

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

KENT, SC.

SUPERIOR COURT

(FILED: February 11, 2016)

MICHAEL DUBIS, STEPHEN BIANCO, :
JOHN DUBIS, ROBERT VESPIA, :
SCOTT MILLETTE, PETER HENRIKSON, :
BRIAN GARDINER, SUSAN HAWKSLEY, :
DAVID MILLER, JON LARSSON, :
ROLAND VESPIA, RICHARD DENICE, :
DAVID DREW, E. STEFAN COUTOULAKIS, :
SEAN BRENNAN, JAMES LORENSON, :
RODNEY HARVEY, PETER CUSICK, :
JOANNE BIANCO, MARY BRENNAN, :
PAMELA A. COUTOULAKIS, KRISTEN :
CUSICK, MARY BETH DENICE, SHARON :
DREW, PATRICIA E. DUBIS, TERRI ANN :
DUBIS, LORI M. GARDINER, KRISTEN :
HENRIKSON, KERRI L. LARSSON, SUSAN :
LORENSON, PAMELA B. MILLER, :
BELINDA J. MILLETTE, ELAINE M. :
VESPIA, and MICHELLE VESPIA, :

Plaintiffs, :

v. :

C.A. No. KC-2014-0688

TOWN OF EAST GREENWICH, by and :
through its Finance Director, KRISTEN :
BENOIT, MICHAEL B. ISAACS, BRAD :
BISHOP, JEFFREY B. CIANCIOLO, MARK :
WATKINS GEE, MICHAEL S. KIERNAN, :
in their capacities as members of the East :
Greenwich Town Council, THOMAS E. :
COYLE III, in his capacity as Town Manager, :

Defendants. :

DECISION

TAFT-CARTER, J. Before the Court for decision are Plaintiffs, Michael Dubis, et al. (Plaintiffs or Retirees), and Defendants', Town of East Greenwich, et al. (collectively, Defendants), cross-Motions for Summary Judgment pursuant to Super. R. Civ. P. 56. Plaintiffs seek a declaration

that the Town of East Greenwich (Town) acted unlawfully and in derogation of Plaintiffs' constitutional rights when it unilaterally altered health insurance benefits Plaintiffs secured in accordance with certain collective bargaining agreements (CBAs) under which they retired. Plaintiffs also seek a permanent injunction enjoining Defendants from depriving Plaintiffs of their vested rights to receive health insurance under the CBAs under which each individual Retiree retired. Defendants also move for summary judgment, arguing that Plaintiffs do not have a vested right to specific health insurance benefits. The Court exercises jurisdiction pursuant to G.L. 1956 §§ 8-2-14 and 9-30-1.

I

Facts and Travel

A

Parties

The Plaintiffs are former members of the East Greenwich Fire District who retired on or after January 1, 1995, their spouses, or former spouses of the Retirees.¹

The current dispute between the Retirees and Defendants concerns multiple CBAs ranging from 1993–2016. Between 1995 and 2013 the members of the East Greenwich Fire District (the District) operated under several CBAs. Agreed-Upon Statement of Facts at ¶ 13. The East Greenwich Firefighters Association, Local 3328 (the Association) negotiated and entered into several CBAs with the District. *Id.* at ¶ 11.

In 2013, pursuant to an Act of the General Assembly, the District ceased to exist and the Town assumed responsibility and liability for all obligations of the District, including retiree benefits. *Id.* at ¶ 15.

¹ Pursuant to the terms of the CBA, the spouses and former spouses of the Retirees are intended third-party beneficiaries. *See* Agreed-Upon Statement of Facts at ¶ 14.

On September 16, 2013, the East Greenwich Town Council ratified the current CBA (the Current CBA), which includes the changes in healthcare coverage that Plaintiffs now challenge. Id. at ¶ 50. The effective date of the change in the healthcare coverage was July 1, 2014. Id. at ¶ 51.

The Retirees were notified of the change in the benefits by letter dated November 7, 2013. Id. at ¶ 52. Subsequent correspondence dated March 6, 2014 advised the Retirees of a March 14, 2014 meeting to discuss the changes. Id. at ¶ 53. At the March 14, 2014 meeting, the Fire Chief, Russell McGillivray, informed the Retirees that the Town had negotiated a new CBA with the Association. Id. at ¶ 56. Fire Chief McGillivray explained that as a result of the negotiations, the Retirees would be receiving the same benefits as the current active employees. Id. At the March 14, 2014 meeting, the Retirees were given information outlining the impending change in their healthcare benefits. Id. at ¶ 57. Specifically, the handouts given to the Retirees detailed a Health Reimbursement Arrangement (HRA). Id. at ¶ 58.

B

The CBAs

The CBAs provided that Retirees would receive their choice of the same medical and dental coverage offered to the active employees (Actives). Id. at ¶¶ 17, 21, 25, 29, 34, 37, 40, and 49.

