plan is ambiguous as to this point, the court should examine extrinsic evidence to determine party intent.¹⁰⁷

The second step is to determine whether the employer has lost its power to reduce benefits because its "offer" of benefits at a particular level has been "accepted" by a retiring employee. This step utilizes unilateral contract analysis.¹⁰⁸ When the employee has rendered the requested services, a binding unilateral contract has been created, and any material modification to the plan must be bargained for and supported with adequate consideration.¹⁰⁹ The practical effect of this approach is to extend bargaining power to retirees who otherwise lack such power because their employment has ceased.

Unilateral contract analysis is illustrated by *Feinberg v Pfeiffer Co.*,¹¹⁰ which involved a contract action for a pension. Feinberg was a bookkeeper who had worked for thirty-seven years when her employer's board of directors passed a resolution that "she be afforded the privilege of retiring from active duty in the corporation at any time she may elect to see fit so to do upon retirement pay of \$200 per month, for the remainder of her life." Feinberg was told about the resolution. She worked for two more years and then retired. She was paid the \$200 per month for seven years, but then the employer cut back the pension payments on the advice of counsel that they were gratuities rather than legal obligations.¹¹¹

Feinberg sued for breach of contract and won in the trial court. The employer appealed on the grounds that, among other things, the pension promise was not supported by consideration. The only ap-

agreement as promising continuing benefits to retirees, extending beyond expiration of agreement).

104. 29 USC § 1132(a)(1)(B) (1982).

105. *Ryan v Chromalloy Am Corp.*, 877 F2d 598, 604 (7th Cir 1989) (affirming summary judgment against retirees; health care benefits did not vest upon retirement).

106. *Id.* at 603-04 (affirming summary judgment against retirees; plan reserved right to terminate health care benefits upon sale of all employer assets).

107. See also *Eardman v Bethlehem Steel Corp.*, 607 F Supp 196 (WD NY 1984); EBCLP § 3.27 regarding contract interpretation; EBCLP § 7.29 regarding admissibility of extrinsic evidence.

108. See EBCLP § 3.8; *Musto*, 861 F2d at 900-01, 907 (allowing modification under reserved right).

109. *Musto*, 615 F Supp at 1498 (1985), rev'd, 861 F2d at 900-01, 907 (6th Cir 1988).

110. 322 SW2d 163 (Mo App 1959).

111. *Id.* at 165.

parent consideration, the employer argued, was past services which cannot be valid consideration. There was nothing in the board resolution making the pension contingent on Feinberg's continued employment, and thus her voluntary employment for the two years after passage of the resolution could not be consideration.¹¹²

Feinberg conceded that a promise based on past services would be unsupported by consideration but argued that two aspects of her conduct provided legally effective consideration. First, she continued employment for two years after knowing of the pension resolution. Second, she changed position by retiring in reliance on the pension resolution.

The court of appeals rejected Feinberg's first argument but accepted the second. Because she was under no obligation to continue working after the promise was made and because the promise was not contingent on her continued employment, continuing to work was not good consideration.¹¹³ Although the court used the discredited "mutuality of obligation" term to support its conclusion, the conclusion is supportable on the grounds that the absence of continued employment as a condition precedent to the pension promise meant that the employer had no intent to induce continued employment as the conduct element of a bargained-for unilateral contract. Nor was it reasonable for the employer to expect continued employment as detrimental reliance under the promissory estoppel theory.

The court of appeals found, however, that Feinberg's retirement was adequate consideration under both the traditional bargain theory¹¹⁴ and under *Restatement (First) of Contracts* section 90's promissory estoppel doctrine.¹¹⁵ It noted that one of the illustrations to *Restatement* section 90 involved retirement in reliance on a pension annuity promise.¹¹⁶ Because Feinberg testified that she retired in reliance on the pension resolution, she gave consideration, making the promise enforceable.¹¹⁷

As in Feinberg's case, if an employee leaves active service and the employer subsequently promises to give the employee benefit payments (e.g., disability pay), it would be difficult to satisfy the consideration requirement. The employee has made no return promise, nor has the employer sought any. The employer has not sought

112. *Feinberg*, 322 SW2d at 167.

