IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

WILLIAM DOUGLAS FULGHUM, et al., Individually and on behalf of all others similarly situated, Plaintiffs, v. EMBARQ CORPORATION, et al., Defendants.	**CIVIL ACTION** **No. 07-2602 (KHV/JPO)** **CLASS ACTION**

PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS THE FIRST, THIRD, FOURTH, FIFTH, SIXTH AND SEVENTH CLAIMS FOR RELIEF IN PLAINTIFFS' AMENDED COMPLAINT

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Plaintiffs William Douglas Fulghum, et al., oppose Defendants' Motion to Dismiss the First, Third, Fourth, Fifth, Sixth and Seventh Claims for Relief in Plaintiffs' Amended Complaint (Doc. # 17).

INTRODUCTION

Although defendants have filed a motion to dismiss under Rule 12(b)(6), Fed. R. Civ. P., their arguments proceed as though this case were at the summary judgment or trial stage. Defendants engage in a one-sided review of isolated pages from ERISA summary plan descriptions, ignoring other portions of the same documents confirming that, as plaintiffs have alleged, defendants consistently promised retiree medical and life insurance benefits that would continue for plaintiffs' lifetimes, ending only "when you die" and "on the date of your death." Defendants also fail to acknowledge controlling principles in the statutes and in caselaw from the

U. S. Supreme Court and Tenth Circuit establishing that there is no defect in plaintiffs' ERISA, ADEA and state law claims.

When the proper standards of decision are applied to the motion, it is apparent that plaintiffs' claims are sound and their factual basis is adequately alleged in the Amended Complaint. Defendants have not shown as a matter of law that plaintiffs cannot prevail on the challenged claims. The motion to dismiss should be overruled.

SUMMARY OF FACTS ALLEGED

In their Amended Complaint ("AC") filed March 31, 2008, plaintiffs allege the following facts, which must be accepted as true for purposes of the motion to dismiss.

Plaintiffs are retired, former long-service employees of defendant Sprint Nextel Corporation ("Sprint") and its predecessors, including several operating subsidiaries which have been engaged in local and regional telephone businesses throughout the United States since at least the 1950's. AC ¶¶ 9-26, 63 and Appendix A thereto. As retired employees, plaintiffs and their eligible spouses and other dependents were participants in various ERISA-governed plans that were sponsored by Sprint and its operating subsidiaries to provide medical, prescription drug, and life insurance benefits during retirement. Id.

Defendants are: (a) Sprint and several of its former operating subsidiaries; (b) Embarq Corporation, the new entity to which Sprint spun-off its landline telephone businesses in May 2006, and which assumed Sprint's obligations to provide to plaintiffs and the members of the proposed class the retiree benefits that are the subject of this suit; (c) the ERISA plans under which these benefits have been provided; and (4) various administrative bodies and other fiduciaries of these plans. AC ¶¶ 27-49.

The retiree benefits which are the subject of this suit are: (a) medical benefits covering participants both before and after attainment of Medicare eligibility; (b) prescription drug

benefits; and (c) life insurance benefits. Until the actions complained of, defendants provided these benefits either at no cost or minimal cost. AC ¶¶ 77, 81, 87, 100-102.

Over at least a 30-year period, defendants repeatedly represented to plaintiffs and other employees generally that the programs of medical, prescription drug, and life insurance were valuable, would ensure financial security during their retirement years, and would last for their lifetimes. This conduct was consistent with practices in the telecommunications industry to attract and retain employees and justify lower levels of compensation during active employment. AC ¶¶ 33, 40, 46, 49, 64, 78-80, 89, 92.

As a result of defendants' conduct, plaintiffs and class members generally were induced to understand that they would continue to receive these promised benefits throughout retirement for their lifetimes. AC ¶¶ 80-83, 92, 98-99.

Defendants exploited their promises of lifetime retiree benefits to solicit and induce employees to take early retirement. Defendants publicized upcoming changes to these retiree benefits, informing employees that only if they retired before the effective date of the changes would they be assured of receiving throughout their retirements the superior benefits in their current unchanged form. Defendants also used the availability of the retiree benefits as inducements for employees to accept periodic special early retirement programs. Plaintiffs and others who received and accepted these offers were informed by defendants, and thereby understood, that acceptance of early retirement would have the desired effect of securing the promised benefits throughout retirement. AC ¶¶ 73-75, 82-83, 84-87, 93-96.

Defendants' written communications and other disclosures about the benefits, including summary plan descriptions, represented that plaintiffs and other retirees would continue to receive their retiree benefits throughout the duration of their retirements, up until their deaths. These written communications did not clearly and conspicuously disclose that the company

purported to reserve a right to reduce or terminate the benefits during their retirements, or warn plaintiffs and other retirees of the existence of any such right. AC ¶¶ 87-89, 91-92, 115.

In November 2005, Sprint announced that it was terminating the program of prescription drug benefits for Medicare-eligible retirees and dependents effective January 1, 2006. Sprint replaced the drug benefits with an inferior plan under which Sprint (and later Embarq) paid a monthly allowance, equal to $ 500 per person per year, to assist participants in obtaining third-party coverage under Medicare Part D. AC ¶¶ 29, 100.

On or about July 26, 2007, following the spin-off of Embarq and the transfer to Embarq of Sprint's benefit obligations, Embarq announced that it was terminating or reducing the subject retiree benefits as follows: (1) effective January 1, 2008, the company terminated completely the program of medical benefits and ended the $ 500 per year prescription drug payments for every retiree and dependent who was then eligible for Medicare or who became eligible in the future; (2) effective September 1, 2007, the company terminated the "grandfathered" company-paid life insurance benefits provided to certain plaintiffs and other retirees who were also participants in the Voluntary Employee Benefit Association ("VEBA") plan sponsored by Carolina Telephone & Telegraph[1]; and (3) effective January 1, 2008, the company reduced the level of company-paid life insurance benefits so that these benefits, which previously had been equal to as much as $ 40,000, would be capped at $ 10,000 in all cases. AC ¶¶ 29-30, 68-69, 77, 81-88, 101-02.

Plaintiffs filed this case to challenge defendants' actions as violations of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq., the Age Discrimination in Employment Act (ADEA), 29 U.S.C. § 623(a), and age discrimination laws of several states.

[1] Since 1971, employees of Sprint subsidiary Carolina Telephone & Telegraph Company had a particular program of life insurance benefits that paid a multiple of a retiree's final annual salary as a death benefit. This company-paid benefit is referred to in the Amended Complaint as the "grandfathered" life insurance. AC ¶¶ 68-70, 81.

ARGUMENT

I. LEGAL STANDARDS FOR DECIDING THE MOTION TO DISMISS

The standards governing decision of defendants' Rule 12(b)(6) motion to dismiss were recently summarized by the Court, as follows:

> In ruling on defendants' motion to dismiss for failure to state a claim under Rule 12(b)(6), Fed.R.Civ.P., the Court assumes as true all well pleaded facts in that complaint and views them in a light most favorable to plaintiffs. See Zinermon v. Burch, 494 U.S. 113, 118 (1990); Swanson v. Bixler, 750 F.2d 810, 813 (10th Cir.1984). Rule 12(b)(6) does not require detailed factual allegations, but the complaint must set forth the grounds of plaintiffs' entitlement to relief through more than labels, conclusions and a formulaic recitation of the elements of a cause of action. See Bell Atlantic Corp. v. Twombly, --- U.S. ----, 127 S.Ct. 1955, 1964-65 (2007). In other words, plaintiffs must allege facts sufficient to state a claim which is plausible – rather than merely conceivable – on its face. See id. The Court makes all reasonable inferences in favor of plaintiffs. See Zinermon, 494 U.S. at 118; see also Rule 8(a), Fed.R.Civ.P.; Lafoy v. HMO Colo., 988 F.2d 97, 98 (10th Cir.1993). The Court, however, need not accept as true those allegations which state only legal conclusions. See Hall v. Bellmon, 935 F.2d 1106, 1110 (10th Cir.1991). In reviewing the sufficiency of plaintiffs' complaint, the issue is not whether plaintiffs will prevail, but whether they are entitled to offer evidence to support their claims. See Scheuer v. Rhodes, 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974), overruled on other grounds by Harlow v. Fitzgerald, 457 U.S. 800 (1982). Although plaintiffs need not precisely state each element of their claims, they must plead minimal factual allegations on those material elements which they must prove. See Hall, 935 F.2d at 1110.

In re Motor Fuel Temperature Sales Practices Litigation, No. 07-MD-1840-KHV, 2008 WL 466061 at *1 (D. Kan. Feb. 21, 2008).

II. UNDER THE PROTECTIVE PROVISIONS OF ERISA REPEATEDLY EMPHASIZED BY THE TENTH CIRCUIT AND THIS COURT, PLAINTIFFS STATE A CLAIM FOR VESTED MEDICAL AND LIFE INSURANCE BENEFITS IN THEIR FIRST CLAIM FOR RELIEF.

Defendants' arguments seeking dismissal of the First Claim for Relief ignore cardinal principles of ERISA and fail to adequately address the law of the Tenth Circuit, which has repeatedly emphasized ERISA's strongly protective purposes and the obligation of employers to make accurate, complete and understandable disclosures about rights to benefits.

In this case, defendants' own exhibits confirm plaintiffs' allegations that the employers continuously promised that the subject benefits would be provided to a retiree for life – until "you die." In the face of these statements of permanent benefits, there is no basis to conclude as a matter of law that defendants effectively reserved the right to amend or terminate the subject benefits for current retirees, or that they clearly disclosed this supposed right. The First Claim for Relief presents questions of fact which can only be resolved on a full record.

A. ERISA Imposes Strict Measures to Ensure that Plan Participants Receive Accurate and Understandable Information About their Benefits.

After decades of state law regulation during which working men and women were repeatedly deprived of promised retirement benefits, Congress acted to impose stringent duties on employers and other ERISA fiduciaries. This protective purpose was declared in the statute's very first section: "It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b).

Accurate and understandable disclosure of benefits rights is a central objective of ERISA. "Congress' purpose in enacting the ERISA disclosure provisions [was to] ensur[e] that 'the individual participant knows exactly where he stands with respect to the plan.'" Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 118 (1989), quoting H.R. Rep. No. 93-533, 93rd Cong., 1st Sess. 11 (1973). "[O]ne of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time." Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 83 (1995). ERISA requires distribution of plan summaries "in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." Id., quoting with emphasis H.R. Rep. No. 93-1280, 93rd Cong., 2d Sess. 297 (1974).

Tenth Circuit law quotes and emphasizes the same principles. Member Services Life Ins. Co. v. Am. Nat'l Bank & Trust Co., 130 F.3d 950, 956 (10th Cir. 1997), quoting Curtiss-Wright Corp., 514 U.S. at 83. The statute thereby implements "the important policy of protecting beneficiaries from misleading or false information contained in a summary plan description." Charter Canyon Treatment Center v. Pool Co., 153 F.3d 1132, 1136 (10th Cir. 1998); accord: Shields v. Continental Cas. Co., 209 F. Supp. 2d 1167, 1178 (D. Kan. 2002).

As one means to achieve these protections, ERISA requires plan administrators to furnish to participants and beneficiaries a summary plan description ("SPD") that is "written in a manner calculated to be understood by the average plan participant" and "sufficiently accurate and comprehensive to reasonably apprise [plan] participants and beneficiaries of their rights and obligations under the plan," including the "circumstances which may result in . . . denial or loss of benefits." ERISA § 102(a)-(b), 29 U.S.C. § 1022(a)-(b).

The Department of Labor regulation on these requirements, 29 C.F.R. § 2520.102-2 and 102-3, became effective on March 15, 1977. See 42 Fed. Reg. 14266. It requires plan administrators to "tak[e] into account such factors as the level of comprehension and education

of typical participants in the plan and the complexity of the terms of the plan." 29 C.F.R. § 2520.102-2(a). The regulation prohibits SPDs that "have the effect of misleading, misinforming or failing to inform participants and beneficiaries. Any description of exceptions, limitations, reductions or restrictions of plan benefits shall not be minimized, rendered obscure, or otherwise made to appear unimportant." 29 C.F.R. § 2520.102-2(b). "The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of the benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted." Id. Finally, SPDs must include a "statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction or recovery . . . of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits." 29 C.F.R. § 2520.102-3(*l*). An employer "is obligated by the SPD to inform its employees" of these limitations on benefits. Chiles v. Ceridian Corp., 95 F.3d 1505, 1518 (10th Cir. 1996) (citing statute).

B. Tenth Circuit Law Requires That Employers and Plan Administrators Who Prepare Summary Plan Descriptions Bear the Consequences of Uncertainty Resulting from their Faulty Drafting.

These protective principles also govern interpretation of plan-related documents. "[T]he relative clarity of plan documents must be viewed against the special obligations that attach in the ERISA context." Haymond v. Eighth Dist. Elec. Benefit Fund, 36 Fed. Appx. 369, 372-73 (10th Cir. 2002) (referring to requirement of 29 U.S.C. § 1022(a) that SPDs be "written in a manner clearly calculated to be understood by the average plan participant"). Plans and administrators have an "obligation to draft an SPD that is clear to participants." Id. at 373.

A court construing plan documents therefore "giv[es] the language its common and ordinary meaning as a reasonable person in the position of the [plan] participant." Chiles, 95

F.3d at 1511, quoting Firestone, 489 U.S. at 115. Specific promises in SPDs that benefits end only on the death of the retiree or spouse must control over any vague, ambiguous references to a general right to amend. "[S]pecific and exact terms are given greater weight than general language." Chiles, 95 F.3d at 1513, quoting Restatement (Second) of Contracts § 203(c); see also Steil v. Humana Kansas City, Inc., 124 F. Supp. 2d 660, 663-64 (D. Kan. 2000).

A plan provision is ambiguous when it is "reasonably susceptible to more than one meaning, or where there is uncertainty as to the meaning of a term." Stewart v. Adolph Coors Co., 217 F.3d 1285, 1290 (10th Cir. 2000). When a court interprets plan provisions to attempt to resolve ambiguity, it may consider extrinsic evidence such as "interpretive statements made by [the employer], past practices, customary usage in the trade, and other competent evidence bearing on the understanding of the parties." Chiles, 95 F.3d at 1519 n. 12.

The Tenth Circuit in Chiles left no doubt that the consequences of loose, inaccurate or ambiguous drafting must be imposed on the employer (or plan administrator) who prepares the summary plan description, not on the employees:

> "Any burden of uncertainty created by careless or inaccurate drafting of the summary [plan description] must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask.

Chiles, 95 F.3d at 1518 (emphasis added), quoting Hansen v. Continental Ins. Co., 940 F.2d 971, 982 (5th Cir. 1991).[2] This Court likewise has ruled that the employer "must bear the burden of

[2] Chiles cited empirical research – published before the issuance of any of defendants' SPD exhibits – showing "how employees reading SPDs can be misled as to their contractual rights." Chiles, 95 F.3d at 1519, citing James F. Stratman, "Contract Disclaimers in ERISA Summary Plan Documents: A Deceptive Practice?," 10 Indus. Rel. L. J. 350 (1988).

Defendants' motion makes no reference to the Second Claim, which alleges ERISA fiduciary violations due to misrepresentations about the retiree benefits. Their brief also

uncertainty created by its carelessly drafted policy" and "the construction most favorable to the [participant] must prevail." Steil, 124 F. Supp. 2d at 662, 664. "Our court has never construed the ambiguities of an ERISA plan against a beneficiary" and so the doctrine of contra proferentem applies. Miller v. Monumental Life Ins. Co., 502 F.3d 1245, 1254 (10th Cir. 2007). "Strictly construing ambiguous terms presents ERISA providers with a clear alternative: draft plans that reasonable people can understand or pay for ambiguity." Id. at 1255.

C. The Allegations, Confirmed by Defendants' SPD Exhibits, Establish that Plaintiffs' First Claim for Relief is Sound.

The Court is deciding a motion to dismiss. It clearly is premature to present evidence, frame factual issues, or resolve disputed questions of fact. Defendants nevertheless chose to file with their motion a limited, selected set of isolated pages from lengthy plan documents and summary plan descriptions, without including pages that contradicted defendants' position. To remedy defendants' one-sided preview of the evidence, plaintiffs present and describe below other pertinent portions of those documents.

