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From the standpoint of the whole system of social economy, no employer has a right to engage men in any occupation that exhausts the individual's industrial life in ten, twenty, or forty years, and then leave the remnant floating on society at large as a derelict at sea.\(^1\)

Although spiraling health care costs have been prompting companies to scale back the amount of retiree health benefits for over a decade, the new accounting rule under FAS 106 ["Financial Accounting Standards Board Rule 106"] has made the problem more severe . . . . The companies' decisions are imposing financial hardship on many retired workers, who believed their health benefits were covered for life.\(^2\)

**INTRODUCTION**

With increasing frequency, retirees are losing company health benefits.\(^3\) Exemplifying this disturbing trend\(^4\) is Societe

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\(^1\) DAN M. MCGILL, FUNDAMENTALS OF PRIVATE PENSIONS 17 (1979) (quoting LEE WELLING SQUIER, OLD AGE DEPENDENCY IN THE UNITED STATES 272 (1912)).

\(^2\) Chairman William J. Hughes made the above comments before Congress at the House Select Committee on Aging Hearings. At the hearings, retirees from several corporations, including McDonnell Douglas Corporation and Unisys Corporation, testified to illicit congressional action that would prevent employers from breaking promises to provide retiree health benefits. FAS 106 Is Prompting Many Companies to Reduce Benefits, House Panel Hears, Pens. & Ben. Daily (BNA) (Mar. 5, 1993) [hereinafter FAS 106 Is Prompting].

\(^3\) A survey conducted by Greenwich associates revealed that 6% of corporate pensions discontinued health coverage for retirees, while another 21% reduced benefits. More Funds Drop Retiree Medical Care, Reduce Coverage, Manager Survey Finds, Pens. & Ben. Daily (BNA) (Apr. 26, 1993). Before the mid-1980s, more than 60% of firms having 500-990 employees provided retiree health benefits. According to a
Nationale Elf Aquitaine, Inc.'s ("Elf Aquitaine") recent treatment of retired Texasgulf, Inc. ("Texasgulf") executives. On July 6, 1981, Societe Nationale Elf Aquitaine Inc., a $25 billion French corporation, and Texasgulf, with its corporate offices located in Stamford, Connecticut, agreed to an amended tender offer made pursuant to section 14 of the Securities Exchange Act of 1934.\(^5\) Under the terms of this agreement, EA Development, Inc., a wholly owned subsidiary of Elf Aquitaine, offered to purchase Texasgulf.\(^6\) Among other provisions, the amended tender offer contained express promises to "maintain all employee benefit plans with levels of benefits payable at least equal to the levels then in effect."\(^7\) Texasgulf was acquired in accordance with the amended tender offer on September 25, 1981.

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7 Section 12 of the amended tender offer provides as follows:

PURPOSES OF OFFER AND PLANS FOR CONTROL OF THE COMPANY
In all events, the Purchaser (EA Development) and SNEA (Societe Nationale Elf Aquitaine) expect to continue whatever pension and other employee benefit plans the Company now has or to offer comparable benefits under new plans.


Texasgulf filed an Amended Schedule 14D-9 on July 10, 1981. The July 10 document emphasized the importance of paragraph 4(c) of the Agreement of July 6, 1981 with respect to benefits by including the following language in item 3:

Upon obtaining the agreement of Elf to amend the Elf offer... the Board of Directors determined that it would be in the best interests of the Company to take steps to provide for management stability in view of the uncertainty created by the Elf offer. In that connection the Company and Elf entered into an agreement dated July 6, 1981 (the "Agreement"). The Agreement provided for... (viii) continuation of other existing employee benefit plans or, where appropriate, the institution of substantially similar plans with comparable levels of benefits. A copy of the Agreement is attached hereto as Exhibit 2 and is incorporated herein by reference.

The July 6, 1981 agreement was signed by plaintiff Mollison in his capacities as Chairman of the Board of Directors and Chief Executive Officer of Texasgulf. Mollison
On April 17, 1990, the president and chief executive officer of Elf Aquitaine sent a letter to former senior officers of Texasgulf notifying them of the Texasgulf Senior Officers Medical Plan’s termination. The letter stated as follows:

April 17, 1990

Re: Termination of Senior Officers Medical Plan

Gentlemen:

You will undoubtedly be aware of the rapid escalation in medical costs occurring throughout the nation.

Our Company is not immune from this trend, and in the years since 1987 our medical costs have doubled.

We are forced by the lack of a national health cost containment plan to increase our employee’s share of medical costs and to tighten up on benefits utilization . . . . In this setting it is increasingly difficult to justify the existence of a separate 100% reimbursement plan for senior officers. The continuation of this plan will create morale problems with our workforce and for this reason is being terminated effective May 31, 1990 . . . .

I regret that this benefit must be terminated and expect that you will agree that it is necessary to do so in the best interests of the company as a whole.

Upon receiving the letter, Richard D. Mollison, a seventy-four year old retiree of Texasgulf, former chairman of its board of directors, and chief executive officer until June 1982, commenced an action for injunctive relief in the United States District Court for the District of Connecticut. Later asserted that the agreement induced him as a shareholder to accept the tender offer, and as a Director and Chairman of the Board to send his letter of July 7, 1981 to all shareholders of Texasgulf. The letter, in relevant part provides as follows: “Your Board of Directors has carefully considered the increased offer. We have decided to facilitate our shareholders making their investment decisions with respect to acceptance of this Elf Aquitaine offer and we will not oppose the offer.”

8 Mollison v. Societe Nationale Elf Aquitaine, Civ. Action No. B90-247, was filed in the United States District Court for the District of Connecticut. A temporary restraining order was issued against Elf Aquitaine on May 29, 1990, and a temporary injunction was granted by the Honorable T.F. Daly on August 17, 1990. The action was settled and the complaint was withdrawn in December 1990. See Retiree Benefit Termination is Halted by Court Restraining Order, WALL ST. J., May 31, 1990, at B11 (ordering injunction); Retiree’s Health Benefits Can’t be Cut For Now, Judge Rules, WALL ST. J., Aug. 22, 1990, at B5; Court Delays Retiree Benefit Cut, BUS. INS., Aug. 27, 1990, at 38 [hereinafter Court Delays]; see also Court: Company Can’t Cut Off Health Benefits, GREENWICH TIME, May 31, 1990, at A15; Bruce Shutan, Altering Retiree Health Plans: Prudence or Broken Promises?, EMPLOYEE BENEFIT NEWS, Aug. 1990, at 3; Court: Firm Can’t Halt Ex-Officer’s Health Plan, STAMFORD ADVOC., Aug. 22, 1990, at A17.
The complaint alleged that Texasgulf had (1) provided liberal health and welfare benefits for all employees and their dependents, at its own expense, prior to and during the plaintiff’s employment which began in 1947 and (2) provided basic health insurance, including eighty percent reimbursement for all medical and dental expenses at no cost to the recipients.

The complaint further alleged that in 1974 Texasgulf implemented another plan in consideration for plaintiff’s and other senior officers’ continued employment with Texasgulf and their contribution and loyalty to the company. This plan provided for and established, at Texasgulf’s complete expense, a medical and health care insurance plan to supplement the basic health and welfare plan for all employees. The supplemental plan (1) was designated as the Senior Officers Medical Plan, (2) provided 100% lifetime reimbursement for all medical and health care costs incurred by Texasgulf senior officers at and above the level of corporate secretary and their surviving spouses, (3) was established in consideration and exchange for employment and services provided, (4) was part of the compensation for Texasgulf senior officers, (5) expressly provided that upon retirement, retired covered senior officers would continue to be entitled to receive 100% lifetime medical reimbursement for all medical and health care costs that Texasgulf had undertaken to provide them and their spouses, at no cost to the recipients, (6) was in existence on July 6, 1981, when the amended tender offer agreement with Elf Aquitaine was signed, and (7) was approved, assumed, continued, and administered by Elf Aquitaine after the merger and through the date of plaintiff’s action seeking an injunction against Elf Aquitaine. Finally, the complaint alleged that Texasgulf failed to reserve the right to terminate the supplemental plan, modify it to reduce the level of benefits received, or impose contributions by covered participants.  

Retirees of Texasgulf, Elf Aquitaine, and other corporations throughout the United States have asked why their employers

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9 The plaintiff alleged that both the basic health care insurance benefits plan for all employees and the supplemental plan, which provided 100% lifetime reimbursement for all senior officers' medical and health care expenses, were "employee welfare benefit plans" as defined in the Employee Retirement Income Security Act, Pub. L. No. 93-406, 88 Stat. 833 (codified at 29 U.S.C. § 1002(1) (1988 & Supp. 1993)) [hereinafter ERISA] and that the defendants were fiduciaries with respect to the plans and programs within the meaning of 29 U.S.C. § 1002(21)(A). The complaint alleged violations of ERISA, breach of contract, estoppel, and other claims.
have broken promises to provide postretirement health care benefits. The answer is that the absence of a national health care plan, escalating health care costs, and the then "proposed" new accounting rule regarding reporting of retiree health benefits liabilities have all contributed to broken promises to provide retiree medical benefits.