113. *Id.*

114. The court cited *Restatement (First) of Contracts* § 75 (1981). *Feinberg*, 322 SW2d at 167. It also observed in its analysis of section 90 that the Missouri courts had reached the same result contemplated by section 90 without abandoning traditional consideration analysis. *Id.* at 168.

115. See *Restatement (Second) of Contracts* § 90 (1981); EBCLP §§ 3.13-3.14.

116. *Feinberg*, 322 SW2d at 168 (citing *Restatement (First) of Contracts* § 90 comment b, illustration 2).

117. *Id.* at 169.

conduct in return for the promise, and the employee has not engaged in any conduct in order to have the promise performed. In contrast to the more usual employee benefit situation, the employer makes the benefit promise, at least in part to induce the employee to perform employment services, and the employee performs services, at least in part to receive performance on the employer's benefit promise.

About the only validation device that could exist in the first hypothetical circumstance is detrimental reliance, recognized by section 90 of the *Restatement* and usually called promissory estoppel. Arguably, it is reasonable for the employer to expect that the disabled employee would rely to her detriment on the benefit promise. It also is reasonable for the employee to rely on the promise and to subsequently fail to accept another job offer or fail to seek rehabilitation that would facilitate finding other employment.

In the majority of cases, however, the validation device for an employer benefit promise is employee performance of services for the employer after the content of the promise has been communicated.

In *UMWA v Royal Coal Co.*,¹¹⁸ the district court held that retiree health benefits could not be modified for retirees absent bargaining and evidence of consideration between the promisors and the retirees. "The modern view of vesting of pension and other retiree benefits holds that the promise of a pension or other retiree benefits constitutes an offer, which, upon performance of the required service of the employee, becomes a binding obligation."¹¹⁹ A collective bargaining agreement which provided benefits and was in effect at the time of retirement was held to constitute the requisite promise. Therefore, the "employee's right to lifetime health benefits vests upon his retirement."¹²⁰ Although the particular decision was reversed, based on the specific language in the collective agreement and the surrounding circumstances,¹²¹ the analytical framework used by the district court was valid. It obviously is traditional common-law unilateral contract analysis.

118. 6 Empl Ben Cases 2117 (BNA) (SD WV 1985), rev'd, 768 F2d 588 (4th Cir 1985).

119. *Id* at 2120, rev'd, 768 F2d 588 (4th Cir 1985) (employer not obligated to provide retiree health benefits beyond expiration of collective agreement). Specifically, the court found that the employer did not follow ERISA's mandate for a description of the circumstances under which benefits could be terminated, forfeited, or suspended. Therefore, the trustees were "precluded from enforcing undisclosed forfeiture provisions." *Id* at 2121, (employer not obligated to provide retiree health benefits beyond expiration of collective agreement).

120. *Id* at 2120.

121. *Royal Coal Co.*, 768 F2d at 592 (employer not obligated to provide retiree health benefits beyond expiration of collective agreement).

In *Royal Coal*, there was no express reservation of the right to amend. Elsewhere, the district judge stated, "No pensioner's benefits may be reduced by virtue of the provisions of a collective bargaining agreement executed after his retirement when he was no longer a union member and therefore unrepresented at negotiations."¹²² "This is particularly true in the absence of any clearly expressed agreement of the parties permitting such reductions."¹²³ *Royal Coal* simply applies the idea adopted by the Supreme Court in *Pittsburgh Plate Glass* that an unequivocal promise of benefits is accepted and becomes vested upon the performance of service. Once thus vested, the employer's obligation to provide such benefits can be modified only by further bargaining, and the bargaining on behalf of retirees does not occur through collective bargaining with the union because the union does not have the statutory right to represent the retirees after they retire.¹²⁴

It is notable that the claim in *Royal Coal* involved a unilateral contract claim based on an expired collective bargaining agreement, while the claim in *Musto*, discussed earlier, did not involve collective bargaining but rather a unilateral contract claim based on an informal employer promise.¹²⁵ Despite this difference, the joint analysis of ERISA federal common law and traditional unilateral contract common law is the same. In other words, there is nothing special about retiree benefits based on collective bargaining agreements. The question is whether the benefits vested (i.e., whether the bargained-for conduct had occurred when the beneficiaries retired).