Examination of these additional portions of defendants' exhibits only serves to confirm that plaintiffs have provided "minimal factual allegations on [the] material elements" of their claims" and "are entitled to offer evidence to support their claims." In re Motor Fuel Temperature Sales Practices Litigation, 2008 WL 466061 at *1. Even if there were some pleading deficiency, plaintiffs could easily cure it by amendment.

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confirms that "Defendants have not moved to dismiss" the claim. Def. Mem. at 12. However, a cryptic request for dismissal of a portion of the Second Claim was inserted into footnotes. Def. Mem. at 1 n. 2, 12 n. 9. Leaving aside its procedural deficiency, this dismissal request also should be overruled. There is no doubt that fiduciary misrepresentation of benefits information is actionable. See, e.g., Horn v. Cendant Operations, Inc., 69 Fed. Appx. 421, 427-29 (10th Cir. 2003); In re Sprint Corp. ERISA Litigation, 388 F.Supp. 2d 1207, 1225-28 (D. Kan. 2004). The question whether defendants' SPDs complied with their duties to provide accurate, clear, and understandable information cannot be determined as a matter of law.

The SPDs specifically informed employees and retirees when their medical and life insurance benefits would end, and clearly and expressly stated that "Your coverage under the Retiree Medical Plan ends . . . when you die." (emphasis added). The earliest SPD presented by defendants, the "United Telecom Retiree Medical Plan Summary Plan Description, effective January 1, 1991" (Def. Ex. 4), stated as follows regarding the medical, prescription drug, and dental benefits for retirees:

> **RETIREE MEDICAL PLAN**
>
> ***When Coverage Ends***
>
> You may stop participating in the Retiree Medical Plan on the first day of any month. Generally, if your coverage ends, your spouse's and dependent children's coverage ends. These rules are described below.
>
> There are other circumstances in which your, your spouse's and your dependent children's coverage ends.
> ***Retiree's***
>
> **Your coverage under the Retiree Medical Plan ends**
>
> — **when you die**, or
>
> — you do not pay your share of the cost of your coverage.
>
> ***Spouse's***
>
> You may terminate your spouse's coverage under the Retiree Medical Plan on the first day of any month. Your spouse's coverage will also end if you and your spouse divorce or your spouse dies.

Pl. Ex. 4 at EQ_FUL_108 (emphasis added). Substantially the same text promising medical benefits until "you die" appears in the subsequent SPDs.[3]

[3] See Pl. Ex. 5 at EQ_FUL_ 161 (Sprint 1997 SPD); Pl. Ex. 6 at EQ_FUL_ 219 (Sprint 1998 SPD); Pl. Ex. 7 at EQ_FUL_ 271-72 (Sprint 2000 SPD); Pl. Ex. 8 at EQ_FUL_ 330 (Sprint 2001 SPD); Pl. Ex. 9 at EQ_FUL_ 390 (Sprint 2002 SPD); Pl. Ex. 10 at EQ_FUL_ 462 (Sprint 2003 SPD); Pl. Ex. 11 at EQ_FUL_ 540 (Sprint 2004 SPD); Pl. Ex. 12 at EQ_FUL_ 619 (Sprint 2005 SPD); Pl. Ex. 13 at EQ_FUL_ 708-09 (Sprint 2005 Non-Flex SPD); Pl. Ex. 14 at EQ_FUL_ 778 (Sprint 2006 SPD); Pl. Ex. 15 at EQ_FUL_ 872 (Embarq 2006 SPD); Pl. Ex. 16 at EQ_FUL_ 967 (Embarq 2007 SPD). For convenient reference, plaintiffs use the same exhibit numbers as defendants.

Defendants correctly presented multiple SPD exhibits, and plaintiffs do so as well. Under Tenth Circuit law, benefits rights must be determined on the basis of the plan documents that were in effect at the time of retirement. "An amendment to any ERISA plan may not operate retroactively if that amendment deprives a beneficiary of a vested benefit." Member Services Life Ins. Co. v. Am. Nat'l Bank & Trust Co., 130 F.3d 950, 954 (10th Cir. 1997). "The notion of protecting vested rights prevents one party to a contract from unilaterally changing the terms of performance after that performance has become due." Id. at 956. See also Bartlett v. Martin Marietta Operations Support, Inc., 38 F.3d 514, 517 (10th Cir. 1994) ("Subsequent modifications to the plan, through the drafting of the summary plan description, do not effect the terms of the written plan in existence when the plaintiff's claim arose.").

Regarding the life insurance benefits, the earliest SPD presented by defendants which includes information about this coverage, the "Sprint Retiree Benefits Summary Plan Description, effective January 1, 2000" (Def. Ex. 7), likewise stated that the benefits "end on the date of your death":

> ***Basic Retiree Life Insurance***
>
> ***Basic Coverage***
>
> The company provides you with coverage of 50% of eligible pay at your retirement rounded up to the next highest $1,000 increment.
>
> ***Maximum Benefit***
>
> The maximum benefit under the basic life insurance plan is $25,000.
>
> ***When Does Coverage End***
>
> **The basic life insurance coverage ends on the date of your death.**

Pl. Ex. 7 at EQ_FUL_303-04 (emphasis added). The identical text appears in the next SPD presented in defendants' exhibits. See Pl. Ex. 8 at EQ_FUL_ 362 (Sprint 2001 SPD). Beginning with the 2002 SPD, the text was rephrased to state that: "Retirees eligible for Basic

Life Insurance will be covered as of their effective pension date. Coverage ends on the date of death." (emphasis added). These SPDs also included statements that beginning in 2002 the company was "phasing out" life insurance benefits for future retirees, with declining coverage amounts for each new annual retiree cohort.[4]

D. The First Claim for Relief is Well-Supported by Tenth Circuit Law.

The allegations when taken as true establish, and these selected documents confirm, that plaintiffs' First Claim is viable and that plaintiffs are entitled to present evidence showing that "a reasonable person in the position of [a plan] participant could find the language in the SPD" to provide secure benefits for life. See Chiles, 95 F.3d at 1517. Under Tenth Circuit law, it is only necessary to show that "a promise to provide vested benefits '[was] incorporated, in some fashion, into the formal written ERISA plan.'" Chiles, 95 F.3d at 1511, quoting Jensen v. SIPCO, Inc., 38 F.3d 945, 949 (8th Cir. 1994). Alternatively, plaintiffs can show "an agreement or other demonstration of employer intent to have [benefits] vest under the plan." Id. Unlike other circuits, the Tenth Circuit has expressly declined to adopt "a hard and fast rule finding a general reservation of rights clause unambiguously controlling any promise located in another part of an ERISA document." Id. at 1512. These Tenth Circuit principles governing the plaintiff's burden of proof operate hand-in-hand with the protective rules governing plan interpretation that are summarized in Subsection B above.

This case most closely resembles two Tenth Circuit decisions decided in favor of the participants. The SPD language here, promising benefits that would end "when you die" or on "the date of your death" is sufficient to "clearly indicate[ ] an intent on the part of [the employer]

[4] See Pl. Ex. 9 at EQ_FUL_ 435 (Sprint 2002 SPD); Pl. Ex. 10 at EQ_FUL_ 511 (Sprint 2003 SPD); Pl. Ex. 11 at EQ_FUL_ 594 (Sprint 2004 SPD); Pl. Ex. 12 at EQ_FUL_ 680 (Sprint 2005 SPD); [Pl. Ex. 13 not applicable – covers only medical benefits]; Pl. Ex. 14 at EQ_FUL_ 837 (Sprint 2006 SPD); Pl. Ex. 15 at EQ_FUL_ 931 (Embarq 2006 SPD); Pl. Ex. 16 at EQ_FUL_ 1026 (Embarq 2007 SPD).

to provide plaintiffs with lifetime health [and life] insurance benefits." DeBoard v. Sunshine Min. & Refining Co., 208 F.3d 1228, 1238 (10th Cir. 2000). DeBoard held that the employer's informational letters to induce employees to accept a special early retirement program, which promised a health plan "fully paid for at [employer] expense until the time of your death," constituted enforceable plans with vested benefits. "[T]he language of the letters clearly indicates an intent on the part of [the employer] to provide plaintiffs with lifetime health insurance benefits." Id. at 1233, 1239, 1241. Also significant is the fact that DeBoard establishes an alternative decisional framework for claims to benefits based on participation in special early retirement programs. Id. at 1241. Although plaintiffs allege that several plaintiffs and members of the proposed class secured their benefits through participation in these programs (AC ¶ 97), defendants ignore this additional basis for relief.

In the second Tenth Circuit decision that is closest to this case, Haymond v. Eighth Dist. Elec. Benefit Fund, 36 Fed. Appx. 369 (10th Cir. 2002), the court considered a claim for health benefits and reversed summary judgment for the plan. The court concluded that, "In light of the Fund's obligation to draft an SPD that is clear to participants" the limitations provisions in the SPD were "clouded by at least two ambiguities." 36 Fed. Appx. at 373. The first ambiguity was "a flat contradiction between the two provisions" in issue. "[T]he provisions appear in different sections of the SPD without cross-referencing one another or providing any suggestion of how they might properly be read together." Id. Although the district court attempted to "harmonize" these conflicting provisions, the Tenth Circuit ruled that "this approach places on the participant the burden of harmonizing apparently unrelated and conflicting provisions, thus contradicting ERISA's mandate that the SPD be clear to the layperson. See 29 U.S.C. § 1022." Id. Invoking Chiles, the court ruled that "an employee should not be required to adopt the skills of a lawyer."

Id., quoting Chiles, 95 F. 3d at 1517-18. The court concluded that the plan was not entitled to judgment, but instead "must bear the consequences of this inaccuracy":

> In short, the provisions of the SPD are at best ambiguous regarding the applicable limitations period. . . . The Fund has failed in its duty to provide this critical information to participants in a clearly understandable manner. As the drafter of the SPD, the Fund must bear the consequences of this inaccuracy.

Haymond, 36 Fed. Appx. at 374.

This case also is indistinguishable from one of defendants' own cited cases, decided by the Eighth Circuit and frequently followed by the Tenth Circuit, Jensen v. SIPCO, Inc., 38 F.3d 945 (8th Cir. 1994), which held that retiree medical benefits were vested. The evidence in Jensen included a generic reservation of rights clause, much like the ones invoked by defendants. The clause, set out in bold type in the SPD, stated vaguely that the employer "reserves the right to terminate, discontinue, alter, modify, or change this plan or any provision of this plan at any time." Jensen, 38 F.3d at 948. However, the section of the SPD with the heading "Termination of Coverage" stated that the medical coverage would terminate for dependents 90 days following the date of death of the retiree; for dependent children on the date of attaining age 19 or marriage; and for spouses on the date of divorce. Id. at 949.

After trial, the district court concluded that the plan provided vested medical benefits for the retirees. This ruling was affirmed on the ground that the "Termination of Coverage" provisions constituted "an ambiguous expression of an intent to vest retiree benefits." Jensen, 38 F.3d at 950. Although the employer cited the provision generally reserving its power to amend or terminate provisions of the plan, the Eighth Circuit ruled that this was insufficient:

> SIPCO relies exclusively on the Plan provisions permitting it to amend or terminate "any of the provisions of this Pensioner Medical Plan." SIPCO argues that this is an unambiguous declaration that retiree benefits are not vested. We agree that a reservation-of-rights provision is inconsistent with, and in most cases would defeat, a claim of vested benefits. But the question at this stage of the analysis is whether these provisions are so unambiguous as to make unnecessary

> any reference to other Plan provisions and extrinsic evidence. We think not. In the first place, the reservation-of-rights provisions are not facially unambiguous – they leave at least some doubt as to whether SIPCO intended to reserve the right to change or terminate benefits to already retired pensioners, or only the right to make prospective changes for those covered by the Plan but not yet retired. In the second place, "[t]he power to modify [a trust] may be relinquished by the settlor." Bogert, The Law of Trusts & Trustees § 993, at p. 232. Whether a power has been relinquished obviously requires examination of extrinsic evidence, which the district court properly undertook.

Jensen, 38 F.3d at 950 (citation omitted; emphasis added).

At the trial to resolve the meaning of plan provisions, the retirees "presented a wealth of extrinsic evidence supporting their contention that [the employer] intended that . . . medical benefits would vest when a Class member retired." Id. This evidence included the practice and intention of company predecessors; eligibility requirements linked to pension eligibility; company practice limiting benefit changes to apply only prospectively to future retirees; and company practice to communicate to employees that the benefits were secure and/or would last for life. Id. at 951. In this case, plaintiffs allege, and are entitled to present, the same types of evidence.

Defendants' challenge to the ERISA claim for benefits ignores the allegations, the contents of their own documents, as well as the principles emphasized in the most pertinent case precedents – Chiles, Haymond, DeBoard and Jensen.

E. Defendants' Plan Documents and Informal Communications Do Not Support their Request for Dismissal.

Defendants' Exhibits 1-3 present a few pages from "plan documents." However, plan documents are not distributed to participants, and terms in plan documents that do not appear in SPDs cannot be used offensively to limit the rights of participants. "Allowing the plan's master documents to trump the SPD would both undermine Congress's intent for the SPD to convey accurately plan information . . . and would tempt plan sponsors to engage in drafting

legerdemain." Chiles, 95 F.3d at 1518. In any event, the amendment clauses in defendants' plan documents, like those in its SPDs, are vague and generalized. They do not state that benefits provided to current retirees may be terminated. See Def. Exs. 1-3. Moreover, two documents, the United Telecom 1990 Retiree Medical Plan and the Embarq Retiree Medical Plan, only cover medical, prescription drug and dental benefits and provide no authority to terminate life insurance benefits. In addition, these two documents only apply to "Eligible Employee" participants who retired after 1990. See Pl. Ex. 1 at EQ_FUL_ 1-3 (1990 Plan); Pl. Ex. 3 at EQ_FUL_ 69-71 (2006 Plan). Defendants present no documents relating to previous retirees.

Defendants also present a 1993 letter addressed to active employees, enumerating several improvements in the pension and savings plans and advising that for retirements after January 1, 1994, "the cost of basic retiree life insurance will be totally paid by the company," with the maximum coverage equal to $ 25,000. Def. Ex. 18. At the end of a two-page attachment, employees are told that "Each plan is governed by the specific terms of the plan documents," rather than that document. The same page also states that "The Company reserves the right to add, subtract, eliminate, or modify benefits. Since some of the plans are subject to approval by the Internal Revenue Service, certain plan provisions may need to be amended to comply with IRS requirements." Def. Ex. 18. Under Tenth Circuit law, such informal documents cannot change the terms of the plan documents. "An employee benefit plan cannot be modified, however, by informal communications." Miller v. Coastal Corp., 978 F.2d 622, 624 (10th Cir. 1992). In addition to being legally ineffective, this statement expressly ties the possibility of benefits changes to legal requirements and therefore is ambiguous.

F. None of Defendants' Cited Cases Supports Dismissal.

Finally, defendants' cited decisions do not establish that the First Claim is deficient as a matter of law. Examination of the substance and procedural status of each of the decisions cited by defendants shows that they do not justify dismissal.

Although they rely on Chiles – which reviewed a summary judgment ruling, not a dismissal on the pleadings – defendants fail to acknowledge a key factual distinction present in that case. In Chiles, the very provision that the plaintiffs cited as the basis for vesting of premium levels for disability insurance also contained an express provision that the coverage could be terminated, and in that event benefits would continue only for those who then were qualified to receive disability benefits. As summarized by the Tenth Circuit, this termination proviso showed that the employer had reserved the right to make other types of changes to the benefits of disabled participants. "By explicitly listing a qualification to the [employer's] ability to change the LTD plan, it is proper to infer that the right to make other changes to disabled participants' benefits was reserved." Chiles, 95 F.3d 1512. The court also noted other evidence showing the employer did not intend to vest the benefits. Id. at 1513 n. 3.[5]

[5] Unlike retirement, disability is not necessarily a permanent condition. Therefore, descriptions of disability benefits often do not support claims of vesting. Two other decisions cited by defendants involved disability benefits. In Anderson v. Intermountain Power Service Corp., No. 98-4175, 1999 WL 824367 at *4 (10th Cir. 1999) (unpublished), the court affirmed summary judgment, determining that "there are no plan documents which state in any way that [the employer] intended to vest" the disability benefits. In Welch v. UNUM Life Ins. Co. of America, 382 F.3d 1078 (10th Cir. 2004), the court reversed summary judgment for the participant, which was based solely on her argument that an amendment terminated the plan and triggered a vesting provision. Id. at 1082-84. On appeal, the court found that the plan had not terminated, so it did not decide whether the termination provision was sufficient to vest benefits. Id. at 1085. The court also ruled that a second, undeveloped vesting argument that was not addressed in the district court and was based solely on the face of a provision terminating benefits "on the earliest of" cessation of disability, end of the benefit period, or death, was not a sufficient basis to affirm summary judgment. Id. at 1086. The court remanded for further proceedings on undeveloped vesting theories. Id. at 1086 & n. 1.