Specifically, Section 32-2 of the 1993–1996 CBA, 1996–1999 CBA, 1999–2002 CBA, 2002–2005 CBA, 2005–2009 CBA, 2008–2010 CBA, 2010–2013 CBA, and 2013–2016 CBA provides that:

“In addition, employees who retire with twenty (20) or more years of service credits at any age up to age 65, shall receive their choice of the same medical and dental coverage which is offered to active employees subject to the provisions of section 30 of this agreement

entitled ‘medical and dental’. In no event shall medical and dental coverage for the spouse of a retired employee continue once said surviving spouse attains the age of sixty-five (65).” Id. at ¶¶ 17, 21, 25, 29, 34, 37, 40, and 49 (emphasis added).

Although the guarantee of the same medical and dental coverage remained throughout the years, the various types of health insurance provided by the Town fluctuated.

For instance, Section 30-2 of the 1993–1996 CBA and the 1996–1999 CBA states, in pertinent part:

“Each employee shall be given the opportunity to select a primary medical plan annually. The following medical plans are offered by the District, however, the District shall pay only an amount equal to the Blue Cross/Blue Shield premium, and the employee shall pay any amount in excess of the Blue Cross/Blue Shield plan.

“a. Blue Cross/Blue Shield

“b. Healthmate

“c. Rhode Island H.M.O

“d. United Health Plans of N.E.

“e. Harvard Comm. Health Plan of N.E. (formerly RIGHA)[.]” Id. at ¶¶ 19, 23 (emphasis added).

With respect to the 1999–2002 CBA, a provision was added that specified that if another insurance carrier was chosen by the District, the Retiree would receive benefits that were at least equal to the previous healthcare plan. Following this change, Section 30-2 of the 1999–2002 CBA states, in pertinent part:

“Each employee shall be given the opportunity to select a primary medical plan annually. The following medical plans are offered by the District, however, the District shall pay only an amount equal to the Blue Cross/Blue Shield premium, and the employee shall pay any amount in excess of the basic cost of the Blue Cross/Blue Shield plan. Effective June 1, 1999 through May 1, 2002 if the District desires to insure such benefits with another insurance carrier, the benefits, which are listed in Exhibit A attached hereto, will be at least equal to those provided by the foregoing plan. In the event the premium from another carrier is less than that charged by Blue Cross/Blue Shield, the District may pay the lower amount.

“a. Blue Cross/Blue Shield

- “b. Healthmate
- “c. Rhode Island H.M.O.
- “d. United Health Plans of N.E.
- “e. Harvard Comm. Health Plan of N.E. (formerly RIGHA)[.]” Id. at ¶ 27 (emphasis added).

In the 2002–2005 CBA, a sentence was added that explicitly stated that “retirees shall be eligible for the same coverage levels that they were receiving prior to [the 2002–2005 CBA].”

Following this change, Section 30-2 states,

“Each employee shall be given the opportunity to select a primary medical plan annually. The following medical plans are offered by the District, however, the District shall pay only an amount equal to the Blue Cross/Blue Shield premium, Health Mate Coast to Coast with preferred Rx script, and the employee shall pay any amount in excess of the basic cost of the Blue Cross/Blue Shield plan. If the District desires to insure such benefits with another insurance carrier, the benefits, which are listed in Exhibit A attached hereto, will be at least equal to those provided by the foregoing plan. In the event the premium from another carrier is less than that charged by Blue Cross/Blue Shield, the District will pay the lower amount. Notwithstanding the foregoing, the employees and retirees shall be eligible for the same coverage levels that they were receiving prior to June 1, 2002 at no additional cost.

- “a. Blue Cross/Blue Shield Health Mate/Coast to Coast with Preferred Rx
- “b. Blue Cross/Blue Shield Classic
- “c. United Health Plans of N.E.” Id. at ¶ 31 (emphasis added).

Notably, the 2002–2005 CBA was the last agreement in which the District actually offered Association members their choice of carriers. Id. at ¶ 32.

The 2005–2009 CBA and the 2008–2010 CBA contained identical language in their respective Section 30 that still provided health benefits at the same coverage levels they had been receiving previously:

“The District shall provide all employees with a primary medical plan annually. The benefits provided under said plan shall meet, exceed or be equivalent to those benefits listed in Exhibit A, attached hereto. Notwithstanding the foregoing, employees and

retirees shall be eligible for the same coverage levels they were receiving prior to June 1, 2002 at no additional cost.” Id. at ¶¶ 35, 38.

However, the 2010–2013 CBA drastically changed its Section 30. Id. at ¶ 41. This CBA provided that the District could change to a higher deductible healthcare plan so long as it provided pre-funded debit cards to help cover the deductible. Id. Following this change, the health benefits provision stated:

“The District shall provide all employees with a primary medical plan annually. The benefits provided under said plan shall meet, exceed or be equivalent to those benefits listed in Exhibit A, attached hereto except that the District may provide a medical plan with higher deductibles (as in the plan in effect as of July 1, 2010) so long as the District annually issues Employees pre-funded debit cards in the sum of \$1,000.00 for employees receiving family plans of coverage and \$500.00 for employees receiving single plans of coverage. Also, to the extent any primary medical plan with higher deductibles has co-pay requirements for covered services which are higher than those co-pays on Exhibit A, the District, upon receipt of proper evidence from an Employee who has incurred a higher co-payment for covered services, shall reimburse the Employee for the co-pay amount in excess of the amount shown on Exhibit A. The District shall not be responsible for Employee misuse of the pre-funded debit cards.” Id. at ¶ 41 (emphasis added).