I. **Financial Accounting Standards Board Rule 106**

FAS 106 has become a kind of scourge of financial termites undermining the foundation of what retirees thought was a solid component of security.\(^\text{10}\)

A. **The Scourge of Financial Termites**

The current national liability for retiree medical benefits is estimated at a staggering \$400 billion to \$2 trillion.\(^\text{11}\) According to William J. Hughes, Chairman of the House Select Committee on Aging, the number of companies joining Elf Aquitaine and cutting promised retiree health benefits has increased since the Financial Accounting Standards Board began requiring employers to report retirees' health benefit liabilities.\(^\text{12}\) Mr. Hughes characterized the situation as both a "personal and national tragedy when corporations renge on their longstanding obligation to provide vital health insurance" benefits to retirees.\(^\text{13}\)

Many of the corporations that have "broken promises" to provide postretirement health benefits blame their action on a new accounting rule.\(^\text{14}\) They assert that to comply with the new rule they were forced to modify or terminate their plans and incur sig-

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\(^{10}\) Comments of Daniel J. Schulder, Director of the National Council of Senior Citizen's Dept. of Legislation. *FAS 106 is Prompting, supra* note 2.


\(^{12}\) *FAS 106 is Prompting, supra* note 2.

\(^{13}\) *FAS 106 is Prompting, supra* note 2; see *AIDS Bill Would Ban Retroactive Change in Terms of Group Health Care Coverage*, Pens. & Ben. Daily (BNA) (Mar. 17, 1993). Rep. Bill Hughes introduced a bill to prohibit employers from retroactively amending the terms of their group health plans. *Id.*

\(^{14}\) *But see FAS 106 is Prompting, supra* note 2. Michael Cotter, Senior Vice President of the Haygroup, believes FAS 106 is a catalyst for the implementation of new policies regarding reduction of retiree health benefits, but not the underlying cause. *Id.*
significant after-tax charges. Unisys Corp., Primerica Holdings, Inc., General Motors Corp., and Ford Motor Co. are among those who have implemented retiree health benefit changes. According to media accounts of information contained in Securities Exchange Commission filing documents, General Motors sustained the largest after-tax charge ever, an enormous $20.8 billion in 1992 to account for its retiree health care obligations. Similarly, Ford Motor Co. reported a $7.5 billion after-tax charge incurred to comply with the rule.

This new accrual accounting standard, controversial Rule 106: “Employers’ Accounting for Postretirement Benefits Other Than Pensions,” (“SFAS 106, Rule 106, or the Rule”), was issued by the Financial Accounting Standards Board (“FASB”) in December 1990. 

15 Musa Al-Darayseh, The $1,000,000,000,000 Dilemma; Accounting for Postretirement Benefits Under FASB Statement 106: Financial Accounting Board, 37 Nat’l Pub. Acc’t 22 (Nov. 1992).

16 FAS 106 is Prompting, supra note 2.

17 Doron P. Levin, G.M. Lost $23.5 Billion Last Year, N.Y. Times, Feb. 12, 1993, at D1.


20 The FASB is a private organization located in Norwalk, Connecticut. It sets standards for use in general purpose financial reporting, a function previously performed by the American Institute of Certified Public Accountants (“AICPA”). The FASB defines its mission as one to establish and improve standards of financial accounting and reporting for the guidance and education of the public, including issuers, auditors, and users of financial information. MILLER & REDDING, supra note 19, at 18-22.


Since 1973, the SEC and the AICPA have recognized the FASB’s pronouncements as authoritative accounting guidelines. The SEC and Committees of Congress oversee
cember 1990, and became effective for fiscal years beginning after December 15, 1992, for publicly held corporations and private employers with more than 500 plan participants as defined by the rule.\textsuperscript{21} Its effective date is delayed to fiscal years beginning after December 15, 1994, for plans outside the United States, nonpublic employers, and certain small employers with 500 or fewer participants as defined by the rule.

**B. Accrual Accounting And Disclosure Under Rule 106**

Pursuant to rule 106, the anticipated cost of postretirement medical expenses and benefits other than pensions must be accrued. The rule also requires that the obligation to pay these benefits be recognized—on the employer’s financial statements—during the employee’s active service in the same manner in which pension benefits are accounted for.\textsuperscript{22} Rule 106 has been characterized as a disclosure regulation, similar to rules arising from the federal securities laws.\textsuperscript{23} However, because rule 106 also requires the employer to accrue and account for the postretirement liabilities, it extends beyond the securities laws.\textsuperscript{24}

\textsuperscript{21} *FAS 106*, supra note 19. Paragraph entitled “Effective Dates,” SFAS No. 106 provides as follows: “This Statement generally is effective for fiscal years beginning after December 15, 1992, except that the application of this Statement to plans outside the United States and certain small, nonpublic employers is delayed to fiscal years beginning after December 1994.” *Id.*

\textsuperscript{22} *FAS 106*, supra note 19. See “Summary” paragraph entitled “Effective Date” which provides:

This Statement establishes accounting standards for employers’ accounting for postretirement benefits other than pensions (hereinafter referred to as postretirement benefits). Although it applies to all forms of postretirement benefits, this Statement focuses principally on postretirement health care benefits. It will significantly change the prevalent current practice of accounting for postretirement benefits on a pay-as-you-go (cash) basis by requiring accrual, during the years that the employee renders the necessary service, of the expected cost of providing those benefits to an employee and the employee’s beneficiaries and covered dependents.


\textsuperscript{24} It can be argued that one of Rule 106’s results, if not objectives, is to force employers to accrue and account for postretirement benefits liabilities, thereby guarding against “gross underfunding” of postretirement benefit plans and preventing a situation as occurred with the savings and loan industry which bankrupted the F.S.L.I.C. Both the Labor Department’s and the Assistant Treasury Secretary Leslie Samuels expressed concerns of this nature. A draft of the Labor Department’s September 30, 1993 proposal to prohibit employers from establishing “age-weighted
Congress adopted the federal securities acts following the stock market crash of 1929, the Depression, and hearings which established that lack of disclosure by issuers and underwriters of securities had caused shareholders to make imprudent investment decisions. Witnesses testified that the failure to disclose relevant information about the issuer and the securities being offered and sold permitted the fraud, manipulation, and deception of shareholders who invested in risky companies and lost fortunes in the securities market. They gave deplorable accounts of how investors had been manipulated into investing in “shares of blue sky” by purchasing the stock of companies that had concealed their lack of assets.

Both Congress and President Roosevelt rejected appeals for federal legislation designed to provide merit review of securities and guarantee the value of new public offerings which would prevent investors from making imprudent investment decisions and buying risky securities. Instead, Congress enacted legislation that requires adequate and meaningful disclosure of material in-profit-sharing plans” contains several reforms “aimed at shoring up the Pension Benefit Guaranty Corporation’s (“PBGC”) financial position.” The proposal’s primary objective is strengthening underfunding rules for defined benefit pension plans; however, it also prohibits age-weighted profit sharing plans which “allow substantial tax shelter for high-paid employees while providing little benefit for rank-and-file workers and none of the protections provided under defined benefit plans.” PBGC Reform Proposal Would Eliminate Use Of Age-Weighted Profit Sharing Plans, Pens. & Ben. Daily at 26 (Oct. 1, 1993).

25 See S. REP. No. 47, 73d Cong., 1st Sess. 875 (1993) (stating that “losses of investors have been appalling. Statistics indicate that such losses have amounted to the colossal sum of $25,000,000,000 during the past 10 years.”).

26 In his message to Congress, President Roosevelt stated:

I recommend to the Congress legislation for Federal supervision of traffic in investment securities in interstate commerce. In spite of many State statutes the public in the past has sustained severe losses through practices neither ethical nor honest on the part of many persons and corporations selling securities. Of course, the Federal Government cannot and should not take any action which might be construed as approving or guaranteeing that newly issued securities are sound in the sense that their value will be maintained or that the properties which they represent will earn profit. There is, however, an obligation upon us to insist that every issue of new securities to be sold in interstate commerce shall be accompanied by full publicity and information, and that no essentially important element attending the issue shall be concealed from the buying public.

Id.

27 A misstatement or omission of information is material if it is “of such a character that it might have been considered important by a reasonable shareholder who was in the process of deciding how to vote.” Mills v. Electric Auto-Lite Co., 396 U.S. 375, 384 (1970); see J.I. Case Co. v. Borak, 377 U.S. 426, 435 (1964) (stating remedial
formation by companies that utilize interstate commerce, the mails, or any national securities exchange facility to sell their securities to the public. 28 The philosophy behind the federal securities acts is that adequate disclosure of financial and other relevant information about the issuer and the securities permits shareholders to make intelligent investment decisions.