Defendants also stray far from Tenth Circuit law, bringing in decisions from six other circuits. However, none of those decisions supports a conclusion that the claims in this case are deficient as a matter of law. All of the decisions involved trial court rulings on preliminary injunction, on summary judgment, or after trial – not on motions to dismiss. See Alday v. Container Corp. of Am., 906 F.2d 660, 665 (11th Cir. 1990) (decision on summary judgment; no argument by plaintiff "that the language of the SPD is ambiguous"); Am. Fed'n of Grain Millers v. Int'l Multifoods Corp., 116 F.3d 976, 982 (2d Cir. 1997) (decision on summary judgment; SPD statements that company would pay cost but not referring to duration of benefits "could not reasonably be interpreted as promising vested benefits"); Frahm v. Equitable Life Assurance Soc'y of the United States, No. 93-0081, 1997 WL 15932 at *12 (N.D. Ill. March 25, 1997), and 137 F.3d 955, 957 (7th Cir. 1998) (SPDs contained no provisions promising lifetime benefits; summary judgment decision on plan provisions not appealed; bench trial on fiduciary misrepresentation claim); Gable v. Sweetheart Cup Co., 35 F.3d 851, 856-57 (4th Cir. 1994) (decision on summary judgment; plaintiffs pointed to no language supporting claim of intent to vest); Howe v. Varity Corp., 896 F.2d 1107, 1109-10 (8th Cir. 1990) (reversing preliminary injunction; language that benefits would "continue in retirement" not sufficient to raise vesting question); Hughes v. 3M Retiree Med. Plan, 281 F.3d 786, 792 (8th Cir. 2002) (decision on summary judgment; plaintiffs "pointed to no vesting language" in relevant SPD); Jones v. Am. Gen. Life & Accident Ins. Co., 370 F.3d 1065, 1068, 1070-71 (11th Cir. 2004) (decision on summary judgment; coverage termination provision specifically referred to termination of policy; use of words "keep" and "continue" insufficient to raise vesting issue); Moore v. Metro. Life Ins. Co., 856 F.2d 488, 491 (2d Cir. 1988) (decision on summary judgment; no appeal from ruling that plaintiffs identified no language in SPDs to counter reservation clause); Sengpiel v. B. F. Goodrich Co., 156 F.3d 660, 667-68 (6th Cir. 1998) (decision on summary judgment; no

language in SPDs expressed intention to vest); Sprague v. General Motors Corp, 133 F.3d 388, 401 (6th Cir. 1998) (decision after trial; following minority Sixth Circuit position that SPD language promising lifetime benefits was insufficient to create ambiguity).

Defendants present no basis to conclude that the First Claim for Relief should be dismissed as a matter of law.

III. PLAINTIFFS' THIRD CLAIM FOR RELIEF CANNOT BE DISMISSED.

Defendants challenge the Third Claim for Relief on three grounds. First, they contend that it is "derivative" of the First Claim and must be dismissed along with the First Claim. Def. Mem. at 15. As shown in Section II, the First Claim is sound and so is the Third Claim.

A. The Appropriateness of Relief Under ERISA Section 502(a)(3) Cannot Be Decided on a Motion to Dismiss.

Defendants argue that plaintiffs cannot simultaneously pursue claims under ERISA § 502(a)(1)(B) in their First Claim and under § 502(a)(3) in their Third Claim. Def. Mem. at 15-17. But this argument is based on a clear misreading of Varity Corp. v. Howe, 516 U.S. 489 (1996), which provided guidance to courts when "fashioning 'appropriate' equitable relief" under § 502(a)(3)(B). Varity concluded that plaintiffs may obtain such relief when § 502(a)(1)(B) or any other remedial provision of ERISA is not adequate to remedy a violation. "[W]here Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" 516 U.S. at 515. This standard governs ultimate choices of remedies, not the viability of claims. Moreover, the words "likely" and "normally" indicate the court's recognition that the general rule does not cover all types of cases.

Varity therefore did not establish any "bright-line rule" categorically barring simultaneous claims under Sections 502(a)(3) and 502(a)(1)(B), but instead stands for the proposition that where relief under § 502(a)(1)(B) does in fact adequately remedy the plaintiffs' injury, it may be that "no additional equitable relief" is required under § 502(a)(3). The sole Tenth Circuit decision cited by defendants, Lefler v. United Healthcare of Utah, Inc., 72 Fed. Appx. 818, 826 (10th Cir. 2003), affirmed a ruling that a single plaintiff making claims for benefits under unamended, existing plan terms can obtain all needed relief under § 502(a)(1)(B). Although not cited by defendants, the same simple scenario was present in Moore v. Berg Enterprises, Inc., 201 F.3d 448 at *2 n. 2 (10th Cir. 1999) (unpublished). Neither decision purports to alter the flexible standard of Varity or establish a categorical rule for all cases.

Unlike Lefler and Moore, this case is not a garden variety claim for benefits. It is a challenge to the permanent elimination of benefits provisions from the plans. It is highly likely that at least some relief that is not available under § 502(a)(1)(B) will be needed to fully remedy the violation, such as an order declaring that the benefits must be restored to the plans and otherwise reforming them, and that the plans must notify participants (including surviving spouses) about their opportunity to submit claims for past due medical and life insurance benefits. Accordingly, at this early stage of the case, there is no basis for defendants to assume that relief under § 502(a)(1)(B) will be adequate and that the Court should be deprived of other remedies. The better course allows claims under § 502(a)(3) to proceed pending further developments. See, e.g., Parente v. Bell Atlantic Pennsylvania, No. 99-5478, 2000 WL 419981 *3 (E.D. Pa. April 18, 2000) ("[I]t is not clear at this stage whether § [502](a)(1)(B) will *in fact* provide the plaintiff adequate relief. Only when the judicial process establishes the extent of the relief provided to plaintiff by § [502](a)(1)(B) may the Court proceed to the question of whether

(and what kind of) equitable relief under § [502](a)(3) is appropriate."); see also Rule 8(d)(2), Fed. R. Civ. P. (alternative claims). § 502(a)(3) claims cannot be dismissed as a matter of law.

B. Relief under the Declaratory Judgment Act is Proper.

Defendants essentially concede that plaintiffs' request for relief under the Declaratory Judgment Act ("DJA"), 28 U.S.C. § 2201, is legally viable and only argue that the Court in its discretion should decline to hear it. Def. Mem. at 17. Dismissal is not warranted.

The Tenth Circuit has identified several factors that a district court should evaluate in determining whether to hear a declaratory judgment claim. See State Farm Fire & Casualty Co. v. Mhoon, 31 F.3d 979, 982-983 (10th Cir. 1994). These "Mhoon" factors are:

> (1) whether a declaratory action would settle the controversy; (2) whether it would serve a useful purpose in clarifying the legal relations at issue; (3) whether the declaratory remedy is being used merely for the purpose of procedural fencing or to provide an arena for a race to res judicata; (4) whether use of declaratory action would increase friction between our federal and state courts and improperly encroach upon state jurisdiction; and (5) whether there is an alternative remedy which is better or more effective.

Id. at 983 (quotations omitted).

At its core, this case presents disputes about whether the subject retiree medical, prescription drug, and life insurance benefits were vested and permanent or otherwise could not be materially reduced or terminated by defendants. It is clear that a declaration regarding the permanency of these benefits would settle this issue, and at a minimum, would "serve a useful purpose in clarifying the legal relations at issue." Accordingly, the first two Mhoon factors weigh in favor of hearing the claim for declaratory judgment. See, e.g., State Farm Mutual Automobile Ins. Co. v. Mid-Continent Casualty Co., 518 F.2d 292, 296-97 (10th Cir. 1975) (declaratory action useful even though it would not settle all differences between the parties).

The third and fourth Mhoon factors are not relevant here. Plaintiffs' declaratory judgment claim is not separate from another concluded or pending matter filed in state or federal

court. All disputes among the parties are presented in this one action, so the claim under the DJA cannot be viewed as an improper attempt to obtain a favorable ruling in advance of a ruling in another case, or to re-open a settled controversy. For these reasons, this case does not present any of the bases to decline jurisdiction addressed in Shannon v. Squeechi, 365 F.2d 827, 829 (10th Cir. 1966) (reexamination of issues previously adjudicated by state and federal courts), or Key Construction, Inc. v. State Auto Property & Cas. Ins. Co., No. 06-2395-KHV, 2008 WL 640799 at *5 (D. Kan. March 5, 2008) (declaratory judgment action would interfere with resolution of pending arbitration).

Regarding the fifth and final Mhoon factor, defendants have failed to show that the relief sought in plaintiffs' First Claim for Relief, under ERISA § 502(a)(1)(B), is better or more effective than the relief sought under the DJA. Defendants state that the relief sought in the First Claim is the same as that sought in the Third Claim (Def. Mem. at 18-19), but that is not a basis to dismiss the declaratory judgment claim.

The DJA expressly provides that "any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. §2201(a) (emphasis added). Consequently, the fact that plaintiffs seek other relief under ERISA is of no moment. See Powell v. McCormack, 395 U.S. 486, 518 (1969) ("a request for declaratory relief may be considered independently of whether other forms of relief are appropriate"); Kunkel v. Continental Casualty Co., 866 F.2d 1269, 1276 (10th Cir. 1989) ("Nor need the relief granted entirely dispose of the matter. A request for relief . . . may be limited.").

Defendants do not cite a single ERISA case in support of their novel view that an ERISA action can never include a claim under the DJA. Instead, they rely upon Rosette Inc. v. United States, 141 F.3d 1394 (10th Cir. 1998). Rosette held that a quiet title action against the United

States can never include a declaratory judgment claim, for reasons idiosyncratic to the Quiet Title Act and irrelevant to ERISA. Noting the Supreme Court's previous observation that the act waived the government's sovereign immunity, and that '"Congress intended the [act] to provide the exclusive means by which adverse claimants could challenge the United States' title to real property,'" the court concluded that the act "is [the] only recourse for haling the United States into court on the issue of ownership." 141 F.3d at 1397, quoting Block v. North Dakota ex rel. Bd. of Univ., 461 U.S. 273, 286 (1983).

This exclusivity-of-remedies rationale is simply not found in ERISA cases. See, e.g., Heimann v. National Elevator Indus. Pension Fund, 187 F.3d 493, 510-511 (5th Cir. 1999) (approving declaratory judgment claims under both ERISA § 502(a)(1)(B) and DJA; "In adopting the [DJA], it was Congress' intent to prevent avoidable damages from being incurred by a person who is not certain of his rights, and afford him an early adjudication of his rights"), overruled on other grounds, Arana v. Ochsneer Health Plan, 338 F.3d 433 (5th Cir. 2003). This Court demonstrated the same understanding in Admin. Comm. of the Wal-Mart Assocs. Health & Welfare Plan v. Willard, 302 F. Supp.2d 1267, 1276 (D. Kan. 2004), aff'd, 393 F.3d 1119 (10th Cir. 2004), holding that it was proper "to include a request for declaratory relief both under ERISA and the Declaratory Judgment Act."

The claim under the DJA is not deficient as a matter of law and there is no valid reason for the Court to decline to exercise jurisdiction over it, as a matter of either its substantive viability or its procedural status. Even if the Court were to later decide that sufficient remedies are available to plaintiffs under ERISA, there is no basis to conclude this now, at the very outset of the case. Accordingly, the motion to dismiss should be overruled.

IV. THE FOURTH CLAIM FOR RELIEF PROPERLY ALLEGES VIOLATIONS OF THE ADEA.

Defendants make two arguments challenging plaintiffs' claims under the Age Discrimination in Employment Act. First, they contend that the plan amendments regarding life insurance benefits are not based on age. Second, they contend that the plan amendments regarding medical and prescription drug benefits are permitted by an EEOC regulation. Def. Mem. at 19-21. These arguments ignore the applicable law and should be overruled.

A. Plaintiffs Have Properly Alleged that the Reduction in Their Life Insurance Benefits Violated ADEA.

Defendants' memorandum cites cases from eleven to twenty-four years old to the effect that the ADEA prohibits only practices that explicitly discriminate on the basis of age. Defendants did not cite the controlling case, Smith v. City of Jackson, 544 U.S. 228, 240 (2005), which held that the ADEA prohibits practices that have adverse impact on older workers and are not justified by a reasonable factor other than age.[6] Plaintiffs have alleged precisely the type of claim permitted by Smith. Plaintiffs will present evidence at trial that the cancellation or limitation of medical, prescription drug and life insurance benefits imposes a heavier burden on working and retired employees as they age, forcing them to pay significant additional amounts to replace the insurance or to forego it altogether. Common sense also makes clear that it costs much more to obtain these benefits as one ages due to underwriting practices which tie cost to attained age. This claim requires resolution of factual questions and cannot be dismissed.

Defendants' challenge to the claim regarding life insurance benefits also appears to rely on a recent EEOC regulation regarding health insurance benefits for retirees who are age 65 and

[6] The Supreme Court heard oral argument on April 23, 2008, in Meacham v. Knolls Atomic Power Laboratory, aka KAPL, Inc., No. 06-1505, on the question whether the plaintiff or defendant has the burden of persuasion on the "reasonable factor other than age" defense in an ADEA disparate-impact case. However this issue is resolved, it is clear that ADEA claims have been stated as a matter of law.

older. 29 C.F.R. § 1625.32, 72 Fed. Reg. 72938-45 (December 26, 2007).[7] However, defendants fail to mention that the regulation does not apply to life insurance benefits. Section 1625.32(b) explicitly applies to health benefits. Section 1625.32(c) states that the purported exemption of health plans does not cover any other type of benefits. The EEOC's Question and Answer 5 make clear that the regulation has no applicability to life insurance benefits.[8]

B. The EEOC's Purported Exemption of Health Insurance Benefits from the ADEA is Contrary to Law. It Does Not Bar Plaintiffs' ADEA Claims as to Health Benefits.

Relying on the EEOC's recent purported exemption of health insurance benefits from the provisions of the ADEA and the decision of the Third Circuit upholding the regulation in American Ass'n of Retired Persons v. EEOC, 489 F.3d 558 (3d Cir. 2007), cert. denied, __ U.S. __, 128 S. Ct. 1733 (2008), defendants urge that plaintiffs' claims as to health insurance benefits should be dismissed. For four separate reasons, the motion should be overruled.

1. Congress Has Spoken Directly to the Issue.

In response to the holding of Public Employees Ret. System of Ohio v. Betts, 492 U.S. 158 (1989), limiting the application of the ADEA to employee benefit plans, Congress enacted the Older Workers Benefit Protection Act of 1990, Pub. L. 101-433, October 16, 1990, 104 Stat 978 ("OWBPA"). Its findings and provisions control the result herein: "[L]egislative action is

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[7] The text of the 2007 EEOC regulation is attached as Appendix A.

[8] Question and Answer 5 in the "Appendix to § 1625.32" state as follows:

> Q5. Does the exemption address how the ADEA may apply to other acts, practices or employment benefits not specified in the rule?
>
> A5. No. The exemption only applies to the practice of coordinating employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefit program. No other aspects of ADEA coverage or employment benefits other than retiree health benefits are affected by the exemption.

necessary to restore the original congressional intent in passing and amending the Age Discrimination in Employment Act of 1967 (29 U.S.C. 621 et seq.), which was to prohibit discrimination against older workers in all employee benefits except when age-based reductions in employee benefit plans are justified by significant cost considerations." Pub. L. 101-433, § 101 (emphasis added). The OWBPA thus amended the definition section of the ADEA to ensure that age-based discrimination in employee benefit plans was prohibited. Id., § 102.