The Current CBA is in place from July 1, 2013–June 30, 2016. The Current CBA shifts the healthcare benefits from the previous healthcare plan to a higher deductible plan. Id. at ¶ 48.

Section 30-9 of the Current CBA details this change:

“Effective July 1, 2014, the Town of East Greenwich agrees to carry and pay for accidental health insurance policy covering each regular member of the Fire Department and his or her own family by providing in amount no less than that provided by Blue Cross Blue Solutions for HSA \$2,000/\$4,000 or Blue Cross Healthcare HDHP for HRA \$2,000/\$4,000.” Id. at ¶ 48.

C

Fire Chief CBAs

Plaintiff Retiree Sean Brennan entered into a contract on or about September 18, 1996 for employment with the District for the position of Fire Chief of the Town (the Brennan Agreement). Id. at ¶ 42. Section 4-2 of the Brennan Agreement states:

“The Fire Chief shall be offered the same health benefits as the other employees of the Fire District. In the event that the Chief is entitled to receive the equivalent health benefits from a third-party, then the Chief may opt to receive an annual \$1,500.00 payment, and the District shall have no obligation to provide such coverage.” Id. at ¶ 43.

Plaintiff Retiree Peter Henrikson entered into a separation agreement on or about September 25, 2013 regarding his position as Fire Chief for the Town (Henrikson Agreement). Id. at ¶ 44. Section 2 of the Henrikson Agreement states:

“Nothing in this agreement shall alter or affect Employee’s vested rights in retirement benefits including health care and pension benefits, to the extent Employee has any such vested rights or accrued amounts owed. Specifically, Employee shall retain the benefits described in section 4, paragraph 5 of his contract of employment with the East Greenwich Fire District dated March 24, 2011.” Id. at ¶ 45.

Mr. Henrikson’s prior employment contract with the Town, dated March 24, 2011, states:

“Upon separation from employment with the Fire District, the Chief shall be afforded the same Retired Employee Benefits set forth in Section 32 of the Personnel Policies and Contractual Agreement then in effect between the Fire District and the IAFF Local. The Chief shall not be entitled to any additional retiree benefits which may be added to subsequent collective bargaining agreements or changes to Section 32. The parties hereto acknowledge that the Chief had 24.8 years of service credits as of July 22, 2010.” Id. at ¶ 46.²

² The language in the Brennan Agreement and the Henrikson Agreement is substantially similar to that of the CBAs; both the Brennan Agreement and the Henrikson Agreement provide that the healthcare benefits are to be the “same” as those of other fire department employees.

D

Summary of Health Benefits Provided Under Past CBAs

The CBAs from 1993–2005 explicitly provided a choice of healthcare plan, including the HealthMate Coast to Coast plan. Id. at ¶¶ 19, 23, 27, and 31. The exact name of the offered plan differs from “Healthmate” to “Blue Cross/Blue Shield Health Mate/Coast to Coast with Preferred Rx.” For clarity and consistency, the Court will refer to the plan as the HealthMate Coast to Coast plan.

CBAs from 2005–2013 did not offer a choice of healthcare plans, rather they provided retirees with the HealthMate Coast to Coast plan. See, e.g., Pl. Susan Hawksley’s Answers to Interrogs. at 2. All of the interrogatories that Plaintiffs provided to the Court indicate that the responding Plaintiff retired under a CBA that provided the HealthMate Coast to Coast plan. See Interrogs. of Pls. Susan Hawksley, Lori M. Gardiner, Kristen Cusick, E. Stefan Coutoulakis, Robert Vespia, Michelle Vespia, Michael Dubis, James Lorensen, David Miller, and Rodney Harvey.

Insured individuals under the HealthMate Coast to Coast healthcare plan have a co-pay and a \$500 deductible for both in and out-of-network costs. Robert Knowles Dep. at Ex. 2, Nov. 7, 2014. The following chart summarizes the relevant coverage.

Additionally, neither party argues that Plaintiffs Brennan and Henrikson should be treated differently than the other Plaintiffs. Accordingly, this Court will treat their claims as identical to those of other Plaintiffs.

Service	HealthMate Coast to Coast In-Network	HealthMate Coast to Coast Out-of-Network
Adult Preventive Care	\$0	\$15 plus 20% after deductible
Pediatric Preventive care	\$0	\$15 plus 20% after deductible
Immunizations	\$0	\$15 plus 20% after deductible
Lab Services, Machine Tests, and X-rays	\$0	20% after deductible
Primary Care Physicians Office Visit	\$15	\$15 plus 20% after deductible
Specialist Office Visit	\$15	\$15 plus 20% after deductible
Outpatient Medical/Surgical Care	0% after deductible	20% after deductible
Outpatient Lab Services, Machine Tests, and X-rays	0%	20% after deductible
Inpatient Hospital Services	0% after deductible	20% after deductible
Mental Health Inpatient Services	0% after deductible	20% after deductible
Urgent Care	\$15	\$15 plus 20% after deductible
Hospital Emergency Room Care	\$75	\$75
Ambulance Services	\$50	\$50
Durable Medical Equipment	20% after deductible	20% after deductible
Physical/Occupational Therapy	20% after deductible (no limit on number of visits per year)	20% after deductible

Id.