E. Standards for Review

In *Firestone Tire and Rubber Co. v Bruch*,¹²⁶ the Supreme Court resolved a split among the circuits, holding that reviewing courts must decide disputes over the interpretation of benefit contract language de novo, unless the contract gives the trustee discretion to interpret disputed or ambiguous language.¹²⁷ In doing so, it expressly embraced the usual principles for evaluating disputed contract pro-

122. *Id.* at 2120-21.

123. *Id.* at 2121.

124. *Pittsburgh Plate Glass Co.*, 404 US at 159.

125. See note 100 and accompanying text.

126. 109 S Ct 948 (1989).

127. *Lowry v Bankers Life Casualty Retirement Plan*, 871 F2d 522, 524 (5th Cir 1989) (plan language granting authority to administrators to "interpret and construe" the plan made *Bruch's* arbitrary and capricious standard applicable); *Bali v Blue Cross & Blue Shield Association*, 873 F2d 1043, 1047 (7th Cir 1989) (language, "determined on the basis of medical evidence satisfactory to the committee," under *Bruch* gave plan administrator discretion to require evidence; de novo standard inappropriate to review reasonable requests administrator made for documentation; approving denial of benefits because claimant refused to provide requested documentation).

visions.¹²⁸ Moreover, courts of appeals generally review trial court contract interpretation decisions de novo.¹²⁹

V. Checklists

Two checklists are provided to help organize further legal research and litigation strategy.

A. *Plaintiff's Checklist for Case Evaluation*

The following checklist guides initial claim evaluation from the plaintiff's perspective:

1. Ascertain exactly the benefits to which the client claims entitlement. Develop a preliminary conclusion as to whether the claims involve more than one plan.
2. Obtain the summary plan description (SPD) if the client has it. Otherwise, consider requesting the SPD from the employer. The summary plan description has much useful information about who the plan fiduciaries are, where the plan assets are held, and what the appeal procedure is.¹³⁰
3. Determine whether the client has exhausted plan procedures. A summary plan description must identify these procedures.
4. Obtain a copy of the plan document from the client, from DOL, or from the employer. A refusal to provide this information may constitute a separate wrong under section 502(c)(1)¹³¹ of ERISA.
5. Determine whether any of the claimed benefits are outside the scope of ERISA preemption because the benefits are of the type not covered by ERISA or because they involve benefits mandated by state insurance law.
6. If the claimed benefits involve a public employee plan or a public employee insurance contract, determine the procedures and forums for presenting benefit claims.
7. Determine the limitation period for each claim and decide when it expires.
8. Identify all persons who may have obligations in connection with a plan, identifying all fiduciaries and all affiliates of a sponsoring employer with potential funding obligations.

128. *Firestone*, 109 S Ct 948 (noting pre-ERISA cases using ordinary contract principles to justify de novo interpretation of plan terms). See *Burnham v Guardian Life Insurance Co.*, 873 F2d 486, 490 (1st Cir 1989) (applying *Bruch* de novo standard to construe plain language requiring certain level of employment as prerequisite for insurance coverage to deny widow benefits under health insurance policy).

129. *Machinists Lodge 1000 v General Electric Co*, 865 F2d 902, 905 (7th Cir 1989) (questioning appropriateness of rule but not rejecting).

130. See EBCLP § 5.7, describing SPD requirement.

131. 29 USC § 1132(c)(1) (Supp V 1987).