The OWBPA also amended the statutory provisions defining lawful employment practices under ADEA, 29 U.S.C. § 623, to explicitly bar the provision of inferior benefits to older workers, unless the employer could demonstrate that its benefits were equal or that it was spending equal amounts on both younger and older workers. In an unusual legislative provision, Congress codified into the statute the EEOC's equal cost/equal benefit regulation, 29 C.F.R. § 1625.10.[9] The statute was amended to permit employers to observe the terms of a benefit plan:

> (i) where, for each benefit or benefit package, the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker, as permissible under section 1625.10, title 29, Code of Federal Regulations (as in effect on June 22, 1989);

Pub. L. 101-433, § 103 (emphasis added).

Congress therefore has clearly spoken and mandated that age-based benefits reductions are lawful only if they conform to 29 C.F.R. § 1625.10 as in effect on June 22, 1989. This mandated regulation includes § 1625.10(e), which explicitly prohibits the type of Medicare-eligibility change in retiree health benefits that defendants made here:

> (e) Benefits provided by the Government. An employer does not violate the Act by permitting certain benefits to be provided by the Government, even though the availability of such benefits may be based on age. . . . However, the availability of benefits from the Government will not justify a reduction in employer-provided benefits if the result is that, taking the employer-provided and

[9] 29 C.F.R. § 1625.10, as it appeared in the 1989 CODE OF FEDERAL REGULATIONS, is attached as Appendix B.

> Government-provided benefits together, an older employee is entitled to a lesser benefit of any type (including coverage for family and/or dependents) than a similarly situated younger employee. For example, the availability of certain benefits to an older employee under Medicare will not justify denying an older employee a benefit which is provided to younger employees and is not provided to the older employee by Medicare.

(emphasis added). In this manner, Congress permitted true coordination, such as making Medicare the primary payor and making the employer-provided plan the secondary payor.[10] But Congress has explicitly prohibited the destruction of employer-provided retiree health benefits because of Medicare eligibility, unless the reduction can be justified by the cost-based provisions of § 1625.10(d) (reproduced in Appendix B).

The EEOC's recent amendment to its regulations purports to override the plain language of the statute on the ground that it would be difficult to implement the analysis required by the 1989 regulation. See 72 Fed. Reg. at 72941. However, the EEOC is not empowered to substitute its own policy choices for those of Congress, nor may it override the express Congressional codification of the EEOC's own regulations in effect at the time of enactment of OWBPA. Congress has spoken directly on these questions. Congress also has spoken directly on the EEOC's ability to override its own regulation in the future. By specifying that the statute incorporates the language of § 1625.10 as in effect on June 22, 1989," Congress explicitly barred the EEOC from altering the meaning and force of that language. The Third Circuit's decision in American Ass'n of Retired Persons v. EEOC did not consider these statutory limitations on the EEOC's authority.

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[10] Defendants rely upon Int'l Union, United Auto., Aerospace, and Agr. Implement Workers of America v. General Motors Corp., 497 F.3d 615, 634 (6th Cir. 2007), but that decision did not authorize elimination of benefits for Medicare-eligible retirees, only the treatment of Medicare as the primary payor and the plan as the secondary payor for charges that Medicare did not cover. In this permitted context, the Sixth Circuit stated: "Nothing about this 'wrap-around' program, and the sensible savings stemming from it, indicates that the settlements are motivated by age animus or that they otherwise discriminate on the basis of age."

2. The EEOC's Power to Issue Reasonable and Narrow Exemptions Does Not Extend to Overruling a Clear Congressional Directive.

Section 9 of the ADEA, 29 U.S.C. § 628, provides that the EEOC "may establish such reasonable exemptions to and from any or all provisions of this chapter as it may find necessary and proper in the public interest." The substance of that provision has not been altered since ADEA's original 1967 enactment.

The OWBPA, which was enacted in 1990, explicitly bars changes in the meaning and force of the 1989 version of 29 C.F.R. § 1625.10, and is a far more specific provision than Section 9. Under the general rules of statutory construction, the general must yield to the specific. "Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one, regardless of the priority of enactment." Morton v. Mancari, 417 U.S. 535, 550-51 (1974) (citations omitted). Accord, Jicarilla Apache Tribe v. United States, 601 F.2d 1116, 1133 (10th Cir. 1979) ("Furthermore, where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one."); 2B SUTHERLAND ON STATUTORY CONSTRUCTION § 51:5 (6th ed. 2007 on-line update). Moreover, earlier-enacted provisions must generally yield to inconsistent later-enacted provisions. The Tenth Circuit has referred to the rule "that the later statute trumps the earlier" as "[t]he paradigmatic canon of statutory construction," although it is not always controlling. Padilla-Caldera v. Gonzales**,** 453 F.3d 1237, 1242 (10th Cir. 2005). Under both canons of statutory construction, the EEOC's authority to issue reasonable exemptions under § 9 has been revoked by Congress as to changes to the 1989 version of 29 C.F.R. § 1625.10.

The EEOC's recent adoption of the exemption in 29 C.F.R. § 1625.32 failed to take into account this explicit "no change" directive by Congress. Virtually by definition, the EEOC's

exemption cannot be considered "reasonable," for no action can be reasonable when it contravenes and ignores an unusually explicit Congressional directive. See Subsection 3 below.

The Third Circuit's decision in American Ass'n of Retired Persons v. EEOC likewise failed to consider the reasonableness of EEOC action in light of the explicit Congressional directive and thus contravened the ordinary rules that later legislation controls earlier enactments and specific provisions control more general terms. The decision also ignored the limitation the OWBPA placed on the EEOC power to issue exemptions. As the Supreme Court held in Public Employees Ret. System of Ohio v. Betts, "But, of course, no deference is due to agency interpretations at odds with the plain language of the statute itself." 492 U.S. at 171.

3. Under Controlling Tenth Circuit Law, Chevron Analysis Requires Examination of the Substantive Provisions of the Statute, Not Just the Exemption Authority.

The Third Circuit made a fundamental error in American Ass'n of Retired Persons v. EEOC. It limited the first step of the required analysis under Chevron U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837 (1984), to just the exemption language of § 9 of the ADEA, and did not also consider the substantive commands of the statute. This may explain why the court never considered the dispositive language of OWBPA. Even putting aside that error, however, the Third Circuit's approach is fundamentally wrong. It would mean that any agency with authority to grant reasonable exemptions could always override substantive law when the policy views of the current exemption-granting Administration differ from those of the Congress that enacted the law, and the court reviewing agency action would review only the exemption section and never examine what Congress expressly directed elsewhere to be done.[11]

[11] The language of ADEA § 9 itself precludes an approach that ignores the substantive purposes and language of the statute from which an exemption may be granted, because the authority to grant exemptions extends only to those that are "reasonable," and that word requires fidelity to the substantive language and purposes of the statute.

The Tenth Circuit's approach to the first step of Chevron analysis is very different. In Hackworth v. Progressive Casualty Ins. Co., 468 F.3d 722, 727 (10th Cir. 2006), a case involving a regulation under the Family and Medical Leave Act, the court stated: "Pursuant to Chevron, we must analyze such a construction in a two-step process. . . . First, we look to whether Congress directly spoke to the precise question at issue. . . . In so doing, we look to, among other things, the statutory text, history, and purpose." (citations omitted.) The analysis mandated by Tenth Circuit law thus is the direct opposite of the Third Circuit approach.

The Tenth Circuit in Hackworth continued: "If congressional intent is clear on the precise question at issue, our analysis ends and the congressional intent is given effect." Id. (citations omitted). Only if there is ambiguity should the inquiry continue to the second stage of Chevron analysis. Id. This, too, is the direct opposite of the approach followed by the Third Circuit.

The Tenth Circuit has been faced with a question similar to that presented by defendants' motion. Congress enacted legislation on odometer information in connection with transfers of title for motor vehicles, 49 U.S.C. §§ 32701-32711, and included a general grant to the Secretary of Transportation of authority to make exemptions. The Secretary exempted all vehicles ten or more years old. In Lee v. Gallup Auto Sales, Inc., 135 F.3d 1359, 1360-61 (10th Cir. 1998), the court held that, applying Chevron analysis and considering the statute's substantive provisions and purposes, the Secretary had no authority to grant blanket exemptions for entire classes of vehicles. "The rulemaking power granted to an administrative agency charged with the administration of a federal statute is not the power to make law. Rather, it is the power to adopt regulations to carry into effect the will of Congress as expressed by the statute." Id. at 1360 (citation omitted). Under controlling Tenth Circuit law, the EEOC exemption is beyond its authority and cannot bar plaintiffs' claims of age discrimination in termination of their health benefits.

4. Defendants Cannot Rely on an Exemption that Became Effective Only After the Challenged Reductions in Benefits.

There is a final reason why the EEOC regulation cannot immunize defendants, even assuming it were otherwise valid. Under black-letter law, the date an employer gives notice of an employment action is the date of the violation for purposes of federal antidiscrimination laws. Ledbetter v. Goodyear Tire & Rubber Co., __ U.S. __, 127 S.Ct. 2162, 2164, (2007); Delaware State College v. Ricks, 449 U.S. 250, 257–58 (1980). Embarq's discriminatory actions took place on July 26, 2007, when it notified retirees of the reductions and terminations of benefits. However, the EEOC regulation on which defendants rely did not become effective until December 26, 2007. See 72 Fed. Reg. 72938.

Even assuming that Congress had permitted the EEOC to issue the 2007 exemption, there is a presumption against retroactive application of new legislation unless Congress clearly states that retroactivity is intended. Landgraf v. USI Film Products, 511 U.S. 244 (1994). The limited exceptions to this rule do not permit the kinds of disruption to private planning by retirees that would result from retroactivity. Id. at 273-78. There is no statement in the regulation remotely meeting the explicitness requirements for retroactivity that Congress itself must meet and thus no basis to give retroactive effect to the exemption.

The motion to dismiss plaintiffs' ADEA age discrimination claims should be overruled.

V. ERISA DOES NOT PREEMPT PLAINTIFFS' STATE LAW AGE DISCRIMINATION CLAIMS IN THE FIFTH, SIXTH, AND SEVENTH CLAIMS FOR RELIEF.

Defendants argue that ERISA preempts plaintiffs' state law claims under the employment discrimination statutes of Ohio, Oregon, and Tennessee.[12]. Def. Mem. at 21-22. However, under ERISA § 514(a), 29 U.S.C. § 1144(a), state employment discrimination laws are preempted only

[12] Ohio Civil Rights Act, Ohio Rev. Code § 4112.02(A); Oregon Civil Rights Act, O.R.S. § 459.030A(1)(b); and Tennessee Human Rights Act, Tennessee Stat. §§ 4-21-101 et seq.

insofar as they prohibit practices that are lawful under federal law. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 108-09 (1983). Section § 514(a) is limited by the "savings clause" of § 514(d), which provides that ERISA shall not "be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States." 29 U.S.C. § 1144(d).

In Shaw, the Supreme Court held that because state employment discrimination laws are important to the enforcement scheme in Title VII of the 1964 Civil Rights Act, ERISA should not be construed to preempt them. 463 U.S. at 108-09. When it passed Title VII, Congress expressly preserved non-conflicting federal laws. Id. at 101. State laws that advance enforcement of federal anti-discrimination laws are not preempted because doing so would "impair" enforcement of the federal law. Id. at 101-02.

Shaw's rationale squarely applies to plaintiffs' state law claims. Like Title VII, the ADEA is specifically designed to work in tandem with state age-discrimination laws. 29 U.S.C. § 633(b). Accordingly, state laws that are consistent with ADEA are not preempted by ERISA. Devlin v. Transportation Communications Intern. Union, 173 F.3d 94, 100-01 (2d Cir. 1999). There, the Second Circuit addressed an issue very similar to the one presented here – whether ERISA preempts state law age discrimination claims challenging the cutback of retiree medical benefits. After being notified that they would no longer receive free medical benefits, five retired union members sued under the New York age law and for breach of contract under New York common law. 173 F.3d at 97. The district court found that both the state statutory and common law claims were preempted by ERISA.

Reversing, the Second Circuit upheld dismissal of the contract claims, but ruled that the New York age discrimination claims were not preempted because the ADEA, like Title VII, relies upon a joint state/federal enforcement scheme. Id. at 100-02. Other federal courts have reached the same conclusion. See Warner v. Ford Motor Co., 46 F.3d 531, 533-35 (6th Cir.

1995) (Michigan age discrimination law not preempted; discharge claim improperly removed); Lane v. Goren, 743 F.2d 1337, 1339-40 (9th Cir. 1884) (California age and race discrimination statute not preempted for wrongful discharge claim).

Defendants' reliance on St. Francis Regional Medical Center v. Blue Cross Blue Shield of Kansas, Inc., 49 F.3d 1460 (10th Cir. 1995), is misplaced. St. Francis dealt with whether ERISA preempted Kansas laws governing assignment of health insurance benefits, not with a state anti-discrimination statute. 49 F.3d at 1464. The Tenth Circuit neither considered nor ruled upon the "savings clause" of ERISA § 514(d) and did not address the issue presented here.

Similarly, the other case relied upon by defendants, Champion Int'l Corp.v. Brown, 731 F.2d 1406 (9th Cir. 1984), is clearly distinguishable. In that case, former employees contended that the Montana age discrimination statute required crediting their years of employment service after age 65 in computing pension benefits, despite the contrary written provisions of plan documents. The Ninth Circuit noted that the plan complied with specific federal regulations interpreting ERISA, which it referred to as the "ERISA-authorized provisions of Champion's pension plan." 731 F.2d at 1407-08. By contrast, in this case, there is no ERISA regulation that authorizes Embarq to terminate or reduce medical and life insurance benefits or engage in age-based discrimination. To the contrary, ERISA § 514(d) provides that the statute will not be construed to "invalidate" or "impair" other federal laws, including the federal ADEA and the state discrimination laws that aid its enforcement.

In short, Plaintiffs' Fifth, Sixth, and Seventh Claims for Relief under the Ohio, Tennessee, and Oregon age discrimination laws are consistent with the ADEA and are not preempted by ERISA. Defendants' motion to dismiss these claims should be overruled.

CONCLUSION

For the foregoing reasons, plaintiffs' Claims for Relief are legally sound and are not subject to dismissal. Plaintiffs respectfully request that defendants' motion to dismiss be overruled.

Dated: May 30, 2008.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of May, 2008, I electronically filed the foregoing Plaintiffs' Memorandum in Opposition to Defendants' Motion to Dismiss the First, Third, Fourth, Fifth, Sixth and Seventh Claims for Relief in Plaintiffs' Amended Complaint and the accompanying Appendix A-B and Collected Exhibits using the CM/ECF system, which will send notice of electronic filing to the following counsel:

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APPENDIX A

H. Paperwork Reduction Act

The provisions of the Paperwork Reduction Act of 1995, Public Law 104–13, 44 U.S.C. Chapter 35, and its implementing regulations, 5 CFR Part 1320, do not apply to this rule because there are no reporting or recordkeeping requirements.

Drafting Information

The author of this document is Elizabeth Gillis; Enforcement Programs and Services; Bureau of Alcohol, Tobacco, Firearms, and Explosives.

List of Subjects in 27 CFR Part 447

Administrative practice and procedure, Arms control, Arms and munitions, Authority delegation, Chemicals, Customs duties and inspection, Imports, Penalties, Reporting and recordkeeping requirements, Scientific equipment, Seizures and forfeitures.

Authority and Issuance

■ Accordingly, for the reasons discussed in the preamble, 27 CFR Part 447 is amended as follows:

PART 447—IMPORTATION OF ARMS, AMMUNITION AND IMPLEMENTS OF WAR

■ 1. The authority citation for 27 CFR Part 447 continues to read as follows:

Authority: 22 U.S.C. 2778.

§ 447.11 [Amended]

■ 2. Section 447.11 is amended by removing the last sentence in the definition of the term ''Defense articles''.

§ 447.21 [Amended]

■ 3. Section 447.21 is amended by removing Category XXII (South Africa) in its entirety from the U.S. Munitions Import List.

■ 4. Section 447.52 is amended by revising the second and third sentences in paragraph (a), and by removing ''(202) 927–8320'' in the ''Note'' at the end of paragraph (a) and adding in its place ''(304) 616–4550'', to read as follows:

§ 447.52 Import restrictions applicable to certain countries.

(a) * * * This policy applies to Afghanistan, Belarus (one of the states composing the former Soviet Union), Cuba, Iran, Iraq, Libya, Mongolia, North Korea, Sudan, Syria, and Vietnam. This policy applies to countries or areas with respect to which the United States maintains an arms embargo (e.g., Burma, China, the Democratic Republic of the Congo, Haiti, Liberia, Rwanda, Somalia, Sudan, and UNITA (Angola)).