E

Changes to Health Benefits Under the Current CBA

The Current CBA instituted a number of changes to the healthcare benefits for Actives and Retirees. Agreed-Upon Statement of Facts at ¶ 48. The Current CBA gave the Actives a Health Savings Account (HSA) and the Retirees a Health Reimbursement Account (HRA) (collectively the New Healthcare Plans). Robert Knowles Dep. 11:17–12:3. Both the HSA and the HRA are high deductible plans set at \$2000 for an individual and \$4000 for a family. Id. In both plans, all medical services are applied to the deductible, and the deductible applies to all services covered by the plan. Id. at 13:22–23, 14:17–19. When the deductible is met, the rest of the costs for health care are covered entirely by the insurer. Russell McGillivray Dep. 13:24–14:1, Apr. 13, 2015.

The funding mechanisms for the HSA and the HRA, however, are different. The HSA is provided to Actives and is owned by the employee. Knowles Dep. 12:15–19. The Town pre-pays the entire deductible for each Actives' plan (\$2000 for an individual and \$4000 for a family plan) and then the Active is responsible for reimbursing the Town for half of the applicable deductible, taken out of an Active's paycheck through pre-tax weekly payroll deductions. McGillivray Dep. 13:10–16. If there is any unused money left over at the end of the fiscal year, it becomes the property of the employee who funded one-half of the deductible. Id. at 14:4–8.

The HRA is provided to Retirees and is owned by the Town. Knowles Dep. 12:18–19. The Town here pre-pays half of the deductible and puts those funds on a debit card for the Retiree to spend on qualified services that apply to the deductible. Id. at 11:24–12:3. Because Retirees are not on the Town's payroll, no weekly payments are made by the Retirees. Id. The money on the debit card is spent tax free. Id. at 12:24–13:6. However, unlike the HSA, if there

are any funds left at the end of the fiscal year for the HRA, those funds are returned to the Town. McGillivray Dep. 15:3–16:22.

Both Actives and Retirees faced a number of changes in their health benefits when they were placed on their HSAs and HRAs, respectively. Knowles Dep. 13:13–15. The New Healthcare Plans have a higher deductible than the prior healthcare plans. Id. at 13:18–24. The prior healthcare plan had a \$500 deductible for both in-network and out-of-network services that accumulated separately, as well as office visit co-pays. Id. at 13:25–14:12. The New Healthcare Plans have a much higher \$2000 or \$4000 deductible (depending on individual versus family plan) for in-network services and a \$12,000 or \$24,000 deductible (depending on individual versus family plan) for out-of-network services. Id. at 14:13–15:4.

Additionally, the cost of various medical services changed. The following chart illustrates the relevant differences.

Service	HealthMate In-Network	New Healthcare Plan In-Network	HealthMate Out-of-Network	New Healthcare Plan Out-of-Network
Adult Preventive Care	\$0	\$0	\$15 plus 20% after deductible	40% per visit after deductible
Pediatric Preventive care	\$0	\$0	\$15 plus 20% after deductible	40% per visit after deductible
Immunizations	\$0	\$0	\$15 plus 20% after deductible	40% per visit after deductible
Lab Services, Machine Tests, and X-rays	\$0	\$0	20% after deductible	40% per visit after deductible
Primary Care Physicians Office Visit	\$15	0% per visit after deductible	\$15 plus 20% after deductible	40% per visit after deductible
Specialist Office Visit	\$15	0% per visit after deductible	\$15 plus 20% after deductible	40% per visit after deductible
Outpatient Medical/Surgical Care	0% after deductible	0% per visit after deductible	20% after deductible	40% per visit after deductible
Outpatient Lab Services, Machine Tests, and X-rays	0%	0% per visit after deductible	20% after deductible	40% per visit after deductible
Inpatient Hospital Services	0% after deductible	0% per visit after deductible	20% after deductible	40% per visit after deductible
Mental Health Inpatient Services	0% after deductible	0% per visit after deductible	20% after deductible	40% per visit after deductible
Urgent Care	\$15	0% per visit after deductible	\$15 plus 20% after deductible	0% per visit after deductible
Hospital Emergency Room Care	\$75	0% per visit after deductible	\$75	0% per visit after deductible
Ambulance Services	\$50	0% per occurrence after deductible	\$50	0% per occurrence after deductible
Durable Medical Equipment	20% after deductible	0% per service/device after deductible	20% after deductible	40% per service/device after deductible
Physical/Occupational Therapy	20% after deductible	0% per visit after deductible (limit 30 visits per year)	20% after deductible	40% per visit after deductible (limit 30 visits per year)

Id. at Exs. 2, 4.

According to Plaintiffs, some medications that were covered under the prior healthcare plan and required no co-pay are now financed by the New Healthcare Plans' deductible. See Pl. Michael Dubis's Answers to Interrogs. at 6. Also, according to Plaintiffs, certain treatments which were not limited under the prior healthcare plan are limited to a set number per year under the New Healthcare Plans. See Pl. Lori Gardiner's Answers to Interrogs. at 6.