The FASB adopted the accrual accounting standard of rule 106 because it believes that failure to disclose and accrue postretirement benefit costs implies that "no obligation exists prior to the payment" of the benefits, and that "failure to recognize an obligation prior to its payment impairs the usefulness and integrity of the employer's financial statements." 29 The accounting method required by the rule ensures that the present value of employees' postretirement benefits will be accrued as of the date they become fully eligible to receive them under the postretirement benefits plan. The philosophy of the FASB, reflected in rule 106, is that requiring accrual and disclosure of relevant information about postretirement benefits obligations in employers' financial state-


29 FAS 106, supra note 19. See "Summary" which provides:

The ability to measure the obligation for postretirement health care benefits and the recognition of that obligation have been the subject of controversy. The Board believes that measurement of the obligation and accrual of the cost based on best estimates are superior to implying, by a failure to accrue, that no obligation exists prior to the payment of benefits. The Board believes that failure to recognize an obligation prior to its payment impairs the usefulness and integrity of the employer's financial statements.

The Board's objectives in issuing this Statement are to improve employers' financial reporting for postretirement benefits . . . .

Id.

Several major corporations, including AT&T, General Motors Corp., Chrysler Corp., and Ford Motor Co., "moved swiftly" in 1992 not to adopt Rule 106 and take a write-off, but to comply with SEC Accounting Bulletin No. 74, or make the required disclosure, get the "bad financial news behind them," and then take the tax write-off. Accounting Bulletin No. 74, Disclosure of the Impact that Recently Issued Accounting Standards Will Have on the Financial Statements of the Registrant When Adopted in a Future Period requires publicly held companies to disclose the "potential impacts of FASB pronouncements not yet in effect and to report them in SEC filings." Stanley Zarowin, How Business is Dealing With FASB 106; Accounting For Postretirement Benefits, 73 J. OF ACCT. 7 (Mar. 1992).
ments will provide adequate information to employees and others who rely on the integrity of those statements.\textsuperscript{30}

C. Contractual Obligations and Deferred Compensation

Rule 106 permits employers to \textit{prefund} or allocate funds necessary to cover employees' postretirement expenses as they are earned, or alternatively, to account for the expenses as a liability on their balance sheets.\textsuperscript{31} Prefunding postretirement benefits will require employers to relinquish control of assets and set them aside in a segregated account \textit{restricted} and used only for payment of the benefits.\textsuperscript{32}

Unlike pension benefits, health care benefits are generally unfunded.\textsuperscript{33} Prior to the adoption of rule 106, most employers accounted for retiree health care benefits and other postretirement nonpension benefits on a "pay-as-you-go" (cash) basis. Claims were made and then paid out on behalf of retirees and their covered dependents and beneficiaries.\textsuperscript{34} The rule explicitly sets forth the FASB's concern about this practice. It states that as "the prevalence and magnitude of employers' promises to provide those benefits have increased, there has been increased concern about the failure of financial reporting to identify the financial effects of those promises."\textsuperscript{35}

\textsuperscript{30} Deborah Harrington, FASB Manager of public relations, expressed the aim of FASB 106 as putting all investors on equal footing so as to facilitate comparison of companies. Higgins, supra note 18.

\textsuperscript{31} The present value of postretirement benefits must be fully accrued by the time an employee is eligible to receive benefits. James R. Wilbert & Kenneth E. Dakdduk, \textit{The New FASB 106: How to Account for Postretirement Benefits}, 72 J. of Accr. 36 (Aug. 1991). The transition is instituted at the beginning of the year in which the plan is adopted. Al-Darayseh, supra note 15. There is an obligation under FASB to account for any existing benefits that arose prior to adoption of the plan. This transitional obligation may be spread over the average expected future service of participants or realized in its entirety in the first year. David Langer, \textit{Planners Cope with SFAS 106; Statement of Financial Accounting Standard; Personal Financial Planning}, 62 C.P.A. J. 75 (1992). It is realization of this liability in the first year that has led to the large paper losses reported by some corporations. Higgins, supra note 18.

\textsuperscript{32} Wilbert & Dakdduk, supra note 31; see Electrics' Transition, supra note 18. Transition obligation may be funded by setting aside additional assets. \textit{Id.} These assets must be placed in a segregated trust account. Higgins, supra note 18.

\textsuperscript{33} Sharon Kahn, \textit{Save Now, Pay Later; Corporations Prepare for the Cost of Retirement Benefits}, 81 Mgmt. Rev. 28 (Apr. 1992). William M. Mercer, a New York consulting firm, estimates that only seven percent of companies currently prefund to any degree. \textit{Id.}

\textsuperscript{34} Id. Accrual at retirement, another method utilized by employees to account for benefits, is also unacceptable under FASB 106. \textit{Id.}

\textsuperscript{35} FAS 106, supra note 19.
Rule 106 requires employers to accrue the expected cost of these nonpension postretirement benefits and to recognize the obligation to pay them as employees earn them—accrual accounting. The rule thus acknowledges that an employer's promise of health care and other postretirement benefits constitutes a contractual obligation rather than a gratuity. According to the FASB, an employer's promise of postretirement benefits reflects "an exchange between the employer and the employee.” The employee gives consideration in the form of "current services" for the employer's promise of future benefits.\(^{36}\)

In "exchange for the current services provided by the employee, the employer promises to provide, in addition to wages and other benefits, health and other welfare benefits after the employee retires."\(^{37}\) Rather than characterizing postretirement benefits as gratuities, the FASB views them as part of an employee's compensation for services rendered during active employment. Since payment is deferred, the benefits are a type of deferred compensation.\(^ {38}\)

The employer incurs the obligation for postretirement health benefits as employees render the services necessary to earn those benefits.\(^ {39}\) In sum, the accrual accounting requirement that Rule 106 imposes on employers reflects the FASB philosophy that postretirement benefits are forms of deferred compensation similar to pension benefits, and that this characterization requires that they be obligations reflected in financial statements and recognized as employees earn the right to receive the benefits — during their active working careers.

### D. Application of Rule 106

Rule 106 applies to all postretirement benefits “expected to be provided by an employer to current and former employees, including retirees,”\(^ {40}\) regardless of whether the benefits are provided under a written or unwritten plan.\(^ {41}\) It applies to such things as cost-sharing where the employer has paid a certain percent of the

\(^{36}\) FAS 106, supra note 19.

\(^{37}\) FAS 106, supra note 19.

\(^{38}\) Wilbert & Dakdduk, supra note 31.

\(^{39}\) FAS 106, supra note 19; see Wilbert & Dakdduk, supra note 31. The present value of postretirement benefits must be fully accrued by the time of employee eligibility. Wilbert & Dakdduk, supra note 31.

\(^{40}\) FAS 106, supra note 19, ¶ 106.6.

\(^{41}\) FAS 106, supra note 19, ¶ 106.8 which provides:
benefit costs and the employee has paid the balance. This situation may evidence a mutual understanding between the employer and employee.

Rule 106 requires employers to consider the terms of their written plans and the mutual understandings even if they are not contained in a writing. The FASB believes that mutual understandings represent substantive plans under rule 106. It also believes that substantive plans may differ from the written plan and create liability for which the employer must account. The rule focuses on the mutual understanding or the substantive plan, and the accrual accounting should reflect the exchange transaction of the substantive plan as understood by the employer and the employee. Rule 106 applies to accounting for life insurance, tuition assistance, health care, day care, disability benefits paid to permanently disabled employees who are deemed retired, legal services, and all postretirement benefits, excluding pensions, which employers reasonably anticipate providing to current and future retirees and their covered dependents and beneficiaries. This Article is limited to rule 106's application to health care because it is the most significant benefit covered. The cost incurred

An employer's practice of providing postretirement benefits may take a variety of forms and the obligation may or may not be funded. This Statement applies to any arrangement that is in substance a postretirement benefit plan, regardless of its form or the means or timing of its funding. This Statement applies both to written plans and to unwritten plans whose existence is discernible either from a practice of paying postretirement benefits or from oral representations made to current or former employees. Absent evidence to the contrary, it shall be presumed that an employer that has provided postretirement benefits in the past or is currently promising those benefits to employees will continue to provide those future benefits.

Id.

The above FASB statement demonstrates that accrual accounting and liability recognition requirements focus on the "substantive plan," which reflects the mutual understanding between the employer and the employee, and which may differ from the "written plan." This FASB position—substantive plan versus written plan—has the potential for even more litigation to determine whether or not a plan exists and what was promised. See generally Langer, supra note 31, at 75 (explaining that "[i]f an unwritten or incomplete plan is in existence, a 'substantive' plan may still be in effect . . . if employees can expect to receive benefits based on prior company practices").

42 Severance pay and wage contribution to disabled or terminated employees are not within the ambit of FASB 106. Wilbert & Dakdduk, supra note 31.