* * * * *

Dated: December 17, 2007.

Michael B. Mukasey,

Attorney General.

[FR Doc. E7–24910 Filed 12–21–07; 8:45 am]

BILLING CODE 4410–FY–P

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Parts 1625 and 1627

RIN 3046–AA72

Age Discrimination in Employment Act; Retiree Health Benefits

AGENCY: U.S. Equal Employment Opportunity Commission

ACTION: Final rule.

SUMMARY: The Equal Employment Opportunity Commission is publishing this final rule so that employers may create, adopt, and maintain a wide range of retiree health plan designs, such as Medicare bridge plans and Medicare wrap-around plans, without violating the Age Discrimination in Employment Act of 1967 (ADEA). To address concerns that the ADEA may be construed to create an incentive for employers to eliminate or reduce retiree health benefits, EEOC is creating a narrow exemption from the prohibitions of the ADEA for the practice of coordinating employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefits program.[1] The rule does not otherwise affect an employer's ability to offer health or other employment benefits to retirees, consistent with the law.

DATES: Effective December 26, 2007.

FOR FURTHER INFORMATION CONTACT: Raymond Peeler, Senior Attorney Advisor, at (202) 663–4537 (voice) or Dianna B. Johnston, Assistant Legal Counsel, at (202) 663–4637 (voice) or (202) 663–7026 (TTY) (These are not toll free numbers). This final rule is also available in the following formats: large print, braille, audio tape, and electronic file on computer disk. Requests for this document in an alternative format should be made to the Publications Information Center at 1–800–669–3362.

SUPPLEMENTARY INFORMATION: Employer-sponsored retiree health benefits provide a much-needed source of health coverage for older Americans at a time when their health care needs are greatest. Without employer-sponsored retiree health benefits, many retirees are forced to go without health benefits between the time they retire and the time they become eligible for Medicare. Older retirees also rely on employer-sponsored retiree health benefits to cover medical costs that are not covered by Medicare.

Employers are not legally obligated to provide retiree health benefits, and many do not. Moreover, over the past several years, the number of employers who offer such benefits has begun to decline. According to an independent study by the United States General Accounting Office (GAO), about one-third of large employers and less than 10% of small employers offered their retirees health benefits in 2000, compared to about 70% of employers in the 1980s.[2] Of those employers that do offer coverage, many ''have reduced the terms of coverage by tightening eligibility requirements, increasing the share of premiums retirees pay for health benefits, or increasing copayments and deductibles—thus contributing to a gradual erosion of benefits.'' [3]

Rising health care costs, larger numbers of workers nearing retirement age, and mandated changes in the way employers must account for the long-term costs of providing retiree health coverage have been substantial factors contributing to the erosion of this valuable employment benefit. However, the Equal Employment Opportunity Commission (Commission or EEOC) believes that concern about the potential application of the Age Discrimination in Employment Act of 1967, 29 U.S.C. 621 *et seq.* (ADEA or Act) to employer-sponsored retiree health benefits also has adversely affected the availability of this benefit. A wide range of stakeholders, including labor organizations, benefits consultants, state and local governments, and private employers, agree that ADEA concerns have created an additional incentive to reduce or eliminate employer-sponsored retiree health benefits.

[1] The EEOC recognizes that eligibility for Medicare and comparable state health benefits is not necessarily limited to retirees. As explained below, this rule only concerns application of the Age Discrimination in Employment Act to employer-sponsored retiree health benefits for individuals who also happen to be eligible to participate in Medicare or a comparable state health benefit. Individuals who are eligible for and/or receive Medicare or comparable state health benefits, but who are not retired, are not affected by this rule.

[2] U.S. GENERAL ACCOUNTING OFFICE, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374 (May 2001).

[3] *Id.,* at 6.

In August 2000, the United States Court of Appeals for the Third Circuit became the first federal court of appeals to examine the relationship between the ADEA and employer-provided retiree health benefits. The Third Circuit held that an employer violated the ADEA if it reduced or eliminated retiree health benefits when retirees became eligible for Medicare, unless the employer could show either that the benefits available to Medicare-eligible retirees were equivalent to the benefits provided to retirees not yet eligible for Medicare or that it was expending the same costs for both groups of retirees.[4] The Commission subsequently adopted this ruling as its national enforcement policy.[5] Before the Third Circuit's decision, many employers had relied on legislative history to the Older Workers Benefit Protection Act of 1990, Public Law No. 101–433, 104 Stat. 978 (1990) (OWBPA), that states that the practice of eliminating, reducing, or altering employer-sponsored retiree health benefits with Medicare eligibility is lawful under the ADEA.[6]

After the Commission implemented the Third Circuit's rule, labor organizations, benefits experts, state and municipal governments, and employers informed us that our actions were further eroding employer-sponsored retiree health benefits by creating an additional incentive for employers to reduce, or eliminate altogether, health benefits for retirees. Under the Commission policy in effect prior to August 2001 (see nn. 2 & 3), employers that chose to provide retiree health benefits had to prove either (1) that the benefits available to Medicare-eligible retirees were the same as the benefits provided to retirees not yet eligible for Medicare or (2) that they were expending the same costs for both groups of retirees. Making such a showing requires complex comparisons of multiple objective and subjective variables, including types of plans, levels and types of coverage, deductibles, geographical areas covered, and level of provider choice offered by each plan. Employers could avoid the problem by simply eliminating retiree health benefits entirely, since no law requires that employers provide retiree health benefits. Alternatively, employers could reduce the coverage they provided to those retirees who were not yet eligible for Medicare, leaving these retirees with fewer benefits. Unions, in particular, argued that the Commission's prior policy made it increasingly difficult to negotiate for the future provision of employer-sponsored retiree health benefits. The prior policy also had a particularly harsh impact on public school employees, who often retire early and rely on employer-provided retiree health benefits until they become eligible for Medicare.

These comments prompted the Commission to study the relationship between the ADEA and employer-sponsored retiree health benefits. On July 14, 2003, EEOC published a Notice of Proposed Rulemaking (NPRM) in the **Federal Register** to address these concerns.[7] In its NPRM, the Commission proposed to create a narrow exemption from the prohibitions of the ADEA for the practice of coordinating retiree health benefits with eligibility for Medicare or a comparable State health benefits program. The Commission now responds to public comments submitted in response to its NPRM and issues a final rule, adopting the NPRM exemption as modified.

The final rule permits employers and labor organizations to offer retirees a wide range of health plan designs that incorporate Medicare or comparable State health benefit programs without violating the ADEA. For example, in order to ensure that all retirees have access to some health care coverage, the ADEA will not prohibit employers and unions from providing retiree health coverage only to those retirees who are not yet eligible for Medicare. They also may supplement a retiree's Medicare coverage without having to demonstrate that the coverage is identical to that of non-Medicare eligible retirees. Thus, for example, employers providing prescription drug benefits to Medicare-eligible retirees under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (2003), need not be concerned about whether the drug benefits provided to Medicare-eligible retirees differ from those provided to retirees not yet eligible for Medicare.

The final rule concerns only the ADEA. It does not affect any non-ADEA obligation that employers may have to provide health benefits under Medicare or any other law. For example, this rule does not affect employers' obligation to use Medicare as a secondary payer, when required by Medicare law.

In promulgating this rule, the Commission recognizes that the issues surrounding health care coverage, especially for retirees, are complex and that retiree health benefits are highly valued by older Americans. Although employers are under no legal obligation to offer retiree health benefits, some employers choose to do so and thereby provide retired workers with access to affordable health coverage at a time when private health insurance coverage might be otherwise cost prohibitive. Because the Commission has determined that its prior policy created an incentive for employers to reduce or eliminate retiree health benefits, the agency has concluded the public interest is best served by an ADEA policy that permits employers greater flexibility to offer these valuable benefits. The final rule is not intended to encourage employers to eliminate any retiree health benefits they may currently provide.

Overview of Public Comments

The Commission received forty-four organizational comments in response to the NPRM. Twenty-seven commenters expressed support for the proposed exemption, including sixteen organizations that requested no revisions to the proposed rule. The Commission also received approximately 30,000 letters from individual citizens. Most of these individual comments were a form letter expressing concern that if the practice of coordinating retiree health benefits with eligibility for Medicare or comparable State health benefits programs is exempted from ADEA coverage, employers might reduce or even

[4] *Erie County Retirees Ass'n v. County of Erie,* 220 F.3d 193 (3d Cir. 2000). The Commission submitted an *amicus curiae* brief in *Erie County,* asserting, based on the plain language of the ADEA, that (1) retirees are covered by the ADEA and (2) employer reliance on Medicare eligibility in making distinctions in employee benefits violated the ADEA, unless the employer satisfied one of the Act's specified defenses or exemptions.

[5] In its October 2000 Compliance Manual Chapter on ''Employee Benefits,'' the Commission explicitly adopted the position taken by the Third Circuit in *Erie County* as its national enforcement policy. When the Commission announced in August 2001 that it wished to further study the relationship between the ADEA and employer-sponsored retiree health plans, the Commission unanimously voted to rescind those portions of its Compliance Manual that discussed the *Erie County* decision.

[6] Final Substitute: Statement of Managers, 136 Cong. Rec. S25353 (Sept. 24, 1990); 136 Cong. Rec. H27062 (Oct. 2, 1990). In addition, the Conference Report for the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066 (2003) also provides that ''the conferees reviewed the ADEA and its legislative history and believe the legislative history clearly articulates the intent of Congress that employers should not be prevented from providing voluntary benefits to retirees only until they become eligible to participate in the Medicare program.'' H.R. Conf. Rep. No. 108–391, at 365 (2003).

[7] The preamble to the Commission's NPRM provides detailed information about the Commission's study, including a comprehensive analysis of why the Commission believes that concern about the application of the ADEA to retiree health benefits is contributing to the erosion of this important benefit. *See* 68 FR 41542–41549 (July 14, 2003), available at *http://edocket.access.gpo.gov/2003/03–17738.htm.*

eliminate the health benefits of Medicare-eligible retirees.

Scope of the Exemption

Two organizational commenters questioned whether the language in Section 1625.32(b) clearly defined the scope of the proposed exemption. One of these two commenters requested that the Commission clearly state that, under the rule, an employer-sponsored health plan that alters, reduces, or eliminates health care benefits based upon the receipt of health benefits under Medicare or a comparable State health benefits program is entirely exempt from coverage under the ADEA, even if a challenged practice is unrelated to the plan's interaction with Medicare (or comparable State health benefits program). The Commission declines to adopt this suggestion because it is wholly inconsistent with the intended scope of the rule. The rule only exempts the narrow practice of coordinating employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefits program. A comparable state health benefits program refers to plans that were created to provide primary health benefits for state and local government employees who were not covered by Medicare and that, like Medicare, base eligibility on age.

ADEA coverage of any other aspect of an employer-sponsored retiree health plan, or of any other employer act, practice, or benefit of employment, including employer-sponsored health plans for current employees, is not affected by the rule. Additionally, as discussed below, the Commission will apply the exemption to the practice of coordinating employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefits program regardless of whether an individual participant actually receives such benefits.

Another organization argued that the phrase ''eligible for'' in Section 1625.32(b) was vague because it was unclear whether the rule requires that an individual retiree actually enroll in, rather than merely be eligible for, Medicare or a comparable State health benefits program before the exemption would apply. The effect and intent of the proposed rule was that the exemption would apply whether or not a particular retiree actually enrolls in Medicare or a comparable State health benefits program, as long as the retiree was eligible for such benefits. While we believe the phrase ''eligible for'' is plain on its face, we have added the phrase ''whether or not the participant actually enrolls in the other benefit program'' to Section 1625.32(b) to further clarify our intent.

This same commenter also questioned whether ''Medicaid offsets'' would be covered by the exemption, but did not further explain the type of employer-sponsored plan contemplated. Medicaid is the joint Federal-state program which provides primarily medical care to low-income Americans pursuant to Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.* Section 1396a(a)(25)(G) of that Title requires that each State Medicaid plan prohibit any health insurer, including an employer-sponsored group health plan, ''from taking into account that [an] individual is eligible for or is provided medical assistance'' under a State Medicaid plan when making enrollment or benefit payment decisions. In light of this specific prohibition under the Medicaid law, the Commission declines to apply its exemption to employer-sponsored group health plans that coordinate benefits with an individual's eligibility for or receipt of Medicaid.

Coverage of Non-Health Retiree Benefits

While expressing overall support for the proposed rule, two organizations requested that the Commission provide a definition of the term ''retiree health benefits'' in Section 1625.32(a) of the rule. Both commenters also requested that the Commission make clear that no inference is intended as to how the ADEA might apply to non-health retiree benefits, such as life insurance or disability programs.

Section 1625.32(c) of the rule provides that the exemption shall be narrowly construed. The only practice exempted by the rule is the coordination of employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefits program. No other aspects of ADEA coverage or benefits other than retiree health benefits are affected by the exemption. In order to further clarify the scope of the exemption, the Commission has added an additional statement to the rule explaining that the exemption only applies to retiree health benefits and not other non-health retiree benefits. The Commission also revised question and answer five in the Appendix to better reflect the scope of the exemption.

In light of these revisions, the Commission concludes that adding a definition of retiree health benefits is unnecessary. Section 1625.32 and the accompanying Appendix set forth the types of employer-sponsored health benefits that may be permissibly coordinated with eligibility for Medicare or a comparable State health benefits program pursuant to the exemption. Under Paragraph (b) of Section 1625.32, the exemption applies to any employee benefit plan that provides health benefits for retired workers that are coordinated with eligibility for Medicare or a comparable State health benefits program. The Appendix further makes clear that the exemption applies to employer-sponsored health benefits that are provided to a retired worker's spouse or dependents. The Commission does not believe that further clarification of the types of employer-sponsored retiree health benefits covered by the rule is needed.

Coverage of Retirees

Several commenters, although generally supportive of the proposed rule, expressed concern about the statement in the Appendix that the ADEA continues to apply to retirees to the same extent that it did prior to the issuance of the exemption. These commenters argued that the ADEA, as amended by OWBPA, only protects older workers, not retirees. It is the Commission's position, however, that all of the anti-discrimination statutes also protect former employees when they are subjected to discrimination arising from the former employment relationship.[8]

Coverage of Existing Employer-Sponsored Retiree Health Benefit Plans

Several commenters requested that EEOC clarify how the rule would apply to existing employer-sponsored retiree health benefit plans. Until the Third Circuit's ruling in *Erie County,* many employers designed coordinating retiree health benefit plans in reliance on statements in the legislative history to OWBPA that the practice of eliminating, reducing, or altering employer-sponsored retiree health benefits with Medicare eligibility is lawful under the ADEA. It is the Commission's intent to allow employers to continue the practice of coordinating retiree health benefits with Medicare eligibility with as little disruption as possible. The Commission does not believe that additional changes to the rule are required in order to achieve this result. The Appendix to the rule states that the Commission will apply the exemption to all retiree health benefits that coordinate with Medicare (or a

[8] *Robinson* v. *Shell Oil Co.*, 519 U.S. 337, 346 (1997) (former employees covered under Title VII); *Passer* v. *American Chem. Soc'y,* 935 F.2d 322, 330 (D.C. Cir. 1991) (former employees covered under ADEA); *Ford* v. *Schering-Plough Corp.*, 145 F.3d 601, 607 (3d Cir. 1998) (former employees covered under ADA), *cert. denied,* 525 U.S. 1093 (1999).

comparable State health benefits plan), whether or not those benefits are provided for in an existing or newly created employee benefit plan.

The Commission's Exemption Authority

The Commission received seventeen comments from advocacy organizations and other groups representing retirees that did not support the Commission's proposal. These commenters questioned the Commission's authority to issue an exemption for the practice of coordinating employer-sponsored retiree health benefits with Medicare eligibility. Many of these commenters also argued that an exemption is inconsistent with the primary purposes of the ADEA. Three of these organizational commenters also asserted that the Commission did not sufficiently support the need for an exemption to the Act. In addition, the Commission received approximately 30,000 letters from individual citizens (the majority of which were a form letter) expressing concern that employers might reduce or even eliminate the health benefits of Medicare-eligible retirees in response to the EEOC's proposal.