9. Identify other potential plaintiffs on the same claim and evaluate potential joinder or class action approaches.
10. For all claims as to which exhaustion of administrative remedies has occurred, draft a complaint.
11. For any claims as to which exhaustion has not occurred, file the necessary claim in the appropriate forum.
12. Decide whether to file the complaint in federal or state court and where.
13. Decide what discovery should be sought.
14. Consider at least the following legal theories under ERISA:
 - a. The plan has failed to disclose information as required by ERISA section 105¹³² and section 502(c).¹³³
 - b. The plan failed to apply the plan language of a plan provision. A deferential arbitrary and capricious standard applies only to ambiguous plan language when the plan administrator is authorized to interpret plan language; otherwise courts construe plan language de novo.
 - c. The plan administrator arbitrarily and capriciously interpreted ambiguous plan language under an express grant of authority. This theory imposes a heavier burden on the plaintiff than the immediately preceding theory.
 - d. The plan administrator applied a plan provision that facially conflicts with a statutory requirement under ERISA.
 - e. The plan administrator interpreted a plan provision so as to conflict with a statutory requirement under ERISA.
 - f. The plan administrator amended the plan so as to conflict with a statutory requirement under ERISA, for example, so as to cause forfeiture of vested benefits.¹³⁴
 - g. The plan fiduciary has violated fiduciary obligations with respect to management of plan assets and these violations have caused loss to the claimant.
 - h. A plan fiduciary failed to disclose information to participants necessary for participants to make informed decisions pertinent to realizing their rights under the plan or apart from the plan.
 - i. The plan sponsor failed to comply with the structural requirements of ERISA. The problem with this theory is that it is hard to prove significant damages.

B. Defendant's Checklist for Case Evaluation

1. Identify as clearly as possible the specific benefits claimed by the plaintiff.

132. 29 USC § 1025 (1982 & Supp V 1987).

133. 29 USC § 1132(c) (1982 & Supp V 1987).

134. This example is applicable only to pension plans.

2. Identify the source of the right claimed to receive each type of benefit (e.g., a plan, an informal promise, or ERISA itself).
3. Determine if the defendant had obligations connected with the right claimed and identify the source of that obligation. Decide if the obligation asserted involved making contributions, paying benefits, or both.
4. Characterize the plaintiff's theory as to how the defendant breached the obligation to pay benefits or to make contributions.
5. Determine whether, as to each type of benefit claimed, the defendant agrees that the plaintiff has the right to receive those benefits.
6. Determine whether, as to each type of benefit claimed, the defendant agrees on the source of the right to receive benefits asserted by the plaintiff.
7. As to any type of benefit for which the defendant agrees with the plaintiff's contentions in the preceding two paragraphs, determine why the defendant believes that no breach of the obligation by the defendant was involved. At least the following possibilities should be considered:
 - a. The plaintiff misconstrued the obligation.
 - b. A condition precedent to defendant's obligation has not occurred.
 - c. A condition subsequent to defendant's obligation has occurred.
 - d. The obligation asserted by the plaintiff has been overridden by other legal authority; for example, an apparent contractual obligation has been superseded by a provision of ERISA.
 - e. Although the defendant admits that a breach asserted by the plaintiff occurred, the damages claimed by the plaintiff are in excess of those permitted by law.
 - f. Even if the plaintiff is correct as to the breach of legal duty asserted, the legal theory for recovery does not exist, for example, because it has been preempted by ERISA.
 - g. Even if the breach of duty occurred and the legal theory asserted by the plaintiff is viable, the plaintiff is in the wrong forum because the plaintiff has not exhausted administrative or contractual remedies.
 - h. Even if the breach of duty occurred and the legal theory asserted by the plaintiff is viable, the plaintiff is in the wrong forum because the jurisdiction of the forum has been preempted by state or federal law.
 - i. Regardless of the merits of the plaintiff's legal theory and

the suitability of the forum, a statute of limitations has run.

8. Determine if a class action is likely because the controversy involves a large group of plan participants or beneficiaries with similar claims. Determine the defendant's position on certifying the proposed class. The defendant may desire class action treatment in order to resolve a controversy once and for all and bind all potential claimants.
9. Consider whether other parties, on either side, should be joined to the litigation.

