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Taft-Hartley Report

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New Republican Bill Could Cripple NLRB

On September 16, 2014, Republican senators Mitch McConnell (R-Kentucky) and Lamar Alexander (R-Tennessee) introduced a Senate bill that would change the composition of the National Labor Relations Board to require an even number of Democrat and Republican board members. The NLRB currently has five board members, three Democrats and two Republicans. McConnell's and Alexander's bill, titled the "National Labor Relations Board Reform Act," would add a sixth board member and require the board to consist of three Republicans and three Democrats.

Senator Alexander stated that the purpose of the bill was very simple, to change the NLRB from a partisan advocate to a neutral umpire. However, many advocates for organized labor feel that the reform bill is nothing more than a blatant attempt to render the NLRB useless. Under the bill, all decisions of the board would require the agreement of at least four board members. This means that the three democratic appointees would need at least one republican vote, and vice-versa, in order for the board to act. Given the current climate in Washington, this requirement would all but guarantee that most major labor issues would get stuck in permanent partisan gridlock. This is almost certainly the desired result for the two republican sponsors of the Bill.

In addition to adding another member to the board, the bill would make several other significant changes to the NLRB's complaint process including a requirement that all unfair labor practice complaints issued by the NLRB General Counsel would be subject to review in Federal District Court. Further proceedings on any NLRB complaint would be prohibited if the challenging party could show in Federal Court that the General Counsel "does not have substantial evidence that [there has been a violation of the] Act." In addition, the NLRB would be required to act on all appeals of Administrative Law Judges decisions within one year. Funding for the NLRB would be reduced by 20 percent if the board is not able to decide 90 percent of its cases within one year during the first two-year period after the law is enacted.

At this time, the bill is unlikely to gain significant momentum given the current composition of the Democrat controlled Senate. However, changes in the composition of the Senate this November could result in the bill receiving greater consideration in the future.

Deadline for Multiemployer Plans to File for IRS Determination Letter is Approaching

Multiemployer defined benefit and defined contribution retirement plans have a January 31, 2015 filing deadline for requesting a favorable IRS Determination Letter. Although not legally required, retirement plans routinely request an IRS Determination Letter as confirmation that the plan meets the requirements for being qualified under the Internal Revenue Code. Obtaining a Determination Letter also allows a plan to utilize the remedial amendment period set up by the IRS for retroactive amendments to comply with various law changes. If the plan document is amended during the applicable remedial amendment period and the plan follows the document as approved by the IRS, the Determination Letter protects the plan against retroactive disqualification.

Under the current staggered system for requesting Determination Letters, multiemployer plans are assigned to Cycle D. The Determination Letters that multiemployer plans previously received for Cycle D expire on January 31, 2015. This means that multiemployer plans must apply for a new Determination Letter by January 31, 2015 in order to receive the protection of the remedial amendment period applicable to Cycle D.

The IRS has revised the Form 5300 for requesting a Determination Letter. The Form 5300 now requests an explanation regarding how any amendments affect the plan and greater detail on the timing and effective date of such

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amendments. These changes will help the IRS streamline its review process and identify any amendments that are not timely.

There is a short list of law changes that apply to multiemployer plans under Cycle D. In some cases the changes were already incorporated into the plan previously submitted to the IRS, such as for the Heart Act changes related to military service. Regardless of the number of changes since the last Determination Letter, each plan must be restated, the Form 5300 completed, and the whole package submitted to the IRS by the January 31, 2015 deadline.

Lost and Not Found – How to Deal with the Issue of Missing Participants

The U.S. Department of Labor (DOL), recently issued Field Assistance Bulletin 2014-01 (FAB 2014-1), which set forth guidance on how to administer the accounts of missing or unresponsive participants and beneficiaries in a terminating defined contribution plan that do not have annuity options. The stated purpose of FAB 2014-1 was to replace Field Assistance Bulletin 2004-02 (FAB 2004-02) and address technological advancements and changes that have occurred in the last ten years.

In FAB 2004-2, the DOL enumerated certain steps available to plan fiduciaries to fulfill their due diligence obligations with regards to missing participants and beneficiaries. These steps included the mandated use of an IRS letter-forwarding service where the IRS would process requests to locate retirement plan participants and beneficiaries. This service was discontinued on August 31, 2012. As a result, the IRS recommended that the plan sponsors and administrators use other methods to locate missing participants and beneficiaries, including commercial locator services, credit reporting agencies and internet search tools.[1]

The DOL then released FAB 2014-01 in an effort to update the outdated guidance in FAB 2004-2. FAB 2014-01 provides that, consistent with their obligations of prudence and loyalty, plan fiduciaries must make reasonable efforts to locate missing participants or beneficiaries so that they can implement directions on plan distributions. The DOL separates the level of due diligence requirements into two tiers based facts and circumstances, specifically the cost of further efforts and the account balance at issue.