Section 9 of the ADEA provides that EEOC ''may establish such reasonable exemptions to and from any or all provisions of [the Act] as it may find necessary and proper in the public interest.'' Implicit in this authority is the recognition that the application of the ADEA could, in certain circumstances, foster unintended consequences that are not consistent with the purposes of the law and are not in the public interest. Such circumstances are rare. However, after carefully studying the issue and reviewing the public comments received in response to the NPRM, the Commission concludes that the practice of coordinating employer-sponsored retiree health benefits with Medicare eligibility presents a circumstance that warrants Commission exercise of its authority under Section 9.

The Commission does not agree that EEOC lacks the authority to enact such a rule. Section 9 confers broad discretion on the Commission to issue rules and regulations interpreting the ADEA and to establish reasonable exemptions from any or all prohibitions of the Act.[9] Nor is the Commission persuaded that the rule is inconsistent with the primary purposes of the ADEA. Given the continuing decline in the availability of employer-provided retiree health benefits, and the disincentive to provide such benefits created by the Third Circuit's ruling and the Commission's prior policy, this final rule reasonably addresses a problem confronting older Americans. The Commission is persuaded that, in order to comply with the Commission's prior policy, many employers would reduce the overall level of health benefits they offer to retirees or cease providing such benefits altogether, leaving many retirees without access to affordable health coverage. Indeed, the Commission has been presented with evidence that some public school districts already have reduced the health benefits they provide to retirees in response to the Commission's prior policy. Clearly, this result is inconsistent with the Act's primary purpose of protecting older workers.

Finally, the Commission believes it has provided the strong and affirmative showing required to justify an exemption from the Act. The Commission conducted a comprehensive study of the relationship between the ADEA and retiree health benefits before it published its NPRM. As part of that study, the Commission met with a wide range of interested parties, including employers, employee and retiree groups, labor unions, human resource consultants, benefits consultants, actuaries, and state and local government representatives. Labor unions, benefits experts, and public and private sector employers all agreed that the Commission's prior policy would have a deleterious effect on the provision of employer-sponsored retiree health benefits, especially given the numerous other factors negatively impacting the availability of such benefits.

Public comments filed in response to the Commission's NPRM only buttress this conclusion. Several organizations representing public school districts and employees noted that many school districts responded to the Commission's prior policy by reducing the overall level of retiree health coverage they were providing or by eliminating the benefit altogether. Moreover, this is what ultimately happened in *Erie County.* After the county made changes to its retiree health benefit plans to comply with the court's ruling, the net effect was a decrease in health benefits for retirees generally; older retirees received no better health benefits, while younger retirees were required to pay more for health benefits that offered fewer choices.

Various other proposals considered by the Commission did not adequately protect and preserve the important employer practice of providing health coverage for retirees. Many of the alternative proposals considered would have required complex calculations regarding the costs of retiree health care.[10] Given the number of variables involved in these calculations, including numerous subjective factors that are difficult to quantify, the Commission concludes that none of the alternatives considered would adequately address the incentive created by the Commission's prior policy to eliminate employer-sponsored retiree health coverage. It is the Commission's view that the ADEA should not present a barrier for employers and labor unions to provide the broadest possible health coverage for retirees. Accordingly, after reviewing all data, views, and arguments presented, EEOC is persuaded that a narrow exemption from the prohibitions of the ADEA for the practice of coordinating employer-sponsored retiree health benefits with Medicare eligibility is necessary and proper in the public interest.

Litigation Regarding the Exemption

AARP filed suit to enjoin publication and implementation of the exemption on Feb. 4, 2005, alleging, *inter alia,* that the exemption violated the ADEA and the Administrative Procedure Act. AARP argued that the rule was age discriminatory because it would allow employers to reduce the benefits of older retirees.[11]

The EEOC agreed not to publish the exemption rule until the district court ruled on AARP's challenges. Although the court initially ruled in favor of AARP on March 30, 2005, it subsequently reversed itself and entered summary judgment in favor of the EEOC on September 27, 2005, finding that the Commission did not exceed its authority in issuing this exemption, that the exemption was not arbitrary or capricious, and that the *Erie County* case did not render the exemption invalid. However, the court did continue its injunction prohibiting publication of the exemption until the Third Circuit could resolve AARP's promised appeal.

The Third Circuit resolved AARP's appeal on June 4, 2007, holding that the EEOC properly exercised its exemption power under Section 9 of the ADEA,

[9] *See, e.g., American Association of Retired Persons* v. *Equal Employment Opportunity Commission,* 823 F.2d 600, 604–605 (D.C. Cir. 1987) (EEOC has ''unusually broad discretion'' under Section 9).

[10] For a more detailed discussion of the alternatives considered by the EEOC, please refer to the ''Executive Order 12866'' portion of this preamble. *See also* 68 FR 41542–41549 (July 14, 2003) (Discussing the alternatives in the Retiree Health Notice of Proposed Rulemaking).

[11] Brief in Support of Complaint at 24–25, *AARP* v. *EEOC,* 383 F. Supp. 2d 705 (E.D. Pa. 2005) (No. 05–CV–509).

thereby affirming the district court's decision and lifting the injunction that prohibited publication of the final rule.[12] The court, noting the Commission's evidence that (1) health care costs continue to rise, (2) employers are not required to provide any retiree health care benefits, and (3) some employers chose to avoid ADEA discrimination by reducing retiree health benefits, specifically rejected AARP's argument that the EEOC exceeded its authority under the ADEA as follows:

> We recognize with some dismay that the proposed exemption may allow employers to reduce health benefits to retirees over the age of sixty-five while maintaining greater benefits for younger retirees. Under the circumstances, however, the EEOC has shown that [its] narrow exemption from the ADEA is a reasonable, necessary, and proper exercise of its section 9 authority, as over time it will likely benefit all retirees.[13]

AARP asked the Third Circuit to rehear the case *en banc*, but that request was denied on August 21, 2007. AARP then petitioned the Supreme Court for a stay of the Third Circuit's mandate pending AARP's writ of certiorari, but that request was denied on September 19, 2007. AARP filed its writ of certiorari asking the Supreme Court to review the Third Circuit's decision on November 20, 2007.

Additional Revisions to the Rule

The Commission made a minor editorial change to Section 1625.32(a)(3) by changing the word ''are'' to ''is.'' The change is not intended to alter the definition of a comparable State health benefit plan for purposes of the exemption. The Commission also simplified the language in question and answer three in the Appendix.

Executive Order 12866

This final rule has been drafted and reviewed in accordance with Executive Order 12866, Section 1(b), Principles of Regulation. This rule is considered a significant regulatory action, but not economically significant, under section 3(f)(4) of that Order and therefore was reviewed by the Office of Management and Budget (OMB). As discussed below, the rule exempts certain practices from the prohibitions of the ADEA in order to ensure that employers may offer retirees a wide range of health plan designs that coordinate with Medicare without violating the Act.

Labor organizations, employees, and employers favor coordinating retiree health plans with Medicare benefits as a way to provide affordable health coverage for older Americans.[14] The final rule benefits employers by allowing them to continue to coordinate retiree health benefits with Medicare. It will decrease, not increase, costs to covered employers by reducing the risks of liability for noncompliance with the statute.[15] Further, this rule also will benefit retirees by eliminating the incentive for employers to reduce or eliminate retiree health coverage in order to comply with the equal benefit/equal cost defense.[16] Thus, the rule should not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State and local tribal governments or communities.

The ADEA applies to all employers with at least 20 employees. 29 U.S.C. § 630(b). The Act prohibits covered employers from discriminating against an employee or job applicant who is at least 40 years of age. 29 U.S.C. 623, 631. According to Census Bureau information, approximately 1,976,216 establishments employed 20 or more employees in 2000.[17]

The exemption would apply to all covered employers who provide health benefits to their retirees. In 2001, the GAO concluded that about one-third of large employers and less than 10% of small employers provided such benefits to current retirees.[18] According to the GAO, in 1999, such employer-sponsored health plans were relied on by 10 million retired individuals aged 55 and over as either their primary source of health coverage or as a supplement to Medicare coverage.[19]

After the Commission took the position that the practice of coordinating retiree health benefits with Medicare eligibility was unlawful unless an employer could meet the equal benefit/equal cost test set forth in Section 4(f)(2)(B)(i) of the ADEA, labor unions and employers expressed concern that the easiest way for an employer-sponsored retiree health plan to comply with the Commission's policy was to reduce or eliminate already existing retiree health benefit coverage. This result has become increasingly likely given the myriad other factors impacting the availability of employer-sponsored retiree health benefits.

In recent years, the cost of employee health care has consistently increased, making it difficult for employers to continue to provide retiree health benefits.[20] As explained in the NPRM, two widely-cited surveys of employer-sponsored health plans—(1) the Health Research and Educational Trust survey sponsored by The Henry J. Kaiser Family Foundation (Kaiser/HRET) and (2) the William M. Mercer, Incorporated survey (formerly produced by Foster Higgins) (Mercer/Foster Higgins)—estimate that premiums for employer-sponsored health insurance increased an average of about 11% in 2001.[21] These studies also identify how cost increases were expected to continue and how such ongoing premium increases are particularly difficult for small employers to cover and continue offering retiree health benefits.[22]

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[12] *AARP* v. *EEOC,* 489 F.3d 558, 2007 WL 1584385 (3d Cir., June 4, 2007). The Third Circuit confirmed that its decision lifted the district court's injunction in response to a motion for clarification. *Id.*, Case No. 05–4594 (3d Cir., August 31, 2007).

[13] *AARP* v. *EEOC*, 489 F.3d at 564–565.

[14] That view is reflected in public comments made by groups such as the American Federation of Teachers, the National Education Association, the Wisconsin Education Association Council, the Delaware State Education Association, the National Council on Teacher Retirement, the American Benefits Council, the American Association of Health Plans, the ERISA Industry Committee, the Equal Employment Advisory Council, the Minnesota School Boards Association, the National Rural Electric Cooperative Association, the Society for Human Resource Management, the U.S. Chamber of Commerce, the Washington Business Group on Health, and the Wisconsin Association of School Boards, among others.

[15] NPRM, 68 FR at 41548.

[16] *See id*. at 41546 (explaining that without the final rule, ''[t]his lack of regulatory protection may cause a class of people—retirees not yet 65—to be left without any health insurance. It also may contribute to the loss of valuable employer-sponsored coverage that supplements Medicare for retirees age 65 and over.'')

[17] CENSUS BUREAU, U.S. DEPARTMENT OF COMMERCE, ''Statistics of U.S. Businesses'' (2000).

[18] Hearing Before the House Comm. on Education and the Workforce, 107th Cong.(2001) (statement of William J. Scanlon, Director of Health Care Services, GAO).

[19] U.S. GENERAL ACCOUNTING OFFICE, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 1 (May 2001).

[20] NPRM, 68 Fed. at 41543.

[21] THE HENRY J. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, ''Employer Health Benefits, 2001 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2001); WILLIAM M. MERCER, ''Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001'' (New York, NY: William M. Mercer, Inc. 2002). The 2001 Kaiswer/HRET study, conducted between January and May 2001, surveyed more than 2,500 randomly selected public and private companies in the United States. The 2001 Mercer/Foster Higgins study used a national probability sampling of public and private employers and the results represented about 600,000 employers.

[22] The NPRM explains that the 2001 Kaiser/HRET survey suggests that these changes would affect small employers, defined as those employing between 3–199 workers, at a greater rate than larger companies, THE HENRY J. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, ''Employer Health Benefits, 2001 Annual Survey'' (2001), and the 2002 Kaiser/HRET survey suggests that the number of small employers offering retiree health benefits has eroded. THE HENRY J. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND

Increased longevity and, thus, increased numbers of retirees, also will continue to mean larger and more frequent payments for health care services on behalf of retired workers.[23] ''The United States General Accounting Office (GAO) projects that, by 2030, the number of people age 65 or older will be double what it is today, while the number of individuals between the ages of 55 and 64 will increase 75 percent by 2020.'' [24] Further, ''it is well-established that utilization of health care services generally rises with age.'' [25] Thus, the demand for and cost of retiree health coverage is likely to grow significantly during a time that there will be comparatively fewer active workers to subsidize such benefits.[26]

Changes in accounting rules also have dramatically impacted the way employers account for retiree health benefit costs.[27] The Financial Accounting Standards Board, which is charged with establishing U.S. standards of financial accounting and reporting, promulgated new rules for retiree health accounting in 1990, referred to as Financial Accounting Standards Number 106 or FAS 106.[28]

FAS 106 requires employers to apportion the costs of retiree health over the working lifetime of employees and to report unfunded retiree health benefit liabilities in accordance with generally accepted accounting principles beginning with fiscal years after December 15, 1992. Because ''the recognition of these liabilities in financial statements dramatically impacts a company's calculation of its profits and losses,'' some companies have said that FAS 106 led to reductions in reported income, thus creating an incentive to reduce expenditures for employee benefits such as retiree health.[29]

''As a result of these increased costs and accounting changes, employers have actively examined ways to reduce health care costs, including by reducing, altering, or eliminating retiree health coverage.'' [30] As explained in the NPRM, studies revealed that employers already were less likely to offer retiree health benefits than in the past and that this trend was expected to continue.[31]

[Further, a]s the number of employers offering retiree health coverage declines, so has the incentive for employers to provide future retirees with such coverage. Unions report that meaningful negotiations about the future provisions of employer-sponsored retiree health benefits are becoming increasingly futile. Union representatives have informed EEOC that increasing numbers of employers have refused to include retiree health among the benefits to be provided to employees.[32]

In this environment, employers are not likely to increase any retiree's benefit in order to comply with the ADEA's equal benefit/equal cost defense. To the contrary, the equal benefit/equal cost rule creates an additional incentive for employers to reduce benefits.

In light of the other factors affecting an employer's decision to provide retiree health benefits, the Commission believes that the current regulatory framework of the ADEA does not provide a sufficient safe harbor to protect and preserve the important employer practice of providing health coverage for retirees.

This lack of regulatory protection may cause a class of people—retirees not yet 65—to be left without any health insurance. It also may contribute to the loss of valuable employer-sponsored coverage that supplements Medicare for retirees age 65 and over. Because almost 60% of retirees between the ages of 55 to 64 rely on employer-sponsored health coverage as their primary source of health coverage, and about one-third of retirees over age 65 rely on employer-provided retiree health plans to supplement Medicare, the Commission believes that such a result is contrary to the public interest and necessitates regulatory action.[33]

As detailed in the NPRM, the Commission examined a variety of ways to end this incentive towards further benefit erosion. These alternatives included various proposals that would have allowed employers to take the cost of Medicare into account when assessing whether they satisfied the equal cost test, or regulations that would require employers to adopt or maintain benefits programs that supplement Medicare in order to satisfy the equal benefits test. However, none of these alternatives reduced the risk to employers of noncompliance with the ADEA while providing them with the flexibility to continue providing coordinated retiree health benefits.

After extensive study, the Commission concluded that ''it does not appear that retiree health costs or benefits can be reasonably quantified in a regulation.'' [34]

Unlike valuation of costs associated with life insurance or long-term disability benefits, calculati[on of] retiree health costs is complex due to the multitude of variables, including types of plans, levels and types of coverage, deductibles, and geographical areas covered. In addition, the subjective nature of some health benefits, such as a greater choice in providers, makes any such valuation more complicated.

EDUCATIONAL TRUST, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002) (reporting that the number of small employers who offer retiree health benefits dropped 6% between 2000 and 2002).

[23] NPRM, 68 FR 41543.

[24] *Id.* (citing U.S. GENERAL ACCOUNTING OFFICE, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 17 (May 2001)).

[25] NPRM, 68 FR 41543 (citing ANNA M. RAPPAPORT, ''Planning for Health Care Needs in Retirement,'' *in* FORECASTING RETIREMENT NEEDS AND RETIREMENT WEALTH 288, 288–294 (Olivia S. Mitchell *et al.* eds., University of Pennsylvania Press 2000)).

[26] NPRM, 68 FR 41543 (citing U.S. GENERAL ACCOUNTING OFFICE, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 17–18 (May 2001)).

[27] NPRM, 68 FR 41543 (citing ANNA M. RAPPAPORT, ''FAS 106 and Strategies for Managing Retiree HealthBenefits,'' *in* COMPENSATION AND BENEFITS MANAGEMENT, 37 (Spring 2001); PAUL FRONSTIN, ''Retiree Health Benefits: Trends and Outlook,'' EBRI ISSUE BRIEF No. 236 (Employee Benefit Research Institute Aug. 2001)).