43 FAS 106, supra note 19, ¶ 106.11 provides that "[t]his Statement does not apply to pension or life insurance benefits provided through a pension plan." It is being noted that Rules 87 and 88 adopted by the FASB in 1987 apply to postretirement pension benefits.
by employers in connection with the other benefits, although accounted for in substantially the same manner, will be relatively insignificant when compared with health care expenses.\(^{44}\)

**E. Implementation of Rule 106**

Employers that provide postretirement health care benefits and are subject to rule 106 may not “opt out” of compliance. To implement rule 106, employers are examining the rule and its accrual accounting requirements and options, performing actuarial valuations to assess the magnitude of their obligation to provide postretirement benefits\(^ {45} \) under currently existing plans,\(^ {46} \) and

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\(^{44}\) FASB “focuses on retiree health benefits more than any other benefits because they are the most costly and the most difficult to [quantify].” Al-Darayseh, *supra* note 15. As an example, General Motors estimates its current obligation as $21 million, the bulk of which pertains to medical coverage. Gunsch, *supra* note 3.

\(^{45}\) *FAS 106, supra* note 19, ¶ 106.20. "Basic Elements of Accounting for Postretirement Benefits" defines an employer’s postretirement benefit obligations as the Expected Postretirement Benefit Obligation ("EPBO") and the Accumulated Postretirement Benefit Obligation ("APBO"). The EPBO is the actuarial present value of all benefits expected to be paid to covered plan participants and their dependents—after the retirement date—as of the measurement date. The APBO is the actuarial present value of future benefits to be paid to employees and their covered dependents based on the service rendered, as of the measurement date. The APBO includes the EPBO for retirees, the EPBO for past service rendered by active employees who have not satisfied eligibility requirements under the plan and the EPBO for active employees who have satisfied eligibility requirements. Pursuant to FAS 106, the EPBO is not required to be disclosed in the institution’s financial statements; however, the APBO must be disclosed. Al-Darayseh, *supra* note 15.

The FASB recommends that employers do the following to ascertain liability for postretirement health benefits and to implement Rule 106:

- a. Review their postretirement benefit plans and make sure they thoroughly understand the promises contained in the plans; study their promises and what benefits they are required to provide.
- b. Gather information on plan participants—the individuals who will receive benefits (i.e. for both active and retired participants), gather information on their age, sex, and number of dependents.
- c. Gather information on the current cost of providing benefits offered by the plan; that provides a base for a projection of the future cost of benefits.
- d. Work with an actuary and auditor to develop assumptions about how future experience is likely to develop under the plan.

According to the FASB, these four steps provide the basis for an informed estimate of the cost of postretirement benefits and the necessary starting point for the accrual accounting required under Rule 106.

\(^{46}\) Postretirement benefit plans vary in eligibility (age and years of service) requirements and cost sharing (premiums, annual deductibles, and co-payments) arrangements. Some provide benefits through self-insurance, whereby the employer assumes the risk for health care claims by its active and retired employees and their covered dependents and beneficiaries. Other plans provide benefits through insurance companies or third party administrators.
considering new plan designs and funding options to temper the new standard’s impact on their financial statements.47

Implementation of rule 106 will necessitate collaboration among many corporate departments. Human resources and benefits personnel will be needed to provide data on covered participants, the number and nature of claims filed, specific terms of retiree benefit plans, and plan modification models. Financial personnel must measure the employer’s obligations under the new accrual accounting requirement, select accounting options and actuarial assumptions to be utilized, and evaluate funding options and decisions. Actuaries must perform calculations and advise management on the measuring process, and auditors must evaluate compliance.

Employers must select a “transition”48 method to adopt. Rule 106 allows employers either to (1) immediately recognize the accumulated obligation for postretirement benefits that have already been earned, which may create a deficit, or (2) “recognize the transition obligation in the statement of financial position and statement of income on a delayed basis over the plan participants’ future service periods,”49 i.e., prospective amortization of the obligation, which may also result in a deficit.

47 Rule 106 requires employers to accrue and report the anticipated cost of postretirement medical benefits. See FAS 106, supra note 19. The cost may be recorded on the balance sheet as an existing liability as well as an increasing annual expense. Id.

48 FAS 106, supra note 19, ¶¶ 106.247-267. Also, a section entitled “Transition” in the official summary to F.A.S. 106 provides: “Unlike the effects of most other accounting changes, a transition obligation for postretirement benefits generally reflects, to some extent, the failure to accrue the obligation in the earlier periods in which it arose rather than the effects of a change from one accrual method of accounting to another.” Id. ¶ 106.247. The official summary further provides: “The Board [believes] that transition is . . . a practical matter. [In addition] a major objective of transition is to minimize implementation costs and mitigate the disruption to the extent possible without unduly compromising the ability of financial statements to provide useful information.” Id. ¶ 106.250.

49 FAS 106, ¶¶ 106.250-160.253 further provide:

Two options [are provided] for recognizing that transition obligation. An employer can choose to immediately recognize the transition obligation as the effect of an accounting change, subject to certain limitations. Alternatively, an employer can choose to recognize the transition obligation in the statement of financial position and statement of income on a delayed basis over the plan participant’s future service periods, with disclosure of the unrecognized amount.

However, that delayed recognition cannot result in less rapid recognition than accounting for the transition obligation on a pay-as-you-go basis. FAS 106, supra note 19, ¶¶ 106.250-160.253.
Employers that select the immediate transition method—and record an increased expense and resulting financial deficit—must realize the potential negative effect on bond ratings in addition to the potential for triggering "events of default" under loan agreements. They should review loan documents and obtain waivers or modifications from lenders of any provisions under which compliance with rule 106 would hinder the employer's ability to maintain designated levels of fund balances or liquid assets.

Implementation of Rule 106 will cause expensive and major changes in practices regarding balance sheets. Whether an employer opts to sustain the entire unfunded liability immediately or to amortize it on the balance sheet for a period not to exceed twenty years,50 the impact of change in accounting standards could have a tremendous budgetary impact. In fact, implementation of the rule has already resulted in a reduction of approximately "$1.5 trillion to set up reserves for retiree medical benefits."51

F. Effects of Compliance with Rule 106: "Economic Downturn," After-tax Charges, Reduction in Shareholder’s Equity, and Broken Promises to Provide Postretirement Health Benefits

Since its adoption, publicly held corporations have grappled with rule 106 and its effect on net worth and stockholder equity.52 Many are attempting to balance compliance and the astronomical growth in liability for health care benefits to active and retired employees. Some corporations are opting to spread their accumulated retiree health care liability over the twenty year allowed period, while others are opting to take a "one time hit."53

50 FAS 106, supra note 19, at ¶ 106.254.
52 See Wilbert & Dakdduk, supra note 31.
53 See supra notes 31-36 and accompanying text.
On February 11, 1993, General Motors Corp. ("General Motors") reported the largest loss ever by an American corporation.\(^{54}\) According to The New York Times,\(^ {55}\) the loss was $23.5 billion for 1992.\(^ {56}\) Most of the "red ink" was sustained because of accounting changes required by rule 106.\(^ {57}\) General Motors charged $20.8 billion against earnings to account for future retiree health benefits.\(^ {58}\) Without the $20.8 billion charge, General Motors would have reported significant earnings for 1992.\(^ {59}\)

The February 10, 1993, The New York Times reported that Ford Motor Co. ("Ford") "posted an $840.3 million fourth-quarter loss today and a $7.4 billion loss for the year."\(^ {60}\) As with General Motors, the loss was primarily due to a one-time $7.5 billion charge against 1992 earnings reflecting an accounting change for retiree health benefits in compliance with rule 106.\(^ {61}\)

The management of Unisys Corp. ("Unisys") determined that compliance with rule 106 would result in an after-tax charge of $170 million in 1993.\(^ {62}\) As a result, Unisys announced on November 3, 1992, that it would modify its benefits plans by phasing out the company's contributions to retiree health insurance costs and, as of 1996, by requiring its 25,000 retirees to pay all of their health care expenses.\(^ {63}\) Unisys projected that these changes

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\(^{55}\) Levin, supra note 17.

\(^{56}\) Levin, supra note 17.

\(^{57}\) Levin, supra note 17.

\(^{58}\) Levin, supra note 17.

\(^{59}\) Most of that aftertax charge ($20.8 billion) was taken to account for GM's accumulated retiree health care obligations in compliance with Rule 106. Id. GM also expected to report a Rule 106 "transitional" obligation of $16 to 24 billion. See supra notes 48-50. Approximately 365,000 retirees and spouses are covered under GM's postretirement health benefits plan. GM has Approximately 362,000 active employees in the United States. See G.M. Takes Largest FAS 106 Hit, supra note 54.

\(^{60}\) Levin, supra note 18.

\(^{61}\) Levin, supra note 18.