F

Impact of the HRA on Plaintiffs

According to Plaintiffs, implementation of the HRAs has not progressed smoothly. A number of Plaintiffs live out of state and have experienced difficulty utilizing the provided debit card to cover medical expenses. See, e.g., Pl. James Lorensen's Answers to Interrogs. at 6. This includes increased out-of-pocket costs where medical providers will not accept the debit card, the need to change pharmacies, and reimbursement paperwork. See id.; see Pl. Rodney Harvey's Answers to Interrogs. at 6.

Plaintiffs state that the increased healthcare costs have led to dire situations. Plaintiff Roland Vespia testified that he stopped taking certain prescription medication in order to purchase medications for his wife. See Pl. Michelle Vespia's Answers to Interrogs. at 6. In addition, limitations on the number of physical and/or occupational therapy visits per year have caused problems for some Plaintiffs suffering from illnesses that require physical and/or occupational therapies. See, e.g., Pl. Lori Gardiner's Answers to Interrogs. at 6.

As a result of the change in healthcare plans, the Town has realized significant savings. One estimate put the Town's total savings in excess of \$400,000. See Resp. of Def. to Pls.' Mot. for Summ. J. at 6.

G

The Filing of the Instant Motion

On July 1, 2014, Plaintiffs filed the instant Complaint seeking a declaratory judgment that the Town's alteration of the Retiree's healthcare benefits violates the following constitutional provisions: the Due Process Clause of the Rhode Island and United States Constitutions; the Takings Clause of the Rhode Island and United States Constitutions; and the Contract Clause of the Rhode Island and United States Constitutions. Compl. at Counts I–VII. Plaintiffs also allege violations of 42 U.S.C. § 1983 and allege that the healthcare changes are estopped by promissory estoppel. Id. at Counts VIII, X. Finally, Plaintiffs seek a permanent injunction enjoining the Town from depriving Plaintiffs of their vested rights to receive healthcare benefits in accordance with the CBAs under which each individual Retiree retired. See id. at Count IX; see also Pls.' Mem. in Supp. of Mot. for Summ. J.

Following discovery, Plaintiffs filed the instant Motion for Summary Judgment seeking a declaratory judgment that the Town's actions were unlawful and a permanent injunction enjoining the Town from changing their healthcare plans. Defendants responded by filing a cross -Motion for Summary Judgment. A hearing on the motions was held on December 14, 2015.

II

Standard of Review

Summary judgment is appropriate where, after “viewing the facts and all reasonable inferences therefrom in the light most favorable to the nonmoving party, the [C]ourt determines that there are no issues of material fact in dispute, and the moving party is entitled to judgment as a matter of law.” Pichardo v. Stevens, 55 A.3d 762, 765 (R.I. 2012) (quoting Delta Airlines, Inc.

v. Neary, 785 A.2d 1123, 1126 (R.I. 2001)). The trial justice makes this determination by looking to “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any[.]” Lavoie v. N.E. Knitting, Inc., 918 A.2d 225, 227–28 (R.I. 2007) (quoting Super. R. Civ. P. 56(c)). A trial justice must refrain from placing weight or credibility on the evidence and instead simply determine whether “there are any issues involving material facts.” Steinberg v. State, 427 A.2d 338, 340 (R.I. 1981) (citing Indus. Nat’l Bank v. Peloso, R.I., 121 R.I. 305, 307, 397 A.2d 1312, 1313 (1979)). In ruling on a motion for summary judgment, the trial justice must be mindful that “[s]ummary judgment is a drastic remedy, and a motion for summary judgment should be dealt with cautiously.” NV One, LLC v. Potomac Realty Capital, LLC, 84 A.3d 800, 805 (R.I. 2014) (quoting Carreiro v. Tobin, 66 A.3d 820, 822 (R.I. 2013)).

“If there are no issues of material fact in dispute, the trial justice must then determine whether the moving party is entitled to judgment under applicable law.” Ferreira v. Strack, 636 A.2d 682, 684 (R.I. 1994) (citing Alfano v. Landers, 585 A.2d 651, 652 (R.I. 1991)). Indeed, “[s]ummary judgment is proper when there is no ambiguity as a matter of law It is the burden of the party opposing a motion for summary judgment to assert facts that raise a genuine issue to be resolved.” W. Mass. Blasting Corp. v. Metro. and Cas. Ins. Co., 783 A.2d 398, 401 (R.I. 2001) (quoting Buonanno v. Colmar Belting Co., 733 A.2d 712, 715 (R.I. 1999)) (internal quotations omitted).