[28] NPRM, 68 FR at 41543.

[29] *Id.* at 41544 (quoting PAUL FRONSTIN, ''Retiree Health Benefits: Trends and Outlook,'' EBRI ISSUE BRIEF No. 236, at 3 (Employee Benefit Research Institute Aug. 2001)).

[30] NPRM, 68 FR at 41544 (noting that a 2001 survey found that both public and private employers considered controlling health care costs as a top business issue for the next two to three years. THAP! ET AL., ''Productive Workforce Survey: Report of Findings Private Employer/Public Agency'' (THAP!, Andersen and CalPERS Aug. 2001); *see also* ANNA M. RAPPAPORT, ''Postemployment Benefits: Retiree Health Challenges and Trends—2001 and Beyond,'' *in* COMPENSATION AND BENEFITS MANAGEMENT, 52, 56 (Autumn 2001) (''Companies seeking to reduce costs are closely examining retiree medical benefits.'')).

[31] The 2001 Mercer/Foster Higgins study showed a 17% decline between 1993 and 2001 in the number of employers with 500 or more workers offering retiree health benefits, William M. Mercer, ''Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001'' (New York, NY: William M. Mercer, Inc. 2002), the 2002 Kaiser/HRET study found that only 34% of employers with at least 200 employees offered retiree health coverage in 2002, as opposed to 66% in 1998, The Henry J. Kaiser Family Foundation & Health Research and Educational Trust,'' ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002), and a study by Hewitt Associates LLC reached similar conclusions. Hewitt Associates LLC, ''Trends in Retiree Health Plans'' (Lincolnshire, IL: Hewitt Associates LLC 2001). The Kaiser study also forecast that this trend would continue.

[32] NPRM, 68 FR at 41544.

[33] NPRM, 68 FR at 41546–47 (citing Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement of William J. Scanlon, Director of Health Care Services, GAO); THE HENRY J. KAISER FAMILY FOUNDATION ET AL., ''Erosion of Private Health Insurance Coverage For Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey,'' at iv (Menlo Park, CA: The Henry J. Kaiser Family Foundation, Health and Research Educational Trust and The Commonwealth Fund April 2002); and additionally noting that ''[o]f the 56.8% of retirees covered by employer-sponsored health coverage in 1999, 36.3% were covered in their own name and 20.5% received health benefits through a spouse. PAUL FRONSTIN, ''Retiree Health Benefits: Trends and Outlook,'' EBRI ISSUE BRIEF No. 236, at 6–7 (Employee Benefit Research Institute Aug. 2001).'').

[34] NPRM, 68 FR at 41546.

Even allowing an employer to take into account the ''cost'' of Medicare is problematic because the government's cost[s in] provid[ing] Medicare services does not reflect what similar benefits would cost an employer in the marketplace. Nor can an employer's Medicare tax obligation, pursuant to the Federal Insurance Contributions Act, 26 U.S.C. §§ 3101 *et seq.* (FICA), be considered the ''cost'' of any specific retiree's Medicare benefits inasmuch as most retirees have been employed by multiple employers over the course of their careers and employer FICA contributions are paid into a general Medicare fund that is not employee-specific. Additionally, the fact that employees themselves pay for a portion of the cost of Medicare further complicates cost valuation.

The Commission therefore believes that quantifying the cost to employers of post-Medicare retiree health benefits under any formulation of the equal cost test would not be practicable. This is particularly true for employers who maintain multiple plans for different categories of employees. Even for employers with only one plan, the variability in health claims data from year to year can be great. As a result, calculating retiree health benefit expenses would be cost prohibitive for many employers.[35]

This is particularly true for small and medium sized employers, and those unable to hire sophisticated employee benefit professionals.[36] ''As a result, repeatedly having to calculate retiree health benefit expenses under the alternative proposals considered by the Commission would have been cost prohibitive or otherwise impracticable for many employers.'' [37]

Thus, even if it were possible to capture the myriad of complexities involved in a retiree health cost analysis in a regulation, the likelihood is that far too many employers might simply reduce or eliminate existing retiree health benefit plans instead of attempting to comply with such a regulation. Further complicating compliance with many of the alternative proposals considered by the Commission is the fact that employers do not have the same flexibility in designing retiree health benefit programs as they do when designing other types of retirement benefit programs, such as cash-based retirement incentives. For example, providing supplemental health benefits to retirees who are eligible for Medicare may require that the employer obtain and administer a separate policy just for that coverage. Many employers are unable or unwilling to bear such a burden. Instead, if faced with such a choice, employers are more likely to simply eliminate retiree health coverage altogether—for retirees under and over age 65. Furthermore, future changes in the private health insurance market or in Medicare likely would necessitate further regulatory action were the Commission to adopt many of the alternative proposals considered. [Thus, t]he Commission does not believe that it is possible to apply the equal benefit/equal cost test, or a variant of that rule, to the rapidly changing landscape of retiree health care.[38]

In contrast, the Commission's final rule allows employers to offer a wide range of retiree health plan designs that coordinate with Medicare without violating the ADEA. The rule does not otherwise affect an employer's ability to offer health benefits to retirees, consistent with the law. ''This approach also benefits the significant number of [retirees] who rely on employer-sponsored retiree health coverage and would otherwise have to obtain retiree health coverage in the private individual marketplace at substantial personal expense.'' [39]

It is not likely that the final regulation will disrupt the efficient functioning of the economy and private market forces. Until recently, when structuring retiree health benefits, most employers relied on legislative history to the OWBPA stating that the practice of coordinating employer-sponsored retiree health benefits with Medicare eligibility is lawful under the ADEA. This final regulation permits the practice of unrestricted coordination of retiree health benefits with Medicare eligibility to continue.

Paperwork Reduction Act

This final rule contains no information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. chapter 35).

Regulatory Flexibility Act

The Commission certifies under 5 U.S.C. 605(b) that this final rule will not have a significant economic impact on a substantial number of small entities, because it imposes no additional economic or reporting burdens on such firms. The rule—which exempts certain practices from regulation—will decrease, not increase, costs to covered employers by reducing the risks of liability for noncompliance with the statute. For this reason, a regulatory flexibility analysis is not required.

List of Subjects in 29 CFR Part 1625 and 1627

Advertising, Aged, Employee benefit plans, Equal employment opportunity, Reporting and recordkeeping requirements, Retirement.

■ For the reasons discussed in the preamble, Chapter XIV of Title 29 of the Code of Federal Regulations is amended as follows:

PART 1627—RECORDS TO BE MADE OR KEPT RELATING TO AGE: NOTICES TO BE POSTED

■ 1. Revise the heading of part 1627 to read as set forth above.

■ 2. The authority citation for 29 CFR part 1627 shall continue to read as follows:

Authority: Sec. 7, 81 Stat. 604; 29 U.S.C. 626; sec. 11, 52 Stat. 1066, 29 U.S.C. 211; sec. 12, 29 U.S.C. 631, Pub. L. 99–592, 100 Stat. 3342; sec. 2, Reorg. Plan No. 1 of 1978, 43 FR 19807.

■ 3. In § 1627.1, remove paragraph (b) and redesignate paragraph (c) as new paragraph (b).

■ 4. In part 1627, redesignate subpart C (consisting of §§ 1627.15 and 1627.16) as subpart C of Part 1625 (consisting of §§ 1625.30 and 1625.31), respectively.

PART 1625—AGE DISCRIMINATION IN EMPLOYMENT ACT

■ 5. The authority citation for 29 CFR Part 1625 is revised to read as follows:

Authority: 81 Stat. 602; 29 U.S.C. 621; 5 U.S.C. 301; Secretary's Order No. 10–68; Secretary's Order No. 11–68; Sec. 9, 81 Stat. 605; 29 U.S.C. 628; sec. 12, 29 U.S.C. 631, Pub. L. 99–592, 100 Stat. 3342; sec. 2, Reorg. Plan No. 1 of 1978, 43 FR 19807.

■ 6. In newly redesignated subpart C of part 1625, revise the heading of newly redesignated § 1625.31 and the first sentence of paragraph (a) to read as follows:

§ 1625.31 Special employment programs.

(a) Pursuant to the authority contained in section 9 of the Act and in accordance with the procedure provided therein and in § 1625.30(b) of this part, it has been found necessary and proper in the public interest to exempt from all prohibitions of the Act all activities and programs under Federal contracts or grants, or carried out by the public employment services of the several States, designed exclusively to provide employment for, or to encourage the

[35] *Id.*

[36] *See id.* at 41548 (noting that ''[i]t is clear that small and medium-sized employers, and those unable to hire sophisticated employee benefit professionals, would be most affected by a complicated rule.'').

[37] NPRM, 68 FR at 41548.

[38] *Id.* at 41546.

[39] NPRM, 68 FR at 41548. *See id.* at 41544 (discussing how those who lose coverage have limited options, such as temporary coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. § 1161 *et seq.* (COBRA) or coverage in the private individual insurance market). COBRA coverage is very expensive because, while it allows the employee to remain in the employer's insurance plan, it requires the employee to pay the entire premium. 68 FR 41544. Coverage in the private health insurance often provides limited benefits, or is prohibitively expensive. *Id.* (citing U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 20–22 (May 2001)).

employment of, persons with special employment problems, including employment activities and programs under the Manpower Development and Training Act of 1962, Pub. L. No. 87–415, 76 Stat. 23 (1962), as amended, and the Economic Opportunity Act of 1964, Pub. L. No. 88–452, 78 Stat. 508 (1964), as amended, for persons among the long-term unemployed, handicapped, members of minority groups, older workers, or youth. * * *

* * * * *

■ 7. Add section 1625.32 to Subpart C of part 1625 to read as follows:

§ 1625.32 Coordination of retiree health benefits with Medicare and State health benefits.

(a) Definitions.

(1) *Employee benefit plan* means an employee benefit plan as defined in 29 U.S.C. 1002(3).

(2) *Medicare* means the health insurance program available pursuant to Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*

(3) *Comparable State health benefit plan* means a State-sponsored health benefit plan that, like Medicare, provides retired participants who have attained a minimum age with health benefits, whether or not the type, amount or value of those benefits is equivalent to the type, amount or value of the health benefits provided under Medicare.

(b) *Exemption.* Some employee benefit plans provide health benefits for retired participants that are altered, reduced or eliminated when the participant is eligible for Medicare health benefits or for health benefits under a comparable State health benefit plan, whether or not the participant actually enrolls in the other benefit program. Pursuant to the authority contained in section 9 of the Act, and in accordance with the procedures provided therein and in § 1625.30(b) of this part, it is hereby found necessary and proper in the public interest to exempt from all prohibitions of the Act such coordination of retiree health benefits with Medicare or a comparable State health benefit plan.

(c) *Scope of Exemption.* This exemption shall be narrowly construed. No other aspects of ADEA coverage or employment benefits other than those specified in paragraph (b) of this section are affected by the exemption. Thus, for example, the exemption does not apply to the use of eligibility for Medicare or a comparable State health benefit plan in connection with any act, practice or benefit of employment not specified in paragraph (b) of this section. Nor does it apply to the use of the age of eligibility for Medicare or a comparable State health benefit plan in connection with any act, practice or benefit of employment not specified in paragraph (b) of this section.

8. In Subpart C of part 1625, add an Appendix to newly added § 1625.32 as follows:

Appendix to § 1625.32—Questions and Answers Regarding Coordination of Retiree Health Benefits With Medicare and State Health Benefits

Q1. Why is the Commission issuing an exemption from the Act?

A1. The Commission recognizes that while employers are under no legal obligation to offer retiree health benefits, some employers choose to do so in order to maintain a competitive advantage in the marketplace—using these and other benefits to attract and retain the best talent available to work for their organizations. Further, retiree health benefits clearly benefit workers, allowing such individuals to acquire affordable health insurance coverage at a time when private health insurance coverage might otherwise be cost prohibitive. The Commission believes that it is in the best interest of both employers and employees for the Commission to pursue a policy that permits employers to offer these benefits to the greatest extent possible.

Q2. Does the exemption mean that the Act no longer applies to retirees?

A2. No. Only the practice of coordinating retiree health benefits with Medicare (or a comparable State health benefit plan) as specified in paragraph (b) of this section is exempt from the Act. In all other contexts, the Act continues to apply to retirees to the same extent that it did prior to the issuance of this section.

Q3. May an employer offer a ''carve-out plan'' for retirees who are eligible for Medicare or a comparable State health plan?

A3. Yes. A ''carve-out plan'' reduces the benefits available under an employee benefit plan by the amount payable by Medicare or a comparable State health plan. Employers may continue to offer such ''carve-out plans''and make Medicare or a comparable State health plan the primary payer of health benefits for those retirees eligible for Medicare or the comparable State health plan.

Q4. Does the exemption also apply to dependent and/or spousal health benefits that are included as part of the health benefits provided for retired participants?

A4. Yes. Because dependent and/or spousal health benefits are benefits provided to the retired participant, the exemption applies to these benefits, just as it does to the health benefits for the retired participant. However, dependent and/or spousal benefits need not be identical to the health benefits provided for retired participants. Consequently, dependent and/or spousal benefits may be altered, reduced or eliminated pursuant to the exemption whether or not the health benefits provided for retired participants are similarly altered, reduced or eliminated.

Q5. Does the exemption address how the ADEA may apply to other acts, practices or employment benefits not specified in the rule?

A5. No. The exemption only applies to the practice of coordinating employer-sponsored retiree health benefits with eligibility for Medicare or a comparable State health benefit program. No other aspects of ADEA coverage or employment benefits other than retiree health benefits are affected by the exemption.

Q6. Does the exemption apply to existing, as well as to newly created, employee benefit plans?

A6. Yes. The exemption applies to all retiree health benefits that coordinate with Medicare (or a comparable State health benefit plan) as specified in paragraph (b) of this section, whether those benefits are provided for in an existing or newly created employee benefit plan.

Q7. Does the exemption apply to health benefits that are provided to current employees who are at or over the age of Medicare eligibility (or the age of eligibility for a comparable State health benefit plan)?

A7. No. The exemption applies only to retiree health benefits, not to health benefits that are provided to current employees. Thus, health benefits for current employees must be provided in a manner that comports with the requirements of the Act. Moreover, under the laws governing the Medicare program, an employer must offer to current employees who are at or over the age of Medicare eligibility the same health benefits, under the same conditions, that it offers to any current employee under the age of Medicare eligibility.

Dated: December 17, 2007.

For the Commission.

Naomi C. Earp,

Chair.

[FR Doc. E7–24867 Filed 12–21–07; 8:45 am]

BILLING CODE 6570–01–P

DEPARTMENT OF DEFENSE

Department of the Navy

32 CFR Part 706

Certifications and Exemptions Under the International Regulations for Preventing Collisions at Sea, 1972

AGENCY: Department of the Navy, DoD.

ACTION: Final rule.

SUMMARY: The Department of the Navy is amending its certifications and exemptions under the International Regulations for Preventing Collisions at Sea, 1972 (72 COLREGS), to reflect that the Deputy Assistant Judge Advocate General (Admiralty and Maritime Law) has determined that USS FREEDOM (LCS 1) is a vessel of the Navy which, due to its special construction and purpose, cannot fully comply with certain provisions of the 72 COLREGS

APPENDIX B

TITLE 29--LABOR
Subtitle B--Regulations Relating to Labor
Chapter XIV--Equal Employment Opportunity Commission.
Part 1625--Age Discrimination in Employment Act
Subpart A--Interpretations

s 1625.10 Costs and benefits under employee benefit plans.