In September of 1986, Sperry Corporation and Burroughs Corporation merged to form Unisys Corporation. After the merger, Unisys maintained the pre-existing medical benefit plans ("the predecessor plans") for Sperry and Burroughs retirees. In 1989, Unisys created the Post-Retirement and Extended Disability Medical Plan ("the old plan") to cover all employees who retired after April 1, 1989, most of whom were former Sperry and Burroughs
would dramatically reduce its retiree benefits liability, estimated at $100 million per year and rising.\(^\text{64}\)

Within days of the announcement, a class action was commenced challenging Unisys' decision.\(^\text{65}\) As with the action against Elf Aquitaine, retirees of Unisys, Primerica Holdings, Inc.,\(^\text{66}\) and other corporations acted against their employers for breach of promises to provide postretirement health care benefits.

While discussions regarding national health care reform and the nation's $400 billion to $2 trillion "health care tab" continue,\(^\text{67}\) employees. At that time, Unisys left the predecessor plans intact. On January 1, 1993, Unisys terminated the predecessor plans and the old plan and replaced these plans with the new Unisys Post-Retirement and Extended Disability Medical Plan ("the new plan"). Under the new plan, the retirees no longer receive free medical insurance. Instead, they must pay a portion of the monthly premiums. After January 1, 1995, the retirees will have to pay the full cost of premiums.

\(^\text{Id. at 672.}\)

\(^\text{64}\) Gnoffo, supra note 62.

\(^\text{65}\) In re Unisys, 837 F. Supp. at 672. Eight separate lawsuits were filed by former employees of Unisys and its predecessors, Sperry Corp. and Burroughs Corp., as a result of this decision. \(^\text{Id.}\) The cases were consolidated by the Judicial Panel on Multidistrict Litigation for disposition as a class action by the Eastern District of Pennsylvania. \(^\text{Id.}\)

\(^\text{66}\) See Alexander v. Primerica Holdings, Inc., 819 F. Supp. 1296 (D.N.J.), mot. denied, 822 F. Supp. 1099 (D.N.J.), mandamus granted, 10 F.3d 155 (3d Cir. 1993). The plaintiffs asserted that American Can Co. (Primerica's predecessor) and Primerica maintained a retirement plan which provided lifetime pension and medical benefits for qualified retired employees. \(^\text{Id. at 1299.}\) On or about January 9, 1989, Primerica notified the plan beneficiaries of a tenfold increase in their monthly mandatory contributions to the group medical insurance plan, \(^\text{Id. at 1300-01,}\) despite alleged promises that the contribution amounts were fixed. \(^\text{Id. at 1299.}\)

On October 26, 1992, almost three years after the retirees filed suit, Primerica announced additional modifications to the plan. \(^\text{Id. at 1303.}\) The letter to the beneficiaries stated:

With this letter, we are notifying you of an additional change in your rates; but, we are offering you some additional coverage choices as well.

In 1993, Primerica will offer the following choice of coverage: 1) a newly designed program (the "New Plan") only for retirees and/or spouses over age 65 that has been designed to cost the same $50 per month as you are currently paying; 2) the programs currently offered to Primerica Corporate . . . retirees, both over and under age 65 (called CCC/SB below); and 3) your current medical programs (the "Current Medical Plan"), both over and under age 65 . . . .

Effective January 1, 1993, retirees in the Primerica Group Insurance Plan for Retired Salaried Employees will begin paying premiums to cover 100% of the cost of continuing medical coverage. This decision is in line with Primerica's policy on medical coverage for retirees in those of its subsidiaries that offer continuing coverage.

\(^\text{Id. at 1303-04.}\)

\(^\text{67}\) See Comments of Stephen Metz, supra note 11 and accompanying text.
employers must find ways to control skyrocketing costs, comply with Rule 106, and fulfill benefits promises to present and future retirees.

II. LEGAL CHALLENGES TO BROKEN PROMISES

Many employers are responding to rule 106 and the recent geometric increases in retiree benefits liability by restricting plan eligibility, cutting spousal and dependent coverage, imposing retiree payment of deductibles and co-insurance, and placing caps on lifetime or annual health benefits. Others are simply terminating their plans.68

In order to support these unilateral modifications, employers are asserting that benefit plans did not exist,69 that termination or modification is their “right or prerogative,” and that the Em-

68 See supra note 64 and accompanying text.

69 There is no clear definition of the word “plan” in ERISA. “Employee welfare benefit plan” is defined, somewhat circularly, as “any plan, fund, or program . . . established or maintained by an employer . . . for the purpose of providing for its participants . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness . . . .” 29 U.S.C. § 1002(1) (1994). Cf. Petrella v. NL Indus., Inc., 529 F. Supp. 1357, 1362 (D.N.J. 1982) (“Neither Congress nor the Department of Labor has been very specific about what constitutes a ‘plan, fund or program’ for purposes of § 1002”).

Nevertheless, entitlement to receive postretirement health care benefits under ERISA may be established by an oral agreement, memoranda, affidavits, or by a practice of providing benefits, and the same is enforceable in federal court. See id.; Alexander, 819 F. Supp. at 1302-03. In fact, a written health care benefits plan is not a prerequisite to ERISA coverage or to the establishment of the right to receive postretirement benefits. Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc). There, the court set forth the following test:

To be an employee welfare benefit plan, the intended benefits must be health, accident, death, disability, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits; the intended beneficiaries must include union members, employees, former employees or their beneficiaries; and an employer or employee organization, or both, and not individual employees or entrepreneurial businesses, must establish or maintain the plan, fund, or program.

Id. at 1373. In Scott v. Gulf Oil Corp., 754 F.2d 1499, 1503 (9th Cir. 1985), the court stated that “the existence of a written instrument is not a prerequisite to ERISA coverage.” And, in Alexander, 819 F. Supp. at 1302-03, the court held that:

Because a Plan document does not exist and because the [summary plan descriptions] are ambiguous, the district court, as the trier of fact, must determine whether the Plan provided lifetime benefits upon retirement . . . . In interpreting an ambiguous ERISA plan, a court may consider the intent of the plan’s sponsor, the reasonable understanding of the beneficiaries, and past practice, among other things. In this regard, we note that the retirees’ affidavits and documents, if believed by the district court, are sufficient to show that the Plan promised lifetime irreducible benefits.
BROKEN PROMISES

Employee Retirement Income Security Act of 1974 ("ERISA") does not apply to postretirement benefits plans other than pensions. Affected beneficiaries are continuously seeking relief for violations of ERISA, breach of collective bargaining agreements or other express or implied contracts, and promissory estoppel. Employers are responding with arguments that postretirement health care plans are not covered under ERISA, that there is no federal

Id. Thus, although ERISA requires plans to be in writing, this is not part of the definition of the word "plan." The requirements are for administrative and reporting purposes only; failure to comply does not exempt a plan from ERISA's coverage. Any other result would be inconsistent with Congress' express intent to protect an employee's interest in employee benefit plans, whether or not his employer satisfied the administrative or reporting requirements. See 29 U.S.C. § 1001 (1988).

These assertions are inconsistent with the Supreme Court's ruling in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), where an employer's termination pay and stock purchase plans were deemed to be "employee welfare benefit plans" or "employee pension benefit plans" covered by ERISA. Also, Congress' express intent in adopting the statute, see 29 U.S.C. § 1001(a) (1988), and other federal court cases support the application of ERISA to postretirement health care benefit plans. See, e.g., Petrella, 529 F. Supp. at 1361.

Postretirement benefit plans are usually established under a union-negotiated collective bargaining agreement with employers, or unilaterally by an employer for the benefit of nonunion employees. In the absence of a written plan or an explicit contractual obligation to provide such benefits, a history of benefits payments to employees or retirees may nevertheless bind employers as implied agreements. See supra note 69. The test for an implied agreement is simply "whether the conduct and acts of the parties show an agreement." Brighenti v. New Britain Shirt Corp., 356 A.2d 181, 183 (Conn. 1974).

Employers may be estopped, by principles of equitable or promissory estoppel, from denying their obligations under existing benefits plans, or from denying that certain employees are covered by these plans, once the employees have relied to their detriment on assurances of coverage by employers. See Amato v. Western Union Int'l, Inc., 773 F.2d 1402, 1419-20 (2d Cir. 1985), cert. denied, 474 U.S. 1113 (1986); Vogel v. Independence Fed. Sav. Bank, 692 F. Supp. 587, 594 (D. Md. 1988), modified, 728 F. Supp. 1210 (D. Md. 1990).

In these cases, employees and retirees have successfully argued that equity prevented their employers from revoking promises of benefits, after receiving the consideration of continued employment, services and loyalty, by withdrawing, reducing, or terminating the promised benefits after employees had retired in reliance on them. Both courts held that a breach of contract action could be brought for violation of an ERISA plan, and that the principle of estoppel applies. See Whitworth Bros. Storage Co. v. Cent. States Southeast & Southwest Areas Pension Fund, 794 F.2d 221, 225 (6th Cir.), cert. denied, 479 U.S. 1007 (1986) (applying federal common law under ERISA to "actions premised on contractual obligations created by ERISA plans"). Employees and retirees argue that revocation of promised postretirement health benefits is unconscionable because senior citizens are in the greatest need of such benefits, they are often unable to acquire them from any other sources, and employers have already received consideration for these benefits in the form of services and loyalty during employment.
common law of employee benefits under ERISA, that no contract or basis for promissory estoppel exist, and that postretirement benefit plans can be modified for both active employees and retirees since there is no vesting of welfare benefits.