The Uniform Declaratory Judgments Act “grants broad jurisdiction to [this Court] to ‘declare rights, status, and other legal relations whether or not further relief is or could be claimed.’” Tucker Estates Charlestown, LLC v. Town of Charlestown, 964 A.2d 1138, 1140 (R.I. 2009) (quoting G.L. 1956 § 9-30-1). This Court’s decision to grant declaratory relief is

discretionary. See Sullivan v. Chafee, 703 A.2d 748, 751 (R.I. 1997) (citing Woonsocket Teachers' Guild Local Union 951, AFT v. Woonsocket Sch. Comm., 694 A.2d 727, 729 (R.I. 1997)). A declaratory judgment is only appropriate in the presence of an actual justiciable controversy. See Sullivan, 703 A.2d at 751. A plaintiff is entitled to declaratory relief if they have “a personal stake in the outcome of the controversy and . . . an entitlement to actual and articulable relief.” McKenna v. Williams, 874 A.2d 217, 227 (R.I. 2005).

The decision to grant or deny injunctive relief rests within the sound discretion of the trial justice. See Cullen v. Tarini, 15 A.3d 968, 981 (R.I. 2011). The moving party must “demonstrate that it stands to suffer some irreparable harm that is presently threatened or imminent and for which no adequate legal remedy exists to restore that plaintiff to its rightful position.” Nye v. Brousseau, 992 A.2d 1002, 1010 (R.I. 2010) (quoting Nat'l Lumber & Bldg. Materials Co. v. Langevin, 798 A.2d 429, 434 (R.I. 2002)). “Irreparable injury must be either ‘presently threatened’ or ‘imminent’; injuries that are prospective only and might never occur cannot form the basis of a permanent injunction.” Nat'l Lumber & Bldg. Materials Co., 798 A.2d at 434 (quoting R.I. Tpk. & Bridge Auth. v. Cohen, 433 A.2d 179, 182 (R.I. 1981)).

In determining whether or not to issue permanent injunctive relief, the Court must “survey the facts and apply the traditional tests for equitable relief, [including] balancing the equities, weighing the hardships to either side, and examining the practicality of imposing the desired relief.” R.I. Tpk. & Bridge Auth., 433 A.2d at 182. Therefore, to grant a permanent injunction, the Court must find (1) the plaintiff demonstrates success on the merits; (2) the plaintiff will suffer irreparable harm if the injunction is not granted; and (3) a balance of the equities and hardships, including the public interest, weighs in favor of the plaintiffs. See Nat'l Lumber & Bldg. Material Co., 798 A.2d at 434; see also Nye, 992 A.2d at 1010; see also Winter

v. Natural Res. Def. Council, Inc., 555 U.S. 7, 32 (2008) (noting that permanent injunctions require a showing of actual success on the merits). Although Plaintiffs request a mandatory permanent injunction, as opposed to a prohibitory permanent injunction, the standard is not altered. See Stanley v. Univ. of S. Cal., 13 F.3d 1313, 1320 (9th Cir. 1994) (noting that a prohibitory injunction preserves the status quo whereas a mandatory injunction requires the opposing party to affirmatively do something); see also Harvard Law Review Association, Types of Injunctions, 78 Har. L. Rev. 1055 (1965) (noting that the distinction between mandatory and prohibitory injunctions only matters for preliminary, not permanent, injunctions); see also Rose Nulman Park Found. ex rel. Nulman v. Four Twenty Corp., 93 A.3d 25 (R.I. 2014) (granting a mandatory injunction using the permanent injunction standard of review).

III

Analysis

A

Due Process, Takings, Contract Clause, 42 U.S.C. § 1983

Plaintiffs argue that the Town's unilateral act of altering the health insurance coverage by requiring Plaintiffs to enroll in an HRA deprived Plaintiffs of their vested rights to health benefits, resulting in four violations: (1) a violation of substantive due process; (2) a taking clause violation; (3) a contract clause violation; and (4) a violation of 42 U.S.C. §1983. See Compl. Counts II–VIII. As described by Plaintiffs in the Complaint, each of these four claims is predicated on the existence and definition of vested rights created by the CBAs under which each Retiree retired. Therefore, in order for the Court to properly rule on any of these four claims, the precise contours of the alleged vested right and the impact of the alleged deprivation of the vested right must be determined.

As an initial matter, the Court recognizes that our Supreme Court’s decision in Arena is controlling here. See Arena v. City of Providence, 919 A.2d 379, 392 (R.I. 2007). There, the City of Providence applied new, less generous cost of living adjustment (COLA) calculations to police and fire department employees who had retired before the effective dates of the ordinances providing the new calculations. Id. at 384. Our Supreme Court considered whether the COLA benefits were vested pension benefits or a gratuitous benefit “separate from the pension” Id. at 392. The Arena Court held that the plaintiff had a vested right to a specific five percent COLA provided by the ordinance. Id. at 394. The Supreme Court noted that “in Rhode Island, pension benefits vest once an employee honorably and faithfully meets the applicable pension statute’s requirements.” Id. at 393. The Supreme Court “look[ed] to the applicable pension ordinance,” and noted that it was “a municipality’s duty to carefully craft an ordinance granting a pension benefit so that it is clear whether the benefit is gratuitous or vested” Id. at 393–94.