(a) (1) General. Section 4(f)(2) of the Act provides that it is not unlawful for an employer, employment agency, or labor organization "to observe the terms of * * * any bona fide employee benefit plan such as a retirement, pension, or insurance plan, which is not a subterfuge to evade the purposes of this Act, except that no such employee benefit plan shall excuse the failure to hire any individual, and no such * * * employee benefit plan shall require or permit the involuntary retirement of any individual specified by section 12(a) of this Act because of the age of such individuals." The legislative history of this provision indicates that its purpose is to permit age-based reductions in employee benefit plans where such reductions are justified by significant cost considerations. Accordingly, section 4(f)(2) does not apply, for example, to paid vacations and uninsured paid sick leave, since reductions in these benefits would not be justified by significant cost considerations. Where employee benefit plans do meet the criteria in section 4(f)(2), benefit levels for older workers may be reduced to the extent necessary to achieve approximate equivalency in cost for older and younger workers. A benefit plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred, in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of benefits or insurance coverage. Since section 4(f)(2) is an exception from the general non-discrimination provisions of the Act, the burden is on the one seeking to invoke the exception to show that every element has been clearly and unmistakably met. The exception must be narrowly construed. The following sections explain three key elements of the exception: (i) what a "bona fide employee benefit plan" is; (ii) what it means to "observe the terms" of such a plan; and (iii) what kind of plan, or plan provision, would be considered "a subterfuge to evade the purposes of [the] Act."

(a)(2) Relation of section 4(f)(2) to sections 4(a), 4(b) and 4(c). Sections 4(a), 4(b) and 4(c) prohibit specified acts of discrimination on the basis of age. Section 4(a) in particular makes it unlawful for an employer to "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age * * *." Section 4(f)(2) is an exception to this general prohibition. Where an employer under an employee benefit plan provides the same level of benefits to older workers as to younger workers, there is no violation of section 4(a), and accordingly the practice does not have to be justified under section 4(f)(2).

(b) "Bona fide employee benefit plan." Section 4(f)(2) applies only to bona fide employee benefit plans. A plan is considered "bona fide" if its terms

(including cessation of contributions or accruals in the case of retirement income plans) have been accurately described in writing to all employees and if it actually provides the benefits in accordance with the terms of the plan. Notifying employees promptly of provisions and changes in an employee benefit plan is essential if they are to know how the plan affects them. For these purposes, it would be sufficient under the ADEA for employers to follow the disclosure requirements of ERISA and the regulations thereunder. The plan must actually provide the benefits its provisions describe, since otherwise the notification of the provisions to employees is misleading and inaccurate. An "employee benefit plan" is a plan, such as a retirement, pension, or insurance plan, which provides employees with what are frequently referred to as "fringe benefits." The term does not refer to wages or salary in cash; neither section 4(f)(2) nor any other section of the Act excuses the payment of lower wages or salary to older employees on account of age. Whether or not any particular employee benefit plan may lawfully provide lower benefits to older employees on account of age depends on whether all of the elements of the exception have been met. An "employee-pay-all" employee benefit plan is one of the "terms, conditions, or privileges of employment" with respect to which discrimination on the basis of age is forbidden under section 4(a)(1). In such a plan, benefits for older workers may be reduced only to the extent and according to the same principles as apply to other plans under section 4(f)(2).

(c) "To observe the terms" of a plan. In order for a bona fide employee benefit plan which provides lower benefits to older employees on account of age to be within the section 4(f)(2) exception, the lower benefits must be provided in "observ[ance of] the terms of" the plan. As this statutory text makes clear, the section 4(f)(2) exception is limited to otherwise discriminatory actions which are actually prescribed by the terms of a bona fide employee benefit plan. Where the employer, employment agency, or labor organization is not required by the express provisions of the plan to provide lesser benefits to older workers, section 4(f)(2) does not apply. Important purposes are served by this requirement. Where a discriminatory policy is an express term of a benefit plan, employees presumably have some opportunity to know of the policy and to plan (or protest) accordingly. Moreover, the requirement that the discrimination actually be prescribed by a plan assures that the particular plan provision will be actually applied to all employees of the same age. Where a discriminatory provision is an optional term of the plan, it permits individual, discretionary acts of discrimination, which do not fall within the section 4(f)(2) exception.

(d) "Subterfuge." In order for a bona fide employee benefit plan which prescribes lower benefits for older employees on account of age to be within the section 4(f)(2) exception, it must not be "a subterfuge to evade the purposes of [the] Act." In general, a plan or plan provision which prescribes lower benefits for older employees on account of age is not a "subterfuge" within the meaning of section 4(f)(2), provided that the lower level of benefits is justified by age-related cost considerations. (The only exception to this general rule is with respect to certain retirement plans. See paragraph (f)(4) of this section.) There are certain other requirements that must be met in order for a plan not to be a subterfuge. These requirements are set forth below.

(d)(1) Cost data--General Cost data used in justification of a benefit plan which provides lower benefits to older employees on account of age must be valid

and reasonable. This standard is met where an employer has cost data which show the actual cost to it of providing the particular benefit (or benefits) in question over a representative period of years. An employer may rely in cost data for its own employees over such a period, or on cost data for a larger group of similarly situated employees. Sometimes, as a result of experience rating or other causes, an employer incurs costs that differ significantly from costs for a group of similarly situated employees. Such an employer may not rely on cost data for the similarly situated employees where such reliance would result in significantly lower benefits for its own older employees. Where reliable cost information is not available, reasonable projections made from existing cost data meeting the standards set forth above will be considered acceptable.

(d)(2) Cost data--Individual benefit basis and "benefit package" basis. Cost comparisons and adjustments under section 4(f)(2) must be made on a benefit-by-benefit basis or on a "benefit package" basis, as described below.

(d)(2)(i) Benefit-by-benefit basis Adjustments made on a benefit-by-benefit basis must be made in the amount or level of a specific form of benefit for a specific event or contingency. For example, higher group term life insurance costs for older workers would justify a corresponding reduction in the amount of group term life insurance coverage for older workers, on the basis of age. However, a benefit-by-benefit approach would not justify the substitution of one form of benefit for another, even though both forms of benefit are designed for the same contingency, such as death. See paragraph (f)(1) of this section.

(d)(2)(ii) "Benefit package" basis As an alternative to the benefit-by-benefit basis, cost comparisons and adjustments under section 4(f)(2) may be made on a limited "benefit package" basis. Under this approach, subject to the limitations described below, cost comparisons and adjustments can be made with respect to section 4(f)(2) plans in the aggregate. This alternative basis provides greater flexibility than a benefit-by-benefit basis in order to carry out the declared statutory purpose "to help employers and workers find ways of meeting problems arising from the impact of age on employment." A "benefit package" approach is an alternative approach consistent with this purpose and with the general purpose of section 4(f)(2) only if it is not used to reduce the cost to the employer or the favorability to the employees of overall employee benefits for older employees. A "benefit package" approach used for either of these purposes would be a subterfuge to evade the purposes of the Act. In order to assure that such a "benefit package" approach is not abused and is consistent with the legislative intent, it is subject to the limitations described in paragraph (f) of this section, which also includes a general example.

(d)(3) Cost data--Five year maximum basis Cost comparisons and adjustments under section 4(f)(2) may be made on the basis of age brackets of up to 5 years. Thus a particular benefit may be reduced for employees of any age within the protected age group by an amount no greater than that which could be justified by the additional cost to provide them with the same level of the benefit as younger employees within a specified five-year age group immediately preceding theirs. For example, where an employer chooses to provide unreduced group term life insurance benefits until age 60, benefits for employees who are between 60 and 65 years of age may be reduced only to the extent necessary to achieve approximate equivalency in costs with employees who are 55 to 60 years old. Similarly, any

reductions in benefit levels for 65 to 70 year old employees cannot exceed an amount which is proportional to the additional costs for their coverage over 60 to 65 year old employees.

(d)(4) Employee contributions in support of employee benefit plans-- (d)(4)(i) As a condition of employment An older employee within the protected age group may not be required as a condition of employment to make greater contributions than a younger employee in support of an employee benefit plan. Such a requirement would be in effect a mandatory reduction in take-home pay, which is never authorized by section 4(f)(2), and would impose an impediment to employment in violation of the specific restrictions in section 4(f)(2).

(d)(4)(ii) As a condition of participation in a voluntary employee benefit plan An older employee within the protected age group may be required as a condition of participation in a voluntary employee benefit plan to make a greater contribution that a younger employee only if the older employee is not thereby required to bear a greater proportion of the total premium cost (employer-paid and employee-paid) than the younger employee. Otherwise the requirement would discriminate against the older employee by making compensation in the form of an employer contribution available on less favorable terms than for the younger employee and denying that compensation altogether to an older employee unwilling or unable to meet the less favorable terms. Such discrimination is not authorized by section 4(f)(2). This principle applies to three different contribution arrangements as follows:

(d)(4)(ii)(A) Employee-pay-all plans Older employees, like younger employees, may be required to contribute as a condition of participation up to the full premium cost for their age.

(d)(4)(ii)(B) Non-contributory ("employer-pay-all") plans Where younger employees are not required to contribute any portion of the total premium cost, older employees may not be required to contribute any portion.

(d)(4)(ii)(C) Contributory plans In these plans employers and participating employees share the premium cost. The required contributions of participants may increase with age so long as the proportion of the total premium required to be paid by the participants does not increase with age.

(d)(4)(iii) As an option in order to receive an unreduced benefit An older employee may be given the option, as an individual, to make the additional contribution necessary to receive the same level of benefits as a younger employee (provided that the contemplated reduction in benefits is otherwise justified by section 4(f)(2).

(d)(5) Forfeiture clauses Clauses in employee benefit plans which state that litigation or participation in any manner in a formal proceeding by an employee will result in the forfeiture of his rights are unlawful insofar as they may be applied to those who seek redress under the Act. This is by reason of section 4(d) which provides that it is unlawful for an employer, employment agency, or labor organization to discriminate against any individual because such individual "has made a charge, testified, assisted, or participated in an investigation,

proceeding, or litigation under this Act."

(d)(6) Refusal to hire clauses Any provision of an employee benefit plan which requires or permits the refusal to hire an individual specified in section 12(a) of the Act on the basis of age is a subterfuge to evade the purposes of the Act and cannot be excused under section 4(f)(2).

(d)(7) Involuntary retirement clauses Any provision of an employee benefit plan which requires or permits the involuntary retirement of any individual specified in section 12(a) of the Act on the basis of age is a subterfuge to evade the purpose of the Act and cannot be excused under section 4(f)(2).

(e) Benefits provided by the Government An employer does not violate the Act by permitting certain benefits to be provided by the Government, even though the availability of such benefits may be based on age. For example, it is not necessary for an employer to provide health benefits which are otherwise provided to certain employees by Medicare. However, the availability of benefits from the Government will not justify a reduction in employer-provided benefits if the result is that, taking the employer-provided and Government-provided benefits together, an older employee is entitled to a lesser benefit of any type (including coverage for family and/or dependents) than a similarly situated younger employee. For example, the availability of certain benefits to an older employee under Medicare will not justify denying an older employee a benefit which is provided to younger employees and is not provided to the older employee by Medicare.

(f) Application of section 4(f)(2) to various employees benefit plans. (1) Benefit-by-benefit approach This portion of the interpretation discusses how a benefit-by-benefit approach would apply to four of the most common types of employee benefit plans.

(f)(i) Life insurance It is not uncommon for life insurance coverage to remain constant until a specified age, frequently 65, and then be reduced. This practice will not violate the Act (even if reductions start before age 65), provided that the reduction for an employee of a particular age is no greater than is justified by the increased cost of coverage for that employee's specific age bracket encompassing no more than five years. It should be noted that a total denial of life insurance, on the basis of age, would not be justified under a benefit-by-benefit analysis. However, it is not unlawful for life insurance coverage to cease upon separation from service.

(f)(ii) Long-term disability. Under a benefit-by-benefit approach, where employees who are disabled at younger ages are entitled to long-term disability benefits, there is no cost--based justification for denying such benefits altogether, on the basis of age, to employees who are disabled at older ages. It is not unlawful to cut off long-term disability benefits and coverage on the basis of some non-age factor, such as recovery from disability. Reductions on the basis of age in the level or duration of benefits available for disability are justifiable only on the basis of age-related cost considerations as set forth elsewhere in this section. An employer which provides long-term disability coverage to all employees may avoid any increases in the cost to it that such coverage for older employees would entail by reducing the level of benefits available to older employees. An

employer may also avoid such cost increases by reducing the duration of benefits available to employees who become disabled at older ages, without reducing the level of benefits. In this connection, the Department would not assert a violation where the level of benefits is not reduced and the duration of benefits is reduced in the following manner:

(f)(ii)(A) With respect to disabilities which occur at age 60 or less, benefits cease at age 65.

(f)(ii)(B) With respect to disabilities which occur after age 60, benefits cease 5 years after disablement. Cost data may be produced to support other patterns of reduction as well.

(f)(iii) Retirement plans. (A) Participation No employee hired prior to normal retirement age may be excluded from a defined contribution plan. With respect to defined benefit plans not subject to the Employee Retirement Income Security Act (ERISA), Pub.L. 93-406, 29 U.S.C. 1001, 1003(a) and (b), an employee hired at an age more than 5 years prior to normal retirement age may not be excluded from such a plan unless the exclusion is justifiable on the basis of cost considerations as set forth elsewhere in this section. With respect to defined benefit plans subject to ERISA, such an exclusion would be unlawful in any case. An employee hired less than 5 years prior to normal retirement age may be excluded from a defined benefit plan, regardless of whether or not the plan is covered by ERISA. Similarly, any employee hired after normal retirement age may be excluded from a defined benefit plan.

(f)(iii)(2) "Benefit Package" Approach A "benefit package" approach to compliance under section 4(f)(2) offers greater flexibility than a benefit-by-benefit approach by permitting deviations from a benefit-by-benefit approach so long as the overall result is no lesser cost to the employer and no less favorable benefits for employees. As previously noted, in order to assure that such an approach is used for the benefit of older workers and not to their detriment, and is otherwise consistent with the legislative intent, it is subject to limitations as set forth below:

(f)(iii)(2)(i) A benefit package approach shall apply only to employee benefit plans which fall within section 4(f)(2)

(f)(iii)(2)(ii) A benefit package approach shall not apply to a retirement or pension plan The 1978 legislative history sets forth specific and comprehensive rules governing such plans, which have been adopted above. These rules are not tied to actuarially significant cost considerations but are intended to deal with the special funding arrangements of retirement or pension plans. Variations from these special rules are therefore not justified by variations from the cost-based benefit-by-benefit approach in other benefit plans, nor may variations from the special rules governing pension and retirement plans justify variations from the benefit-by-benefit approach in other benefit plans.

(f)(iii)(2)(iii) A benefit package approach shall not be used to justify reductions in health benefits greater than would be justified under a benefit-by-benefit approach. Such benefits appear to be of particular importance to older

workers in meeting "problems arising from the impact of age" and were of particular concern to Congress. Therefore, the "benefit package" approach may not be used to reduce health insurance benefits by more than is warranted by the increase in the cost to the employer of those benefits alone. Any greater reduction would be a subterfuge to evade the purpose of the Act.

(f)(iii)(2)(iv) A benefit reduction greater than would be justified under a benefit-by-benefit approach must be offset by another benefit available to the same employees No employees may be deprived because of age of one benefit without an offsetting benefit being made available to them.

(f)(iii)(2)(v) Employers who wish to justify benefit reductions under a benefit package approach must be prepared to produce data to show that those reductions are fully justified Thus employers must be able to show that deviations from a benefit-by-benefit approach do not result in lesser cost to them or less favorable benefits to their employees. A general example consistent with these limitations may be given. Assume two employee benefit plans, providing Benefit "A" and Benefit "B." Both plans fall within section 4(f)(2), and neither is a retirement or pension plan subject to special rules. Both benefits are available to all employees. Age-based cost increases would justify a 10% decrease in both benefits on a benefit-by-benefit basis. The affected employees would, however, find it more favorable--that is, more consistent with meeting their needs--for no reduction to be made in Benefit "A" and a greater reduction to be made in Benefit "B." This "trade-off" would not result in a reduction in health benefits. The "trade-off" may therefore be made. The details of the "trade-off" depend on data on the relative cost to the employer of the two benefits. If the data show that Benefit "A" and Benefit "B" cost the same, Benefit "B" may be reduced up to 20% if Benefit "A" is unreduced . If the data show that Benefit "A" costs only half as much as Benefit "B", however, Benefit "B" may be reduced up to only 15% if Benefit "A" is unreduced, since a greater reduction in Benefit "B" would result in an impermissible reduction in total benefit costs.

(g) Relation of ADEA to State laws The ADEA does not preempt State age discrimination in employment laws. However, the failure of the ADEA to preempt such laws does not affect the issue of whether section 514 of the Employee Retirement Income Security Act (ERISA) preempts State laws which related to employee benefit plans.

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29 CFR s 1625.10

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