A. ERISA's Application to Postretirement Health Care Plans

In 1974, Congress enacted ERISA to "promote the interest of employees [and retirees] and their beneficiaries in employee benefit plans and to protect contractually defined benefits." Senator Jacob Javits elaborated on the intent of Congress:

In view of Federal preemption, state laws compelling disclosure from private welfare or pension plans [and] imposing fiduciary requirements on such plans . . . will be superseded. It is also intended that a body of Federal substantive law will be developed by the Courts to deal with issues involving rights and obligations under private welfare and pension plans.

Prior to adopting ERISA, Congress conducted an investigation which revealed that employees looked to pension income as a means of financial security for their old age, and that employer abuses and mismanagement of pension plan assets had deprived millions of retirees of their pensions and economic security.

Following the investigation, Congress enacted the Welfare and Pension Plan Disclosure Act of 1958 ("WPPDA"), essentially a fed-

74 Firestone Tire and Rubber Co., 489 U.S. at 113.
75 120 CONG. REC. 29,942 (1974).
In 1958 Congress concluded an investigation which revealed that millions of dollars in pension plan assets had been stolen or embezzled by officers of some unions. It was also discovered that many employee pension plan assets were wasted due to payment of unjustifiably large salaries to plan administrators and union officials, kickbacks, self-dealing by administrators, and failure of administrators to exercise reasonable care and prudence in investing pension funds.
In 1958, the Senate Committee on Improper Activities in Labor Management Relations ("the Committee") concluded an extensive investigation which uncovered widespread embezzlement, payment of exorbitant salaries, self-dealing, waste, and general mismanagement of some private pension plan assets by their administrators. The Committee concluded that the abuses resulted from the absence of a comprehensive federal statute which would provide uniform and effective regulation of private pension plans, and which would remedy the almost complete absence of any financial
eral disclosure statute that provided pension plan participants with information about their plans. ERISA, a comprehensive statute specifically adopted to protect pension plan assets from abuse and mismanagement and to protect employees' interests in those assets, replaced and repealed the WPPDA. Although ERISA does not require employers to provide any employee benefits plans, it does regulate the establishment and operation of employer pension plans, which provide retirement income and welfare plans, which in turn provide all other employee benefits. When Con-

accounting or reporting regarding pension plan assets to participants, beneficiaries, or governmental authorities. See Ford, supra note 76.

After concluding its investigation, the Committee prepared a report which recommended the adoption of a federal disclosure act mandating publicly available information concerning the operation and administration of private pension plans. The report articulated the Committee's belief that public disclosure of pertinent information about private pension plans and their assets would protect the assets and millions of people relying on those assets for future economic security. Id.

Congress adhered to the Committee's recommendation by adopting the WPPDA, which was essentially a federal disclosure statute designed to protect pension plan assets from abuse by plan administrators. The Act was also designed to provide private pension plan participants and their beneficiaries with sufficient information about their pension plans so that they could discover any mismanagement, and if necessary, seek relief under applicable federal and state laws. Id.


When postretirement benefit plans are established on behalf of union employees under collective bargaining agreements, actions to challenge modification and to enforce rights to receive promised benefits may be brought under § 502 of ERISA. The plaintiffs may sue in federal district court and allege breach of the plan document under ERISA. Union members and their beneficiaries may also allege breach of the collective bargaining agreement terms and bring their action under Section 301 of the Labor Management Relations Act of 1947 (“Section 301”). Similarly, they may seek to enforce rights to receive promised benefits under promissory estoppel, alleging either Section 301 promissory estoppel or ERISA promissory estoppel in some jurisdictions. When postretirement benefits plans are provided unilaterally to nonunion salaried employees, actions challenging plan modification or seeking to enforce rights to receive payment of benefits may also be brought under Section 502 of ERISA, promissory estoppel, and other contract claims. Id.

79 See Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (setting forth four-prong test to determine meaning of “plan, fund or program” under ERISA).

To be an employee welfare benefit plan, the intended benefits must be health, accident, death, disability, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits; the intended beneficiaries must include union members, employees, former employees or their beneficiaries; and an employer or employee organization, or both, and not individual employees or entrepreneurial businesses, must establish or maintain the plan, fund, or program.
gress adopted the statute, the primary concern was to protect promised retiree pension benefits. The enactment of ERISA responded to recurring financial instability in private pension plans and to employer abuses and mismanagement of plan assets. These problems resulted in the loss of promised postretirement pension benefits to retired employees.

ERISA was enacted at a time when most employees retired at age sixty-five and obtained postretirement medical coverage through Medicare. Welfare plans were not prefunded, employee contributions were not required, and costs were low. Employers were not as concerned about costs because they operated welfare plans on a pay-as-you-go basis. Expenses were met out of current revenue, costs were spread over twenty or more years, and active employees provided the revenue needed for retiree welfare benefits.\(^80\)

Welfare benefits, especially postretirement health care, have become increasingly important to active employees, retirees, and employers in the years since ERISA's adoption. Medical care costs have been escalating at an uncontrollable rate. Employees have been working for several employers during their active careers and have been retiring at younger ages from their last place of employment with less than twenty years of service. For various reasons, many employees have taken "early retirement" between fifty-five and sixty years of age. They rely exclusively on their health care plans for medical benefits until they reach age sixty-five, whereupon they qualify for Medicare.

Today, when employees take early retirement, their last employer usually pays the entire cost of postretirement health care benefits received until they reach age sixty-five. Employers are incurring astronomical expenses in maintaining postretirement health care plans, especially plans that provide lifetime benefits for retirees and their dependents. The extraordinary expenses re-

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\(^80\) In the past, most corporations had several active employees for every one retiree receiving benefits. Today, many corporations have one working employee for every retiree and are enduring an almost impossible financial burden in maintaining escalating medical benefits payments. See Ruling In Favor of GM's Early Retirees Contains Important Lessons For Employers, Pens. & Ben. Daily (BNA), at 4 (Aug. 5, 1991). According to Gregory McDonald of the General Accounting Office, there are approximately nine million private sector retired workers who are currently covered by private company health care plans and 32 million active employees who anticipate coverage under these plans when they retire. Id. at 5.
sult from increases in the number of retirees, longer lifespans, higher health care costs, and rising costs of health insurance.

Pursuant to ERISA, Congress imposed reporting requirements, disclosure provisions, funding safeguards, plan termination insurance requirements, participation and minimum vesting requirements, and fiduciary standards. The requirements with respect to the funding, participation, and vesting of benefits were designed to prevent further abuse by employers in the establishment and operation of pension plans. ERISA's requirement that employers provide detailed material information regarding their plans is designed not only to ensure proper pension management, but also to ensure that adequate funds are set aside to provide retirees with promised pension benefits.

Although ERISA regulates both pension plans and welfare plans, it does not contain similar requirements with respect to the participation, funding, and vesting of benefits. Thus, courts have held that there is no automatic statutory health care benefits vesting right. Congress did not provide strict requirements for

81 29 U.S.C. §§ 1001-1461 (1988). Pension plan administrators are required to prepare and file a description and summary of the pension plan and its annual report with the Secretary of Labor. Id. §§ 1021(b), 1023(a), 1024(a).

82 Plan administrators are required to provide each participant with a summary and detailed description of the plan within 120 days of establishment of the plan or within 90 days after one becomes a participant, whichever occurs later. ERISA also requires the plan administrator, upon request, to provide each participant with a record of his accumulated and vested benefits and other documents relevant to the plan. Id. §§ 1021(a), 1023(a), 1024(b), 1025(a).

83 Id. §§ 1081-1082.

84 Id. §§ 1301-1368 (1988).

85 Id. §§ 1052-1053 (1988).

86 Id. §§ 1101-1114.

87 In the absence of automatic statutory vesting rights for welfare benefits under ERISA, retirees' claims of vested lifetime health care benefits must be based on the plan's terms expressed in the summary plan descriptions, other documents, or other "persuasive evidence." Courts have generally held that unlike pension benefits, post-retirement health care benefits do not automatically vest when the employee retires. See Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988).


88 See Moore, 856 F.2d at 488 (holding that welfare benefits do not automatically vest under ERISA). The court stated that "to require the vesting of these ancillary benefits (those that fall under welfare plans) would seriously complicate the administration and increase the cost." Id. at 491. The court found that the plan documents and summary plan description documents provided by Metropolitan had reserved the
welfare plans, which cover all benefits other than pensions, because they were already regulated by the states and were not viewed to be as significant as pension plans.