Arena’s holding compels the conclusion in the instant matter that the specific health benefits are a vested right. See id. at 394 (noting that benefits negotiated by collective bargaining are more likely to be vested benefits); see also Local 369 Util. Workers v. NSTAR Elec. and Gas Corp., 317 F. Supp. 2d 69, 75–76 (D. Mass 2004) (“It is certainly possible for an employer to ‘oblige itself contractually to maintain benefits at a certain level’”) (quoting Vasseur v. Halliburton Co., 950 F.2d 1002, 1006 (5th Cir. 1992)). The CBAs from 1993–present have consistently included a stated level of health insurance benefits. See Agreed-Upon Statement of Facts at ¶¶ 17, 21, 25, 29, 34, 37, and 40 (specifying that Retirees “shall receive their choice of the same medical and dental coverage which is offered to active employees subject to the provisions of section 30 of this agreement”) (emphasis added). However, based on the

record before it, the Court cannot determine whether the health benefits remain the same or have changed. There are genuine issues of material fact reaching the core of the impact of the alleged deprivation that preclude the issuance of summary judgment.

First, there is a genuine issue of material fact as to the differences, if any, between the HRA provided to Retirees and the HSA provided to Actives. Plaintiffs maintain that the HRA offered to Retirees “is markedly different, and less favorable, than the [HSA] plan offered to active employees” Pls.’ Mem. in Supp. of Mot. for Summ. J. at 11. Plaintiffs focus on two key differences: (1) the HSA’s entire deductible is pre-funded and available to Actives (and then subsequently half paid back by the Active through payroll deductions), whereas only half of the HRA’s deductible is provided to Retirees who must provide the other half of the deductible out-of-pocket; and (2) if an Active does not use the entirety of their pre-funded deductible, the remaining funds roll over to the subsequent year, whereas if a Retiree does not use the entirety of their half pre-funded deductible, the funds return to the Town. See Pl. Susan Hawksley’s Answers to Interrogs. at 3–4. In contrast, Defendants maintain that there is no difference between the HRA offered to Retirees and the HSA offered to Actives. Defendants contend that “[t]he Town is upholding its contractual obligations by providing retirees with the benefit plan available to current active employees.” Resp. of Def. to Pls.’ Mot. for Summ. J. at 6; see also Defs.’ Mem. of Law at 5 (“It is submitted that the benefit plan [offered to Retirees] is no different [than the benefit plan offered to Actives], and the only difference is the funding which requires a single retiree to contribute up to \$1,000.00 and a retiree family to contribute up to \$2,000.00, all depending upon the level of [medical] spending.”).

Second, there is a genuine issue of material fact as to the precise coverage the HRA provides. Plaintiffs contend that the HRA is substantially different from previous healthcare

plans in terms of the services it covers. Plaintiff Lori M. Gardiner maintains that the HRA limits the number of physical and occupational therapy visits to thirty per year, a limit that the previous healthcare plan did not contain. See Pl. Lori M. Gardiner’s Answers to Interrogs. at 6. Plaintiff Michael Dubis contends that the HRA plan does not cover medication that was covered under the previous healthcare plan. See Pl. Michael Dubis’ Answers to Interrogs. at 6. Conversely, Defendants maintain that “the actual health insurance coverage afforded to the plaintiffs did not change” and that the coverage is the same as active employees. Defs.’ Mem. of Law at 3.

These genuine issues of material fact go to the essence of Plaintiffs’ arguments on substantive due process, takings clause, contract clause, and 42 U.S.C. § 1983. See Moore’s Federal Practice § 56.23[1] (3d 2013) (“[A] fact is ‘material’ if it might affect the outcome of the suit under the substantive law applicable to the case.”). Whether or not the HRA and HSA are identical in coverage is an issue that determines whether the dimensions of the vested right have been changed, as each relevant CBA provides that Retirees “shall receive their choice of the same medical and dental coverage which is offered to active employees” Agreed-Upon Statement of Facts at ¶¶ 17, 21, 25, 29, 34, 37, 40, and 49 (emphasis added). The Court cannot determine if the Retirees are actually getting the “same medical and dental coverage which is offered to active employees” without weighing the two factual positions offered by the parties. Id. Additionally, whether or not the HRA provides the same coverage as the previous healthcare plan is an issue that determines the extent of the alleged deprivation of the vested right. Again, the Court cannot define the extent of the alleged deprivation of the vested rights unless it weighs the evidence offered by the parties. At the summary judgment stage, such weighing of evidence is impermissible. See Pichardo, 55 A.3d at 766 (“[T]he motion justice ‘must refrain from weighing the evidence or passing upon issues of credibility.’”) (quoting Doe

v. Gelineau, 732 A.2d 43, 48 (R.I. 1999)); see also Plainfield Pike Gas & Convenience, LLC v. 1889 Plainfield Pike Realty Corp., 994 A.2d 54, 58 (R.I. 2010) (“The purpose of the summary-judgment procedure is to identify disputed issues of fact necessitating trial, [and] not to resolve such issues.”) (quoting Rotelli v. Catanzaro, 686 A.2d 91, 93 (R.I. 1996)). To assess credibility and reach beyond the record before the Court would be error. See Steinberg, 427 A.2d at 340. Additionally, the Court is mindful that summary judgment is a drastic remedy and that it should be applied cautiously. See NV One, LLC, 84 A.3d at 805. The Court is therefore satisfied that these genuine issues of material fact preclude the granting of summary judgment on all claims that are predicated on the alleged vested rights. Accordingly, the Court denies both Plaintiffs and Defendants’ Motions for Summary Judgment with respect to Plaintiffs’ substantive due process, takings clause, contract clause, and 42 U.S.C. § 1983 claims.

B

Promissory Estoppel

Plaintiffs’ remaining substantive claim—based on promissory estoppel—does not involve the definition of a vested right. See Compl. Count X. Instead, as an equitable claim, Plaintiffs’ promissory estoppel claim involves a determination of Plaintiffs’ reasonable reliance. The genuine issues of material fact therefore do not preclude the Court from addressing this claim and the Court can decide the issue as a matter of law.

Plaintiffs maintain that the Town can be held liable for changes to the healthcare benefits via the doctrine of promissory estoppel. Plaintiffs contend that the Retirees reasonably relied on the promise of healthcare benefits in accordance with the CBAs under which the individual Retiree retired and that injustice would result if the Town’s promises were not upheld.

Defendants respond that it is unreasonable to assume lifetime entitlements to specific benefits and therefore Plaintiffs do not have a viable claim for promissory estoppel.

Promissory estoppel is “[a] promise which the promisor should reasonably expect to induce action or forbearance on the part of the promisee or a third person and which does induce such action or forbearance, [and thus] is binding if injustice can be avoided only by enforcement of the promise.” Alix v. Alix, 497 A.2d 18, 21 (R.I. 1985) (quoting Restatement (Second) Contracts § 90 at 242 (1981)). However, “notions of promissory estoppel that are routinely applied in private contractual contexts are ill-suited to public-contract-rights analysis.” D. Corso Excavating, Inc. v. Poulin, 747 A.2d 994, 1001 (R.I. 2000) (quoting Retired Adjunct Professors of the State of R.I. v. Almond, 690 A.2d 1342, 1346 (R.I. 1997)). Indeed, “courts have consistently refused to give effect to government-fostered expectations that, had they arisen in the private sector, might well have formed the basis of a contract or an estoppel.” Retired Adjunct Professors, 690 A.2d at 1346 (quoting Pineman v. Fallon, 662 F. Supp. 1311, 1316 (D. Conn. 1987), aff’d, 842 F.2d 598 (2d Cir.), cert. denied, 488 U.S. 824 (1988)). In Rhode Island it is well settled that promissory estoppel claims cannot be pursued in public pension cases. See id.; see also Romano v. Ret. Bd. of Emps.’ Ret. Sys. of R.I., 767 A.2d 35, 39 (R.I. 2001). Plaintiffs provide no reasons for this Court to depart from well-established Rhode Island precedent, and the Court declines the invitation to do so.

Moreover, a claim for promissory estoppel cannot prevail where there is a contract. See 31 C.J.S. Estoppel and Waiver § 116 (“Promissory estoppel applies only where there is no contract.”). Our Supreme Court has noted that promissory estoppel “is applicable in a situation in which consideration is lacking in a contract” Filippi v. Filippi, 818 A.2d 608, 626 (R.I. 2003) (quoting Alix, 497 A.2d at 21). “[T]he doctrine of promissory estoppel is invoked ‘as a

substitute for a consideration” Hayes v. Plantations Steel Co., 438 A.2d 1091, 1096 (R.I. 1982) (quoting E. Providence Credit Union v. Geremia, 103 R.I. 597, 601, 239 A.2d 725, 727 (1968)). Here, both parties agree that the relevant CBAs are contracts. See also Collective Bargaining Agreement, Black’s Law Dictionary (10th ed. 2014) (“A contract between an employer and a labor union regulating employment conditions, wages, benefits, and grievances.”) (emphasis added). The Court is therefore satisfied that Plaintiffs’ promissory estoppel claims fail and Defendants are entitled to judgment as a matter of law. See Ferreira, 636 A.2d at 684. As such, the Court grants Defendants’ Motion for Summary Judgment and denies Plaintiffs’ Motion for Summary Judgment on Plaintiffs’ promissory estoppel claim listed in Count X of the Complaint.

C

Permanent Injunction

Having denied Plaintiffs’ Motion for Summary Judgment on Plaintiffs’ substantive due process, takings clause, contract clause, 42 U.S.C. § 1983, and promissory estoppel claims, the Court does not find that Plaintiffs have demonstrated actual success on the merits of any claim. See Nat’l Lumber & Bldg. Materials Co., 798 A.2d at 434 (“A party seeking an injunction must also demonstrate likely success on the merits”). Accordingly, Plaintiffs’ request for a permanent injunction is denied.

IV

Conclusion

Based on the foregoing, Plaintiffs’ Motion for Summary Judgment is denied, and Defendants’ Motion for Summary Judgment is granted in part and denied in part. Counsel shall submit appropriate order for entry.



RHODE ISLAND SUPERIOR COURT

Decision Addendum Sheet

TITLE OF CASE: **Dubis v. Town of East Greenwich, et al.**

CASE NO: **KC-2014-0688**

COURT: **Kent County Superior Court**

DATE DECISION FILED: **February 11, 2016**

JUSTICE/MAGISTRATE: **Taft-Carter, J.**

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