B. Challenges to Broken Promises Based on ERISA

Employees did not have “rights” in employer-established benefit plans prior to ERISA. The benefits payable under the plans were considered to be revocable gifts which employers bestowed upon deserving employees. Because the benefits were viewed as gratuities provided at the employers’ discretion with no consideration received from the employee, the employer could withdraw the benefits and terminate the plan at will.89

Employee rights in employee benefit plans were first recognized in *Inland Steel v. NLRB.*90 The United States Court of Appeals for the Seventh Circuit held that an employee gives his services as consideration for pension benefits. Following the *Inland Steel* decision, employee benefit plans have not been considered gratuities or revocable gifts.

employer’s right to modify or terminate the plan at any time, and since welfare benefits do not automatically vest, the plaintiff Moores could not prevail. *Id.*

But see *Eardman v. Bethlehem Steel Corp. Employee Benefit Welfare Plans,* 607 F. Supp. 196 (W.D.N.Y. 1984), where the court held that benefits received by retirees are status benefits that vest and that retirees have the right to continue to receive them for life as long as they remain retired despite increased cost to their former employer. In *Eardman,* the court considered whether the employer had “reserved the right to reduce the terms of pensioner health care programs’ coverage and to require the payment of contributions by [him] in these programs.” *Id.* at 198. The court rejected the employer’s argument that it had reserved the right to modify the plan, to reduce the level of health care coverage, or to require contributions by retirees covered under the plan, despite some disputed language, in view of the employer’s oral and written representations regarding continued benefits made to participants prior to their retirement. *Id.* at 209. The court held that to allow the employer to terminate or modify the plan, to reduce benefits, or to impose a deductible “would require the Court to ignore the representations made by [defendants’] own agents to retirees . . . concerning the scope of their benefits.” *Id.* The court found “persuasive evidence” that the employer intended to provide non-terminable lifetime health care benefits. *Id.* at 212. Then it found that the plaintiffs were “entitled as a matter of law to enforcement of their rights to non-terminable medical and life insurance benefits under the terms of the Plan documents in existence,” *id.* at 215, during their employment and prior to the adoption of a later plan which provided for payments and contributions to the cost of medical care benefits by participants, deductibles prior to medical reimbursement, and the right to modify the plan. *Id.*

89 McNevin v. Solvay Process Co., 53 N.Y.S. 98 (App. Div. 4th Dep’t 1898), aff’d, 60 N.E. 1115 (N.Y. 1901); Menke v. Thompson, 140 F.2d 786 (8th Cir. 1944).

90 170 F.2d 247 (7th Cir.), cert. denied, 336 U.S. 960 (1948).
Today, it is generally recognized that pension and postretirement welfare benefits are forms of deferred compensation which an employee earns during active employment. Employers may no longer modify benefits or terminate plans at will without reviewing them and considering liability for any commitments made.91

The legislative history and court decisions demonstrate that postretirement health care benefit plans were intended to be covered by ERISA, which was enacted to “promote the interest of employees (and retirees) and their beneficiaries in employee benefit plans, and to protect contractually defined benefits.”92 Congress intended to protect employee and retiree rights in welfare benefits as well as in pension benefits, and it intended that ERISA actions seeking to enforce these rights be brought in federal district court.

To achieve the intent and purpose of ERISA, the federal courts developed and apply a “federal common law of rights and obligations under ERISA-regulated plans.”93 The legislative history of ERISA demonstrates that Congress intended for federal courts to “fashion” a common law of employee benefits under ERISA in the same manner in which they fashioned federal common law under section 301 of the Labor Management Relations Act of 1947.94 In fact, the conference report95 states that ERISA actions are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301.

It is a well recognized principle that federal courts have developed federal common law under section 301.96 Development of federal common law under ERISA in connection with actions concerning postretirement health care benefit plans is consistent with the congressional intent in adopting that statute.

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91 See UAW v. Yard-Man, Inc., 716 F.2d 1476 (6th Cir. 1983), cert. denied, 465 U.S. 1007 (1984) (utilizing basic contract principles to interpret plan to determine if it provided for lifetime health benefits and if benefits vested). The court stated that explicit language of collective bargaining agreements prevails where ambiguity exists about the employer’s right to terminate benefits. Id. at 1479. It also stated that when there are remaining ambiguities in the health coverage provision of a plan, the parties must look to durational limitations of those provisions of the plan. Id. at 1480-82.


93 Id. at 110 (quoting Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987)).

94 REPORT, supra note 87.

95 REPORT, supra note 87.

C. The Unisys and Primerica Cases Challenging Modification or Termination of Postretirement Health Care Benefits

ERISA requires trustees and other fiduciaries of postretirement benefit plans to discharge their duties for the exclusive purpose of providing benefits in accordance with the employee benefit plans in the same manner as a reasonably prudent person would under principles of trust law. 97 They must be aware of ERISA and the fiduciary duty it imposes when deciding to terminate or modify postretirement benefit plans. Employees and retirees of Elf Aquitaine, Unisys, Primerica, and other corporations have challenged their employers' attempts to terminate or modify their plans, and argued that the fiduciaries violated their ERISA obligations.

On November 3, 1992, Unisys announced that, effective January 1, 1993, it would terminate its existing postretirement health care benefit plans—the Sperry Plan, the Burroughs Plan, and the Unisys Plan—and replace them with a new plan. Unisys identified the new plan as the “Unisys PostRetirement and Extended Disability Medical Plan,” (“Unisys PRM Plan”). It announced that all medical coverage provided under preexisting plans would terminate on December 31, 1992. 98 Immediately after the announcement, a class action suit, Romano v. Unisys Corp., was filed against Unisys in the United States District Court for the Eastern District of Pennsylvania. 99 The complaint alleged that during the week of November 2, 1992, Unisys mailed an announcement booklet to participants and notified them that beginning in 1996, participants would pay the entire cost of the PRM Plan. Unisys projected that the cost in 1996 would be approximately $396 per

99 Id. A complaint in Romano v. Unisys Corp., Civil Action No. 92-CV-6938 was filed in the United States District Court for the Eastern District of Pennsylvania.

month (or $4760 per year) for each covered person under age sixty-five and $148 per month (or $1766 per year) for each covered person over sixty-five. The complaint alleged that participants were notified that beginning in 1995 under the new Unisys plan, they would pay two-thirds of the cost of their coverage; in 1994 they would pay one-third of the cost; and in 1993 they would pay approximately eleven percent of the cost. The complaint further asserted that Unisys predicted that during the calendar year 1993 “for some participants and their spouses, costs of medical coverage will increase as much as $573 and require class members to choose between medical coverage and necessities of life.”

Paragraph thirty-six of the complaint alleged the following regarding rule 106:

36. In its public announcement of these changes, Unisys stated that it had adopted Standard 106 of the Financial Accounting Standards Board and that Standard 106 required Unisys to set-aside in reserve the funds required to pay medical coverage under the existing Plans. In order to avoid these adverse consequences for its balance sheet, Unisys advised, it was unilaterally terminating the prior plans.

In ruling on summary judgment motions, the court distinguished the “ambiguous” language reserving the right to modify health benefits plans in other cases from the explicit language in the Unisys plans. It held that Unisys had “unambiguously reserved its unilateral right to terminate the plan” and thus granted the motion for “the denial of benefits claims of the Unisys subclass.”

The court also ruled that the Burroughs plan “unambiguously reserved the termination rights” which Unisys sought to exercise and thus granted the motion for the Burroughs subclass’s denial of benefits claims.

The court found that the Sperry plan documents were “ambiguous” and rejected the motion for the Sperry sub-class’s denial of benefits claim. Finally, the court held that Unisys’ decision to modify its benefits plans was not “constrained by ERISA’s fiduciary duty provisions,” and that “oral representations” regarding the terms of the plans by “agents of Unisys and its successors, in their capacity as plan administrators,” did not constitute breaches of fiduciary duty.

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100 Unisys, 837 F. Supp. at 672.
101 Id. at 676.
102 Id.
103 Id.
104 Id. at 681.
In a similar case, Alexander v. Primerica Holdings, Inc., the plaintiffs filed a class action suit and sought a preliminary injunction to prevent their employer from increasing their health and life insurance monthly contributions and premiums. The plaintiffs alleged that American Can Co. (Primerica's predecessor) and Primerica maintained a retirement plan that provided lifetime pension and medical insurance benefits for qualified salaried employees who retired. On or about January 9, 1989, Primerica notified the participants of an increase in their monthly mandatory contributions to the group medical insurance plan. The complaint, filed against Primerica in the United States District Court for the District of New Jersey on December 14, 1989. The plaintiffs further alleged that by letter dated October 26, 1992, Primerica notified its retirees of additional plan modifications:

With this letter, we are notifying you of an additional change in your rates; but, we are offering you some additional coverage choices as well.

In 1993, Primerica will offer the following choice of coverage: 1) a newly designed program (the "New Plan") only for retirees and/or spouses over age 65 that has been designed to cost the same $50 per month that you are currently paying; 2) the programs currently offered to Primerica Corporate retirees, both over and under 65 (called CCC/SB); and 3) your current medical programs (the "Current Medical Plan"), both over and under age 65 . . . .

Effective January 1, 1993, retirees in the Primerica Group Insurance Plan for Retired Salaried Employees will begin paying premiums to cover 100% of the cost of continuing medical coverage. This decision is in line with Primerica's policy on medical coverage for retirees in those of its subsidiaries that offer continuing coverage.

In granting the original motion for summary judgment, the district court noted that Primerica would be exposed to significant economic loss if, while waiting for a trial on the merits, it were enjoined from making the proposed changes and from increasing employee contributions and premiums for health and life insurance benefits. The court reasoned that if the injunction was granted, Primerica would bear the financial burden of maintaining the medical and life insurance coverage at the current levels.

106 Id. at 1031 (quoting Oct. 26, 1992 letter, at 1).
for all plaintiffs in the class. The court found that an injunction would cause Primerica to expend in excess of $1.7 million while awaiting trial, and over $7 million by the time the appellate process ran its course. In addition, the Third Circuit held that the language in the Summary Plan Descriptions was different, and the reservation of the right to modify the plans was ambiguous and "subject to reasonable alternative interpretations."

D. Legal Challenges to Modification or Termination of Postretirement Health Care Benefit Plans Based on Breach of Contract and Provisions Contained in Merger Documents

In the absence of language reserving the right to terminate or modify postretirement benefits, courts generally apply the legal maxim: *The law abhors a forfeiture*. The plaintiff in *Elf Aquitaine* urged the court to apply this aphorism and forbid his former employer from terminating or modifying its plan. Section 12 of the amended tender offer agreement in the *Elf Aquitaine* case specifically provided that "in all events, the Purchaser (EA Development) and SNEA (Societe National Elf Aquitaine) expect to continue whatever pension and other employee benefit plans the Company now has or to offer comparable benefits under new plans." The plaintiff argued that the maxim should be applied because Elf Aquitaine explicitly agreed to maintain the postretirement health care plan, which provided lifetime benefits.

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107 Id. at 1036. The court stated:

In this case, Primerica will be exposed to significant economic loss should it be enjoined from making the proposed changes in the Plan. Primerica will be required to bear the financial burden for maintaining the medical and life insurance coverage at the present levels for all Plaintiffs in the class. As indicated below . . . such an injunction would cause Primerica to expend over $1.7 million between now and the anticipated time of trial . . . . In all likelihood, by the time the appellate process runs its course, Primerica will have expended more than $7,000,000 as a result of the injunction.

Id.


110 See supra text accompanying notes 5-9.
Furthermore, the plaintiff maintained that there was no language in the plan reserving the right to terminate or modify it; therefore, Elf Aquitaine was not legally authorized to modify or terminate the plan.\textsuperscript{111}

In cases such as \textit{Elf Aquitaine},\textsuperscript{112} where the contractual commitments to maintain postretirement health benefits are contained in merger documents, employees who are shareholders may sue for violations of section 14(a) of the Securities Exchange Act of 1934\textsuperscript{113} if the acquiring company terminates or modifies the plan. They may argue that the merger documents contain promises to continue benefits; that the promises were \textit{material}; that they were stockholders to whom the solicitations and the tender offer were addressed; and that the promises reasonably influenced their decision as stockholders to accept the offer and tender their shares.\textsuperscript{114}

When plaintiffs allege that termination or modification of their postretirement benefits plan contravene a tender offer agreement or breaches a contract under section 14(a),\textsuperscript{115} the ac-

\textsuperscript{111} See supra notes 8-9 and accompanying text; see also GAF Corp. v. Poole, 715 F. Supp. 1212, 1215 (S.D.N.Y. 1989); Eardman, 607 F. Supp. at 209.
\textsuperscript{112} See supra note 9 and accompanying text.
\textsuperscript{115} Section 14 (a) of the 1934 Act, 15 U.S.C. § 78n(a) provides:

\begin{quote}
It shall be unlawful for any person, by the use of the mails or by any means or instrumentality of interstate commerce or of any facility of a national securities exchange or otherwise, in contravention of such rules and regulations as the Commission may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of his name to solicit any proxy or consent or authorization in respect of any security (other than an exempted security) registered pursuant to section 78l of this title.
\end{quote}

\textit{Id.} Management, shareholders, and "any person" soliciting shareholder votes use the proxy solicitation process because it is almost impossible for a sufficient number of shareholders to physically assemble at a shareholders meeting and vote in person.

The purpose of Section 14(a) is to prevent management or others from obtaining authorization for corporate action by means of deceptive or inadequate disclosure in proxy solicitation. The section stemmed from the congressional belief that 'fair corporate suffrage is an important right that should attach to every equity security bought on a public exchange.' H.R. REP. No. 1383, 73d Cong., 2d Sess. 13 (1934). It was intended to "control the conditions under which proxies may be solicited with a view to preventing the recurrence of abuses which . . . (had) frustrated the free exercise of the voting rights of stockholders." J.I. Case Co., 377 U.S. at 431 (quoting H.R. REP. No. 1383, 73d Cong., 2d Sess. 1 (1934)).
tion should be brought in federal district court. Section 27 of the 1934 Act provides: "The district courts . . . shall have exclusive jurisdiction of violations of this title or the rules and regulations thereunder, and of all suits in equity and actions at law brought to enforce any liability or duty created by this title or the rules and regulations thereunder." Section 27 grants the United States district courts exclusive jurisdiction over actions brought under section 14(a). Pursuant to sections 27 and 29(b) of the 1934 Act, courts may award damages, rescission of a contract, issue an injunction to prevent violation of the agreement, "use any available remedy to make good the wrong done," or fashion any "appropriate relief" for breach of a merger agreement provision.

CONCLUSION

In the absence of a national health care plan, an uncontrollable rate of increase in health care costs continues. To comply with the rule, employers subject to rule 106 are providing reasonable health care benefits for active and retired employees. Many employers are attempting to lessen the budgetary impact of compliance with rule 106 by modifying their postretirement benefit plans. Some are terminating their plans altogether. Others are designing plans that reduce benefits or require employees and retirees to contribute more to the cost of their benefits, or both.

It could be argued that courts should relieve employers of their obligation and permit them to modify or terminate their postretirement benefit plans upon presenting clear and convincing evidence of severe financial emergencies or other extraordinary and extreme supervening circumstances (e.g. financially distressed corporation facing liquidation must terminate benefits and reorganize to survive). It is unlikely, however, that employers will prevail in arguing that such compliance with rule 106 causes such emergencies.

While the nation awaits an acceptable national health care plan, employees and retirees are suing to enjoin employers from

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117 Id. § 78cc.
118 J.J. Case Co., 377 U.S. at 433 (citation omitted).
120 See Plaza Health Lab. Inc. v. Perales, 878 F.2d 577, 580 (2d Cir. 1989); Jackson Dairy Inc. v. H. P. Hood & Sons, Inc., 596 F.2d 70, 72 (2d Cir. 1979) (per curiam); Hamilton Watch Co. v. Benrus Watch Co., 206 F.2d 738, 740 (2d Cir. 1953); Caufield
breaking their promises by terminating or modifying postretirement plans. Meanwhile, employers that are subject to rule 106 and that have incurred substantial after-tax charges to comply with the rule—and shareholders who have sustained significant reductions in their equity—are looking for “relief” from the geometrically increasing financial burden.

v. Board of Educ. of the City of N.Y., 486 F. Supp. 862 (E.D.N.Y. 1979), aff’d, 632 F.2d 999 (2d Cir. 1980), cert. denied, 450 U.S. 1030 (1981) (setting forth the standard for issuance of preliminary injunction). The United States Court of Appeals, Second Circuit held that there must be a showing of possible irreparable injury and either (1) probable success on the merits or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly toward the party requesting the preliminary relief.

The party seeking the injunction must demonstrate that he will be irreparably harmed if the injunction is not issued. Norlin Corp. v. Rooney Pace, Inc., 744 F.2d 255, 269 (2d Cir. 1984). As a general rule, an “irreparable injury is . . . one for which the court could not compensate the movant should he prevail on the merits of his action.” 7 J. MOORE ET AL., MOORE’S FEDERAL PRACTICE, § 65.04(1) (2d ed. 1989). To prevail, the moving party must also demonstrate that the irreparable injury is actual and imminent, not remote or speculative. State of N.Y. v. Nuclear Regulatory Comm’n, 550 F.2d 745, 755 (2d Cir. 1977). Retirees often attempt to demonstrate irreparable harm by asserting that their advanced age and poor health, coupled with the increased health insurance costs and fixed incomes, make it impossible for them to obtain substantially similar health benefits if their employer is permitted to reduce or terminate their benefits.