FAB 2014-1 first sets out the minimum steps that a plan fiduciary must take regardless of the account balance. Included in these steps are certified mail, review of plan and employer records, contact of designated beneficiary and free electronic search tools. In the event that these listed steps do not find the missing participant or beneficiary, the fiduciary must make a cost and benefit analysis based on facts and circumstances. The DOL suggests the fiduciary explore the use of more expensive options such as commercial locator services, credit reporting agencies, information brokers, investigation databases where the participant balance in the account warrants such additional steps. Provided that the decision of the fiduciary is reasonable based on the facts and circumstances, the DOL will consider the due diligence requirement satisfied.

It is important to note that FAB 2014-14 specifically addresses terminating plans. However, due diligence regarding missing participants may still be a concern for non-terminating plans. Accordingly, it is important that plan fiduciaries take the following actions: (1) review existing policies to determine if updates are necessary and (2) investigate whether the establishment of a missing participant policy would be beneficial to the plan.

[1] *Missing Participants or Beneficiaries.* IRS.gov. http://www.irs.gov/Retirement-Plans/Missing-Participants-or-Beneficiaries (October 3, 2014).

D.C. Circuit Court Rules Federal Subsidies Not Authorized by ACA on Federal Exchange

The U.S. Court of Appeals for the District of Columbia Circuit recently overturned an Internal Revenue Service ("IRS") rule allowing subsidies for health insurance plans bought in Patient Protection and Affordable Care Act ("ACA") marketplaces run by the federal government. *Halbig v. Burwell*, 2014 BL 245948 (D.C. Cir. 2014). *Halbig v. Burwell* challenges whether the federal government can provide subsidies to those who purchased coverage through the ACA's federal insurance exchange.

The Court opined that Congress enacted the ACA to increase the number of Americans covered by health insurance and decrease the cost of health care. Central to this effort are exchanges. Exchanges are governmental agencies or nonprofit entities that serve as both gatekeepers and gateways to health insurance coverage. As of the Court's ruling, only fourteen states and the District of Columbia had established exchanges. The federal government has established exchanges in the remaining thirty-six states.

Halbig v. Burwell targets a May 2012 IRS rule that allows subsidies to be offered through the federal insurance exchange. Section 36B of the Internal Revenue Code ("Code"), enacted as part of the ACA, makes tax credits available as a form of subsidy to individuals who purchase health insurance through exchanges. The IRS interpreted Section 36B broadly to authorize the subsidy for insurance purchased on an exchange established by the federal government under Section 1321 of the ACA.

Exchanges also serve as the gateway to the refundable tax credits through which the ACA subsidizes health insurance. Section 36B of the Code authorizes credits for applicable taxpayers, defined as those with household incomes between 100 and 400 percent of the federal poverty line. The Court points out that the tax credit is available only to subsidize the purchase of insurance on an exchange established by the State. However, the IRS interpreted Section 36B to allow credits for insurance purchased on either a state or federally established exchange. Thus, the IRS rule significantly increases the number of people who must purchase health insurance or face a penalty.

In its ruling, however, the Court stated that tax credit subsidies would be available only to subsidize the purchase of insurance on exchanges established by the State under Section 1311 of the ACA. According to the Court, federal exchanges, which are established under Section 1321 of the ACA, are not established by the states under Section 1311. Ultimately, the Court found that the ACA plainly distinguished between state and federal exchanges; found that prohibiting subsidies for federally facilitated exchanges would not generate absurd results; and determined that the ACA's purpose and the scant legislative history cited by the government were insufficient to overcome the plain meaning of Section 36B's text.

Thus, the Court determined that a federal exchange is not considered an exchange established by the State, and Section 36B does not authorize the IRS to provide tax credits for insurance purchases on federal Exchanges. Having found Section 36B of the Code unambiguous, and that the legislative history did not override Section 36B's plain meaning, the Court concluded that the ACA does not authorize federal subsidies to those in health insurance exchanges established by the federal government.

Importantly, the Court recognized that its decision denying subsidies in the thirty-six states that declined to operate their own health insurance exchanges will have significant consequences. ACA supporters requested an en banc review from the D.C. Circuit Court and argue that the decision will never go into effect. ACA opponents insist that the Court interpreted the law correctly and argue that Congress needs to fix the law. The government filed a petition for rehearing en banc on August 1, 2014. In an Order dated September 4, 2014, the U.S. Court of Appeals for the District of Columbia Circuit granted an en banc review and elected to rehear the case. The decision to rehear the case vacates the prior decision by the the D.C. Circuit. Oral arguments are scheduled for December 17, 2014.

United States Supreme Court Will Take Up Issue of Retiree Health Care Benefits

On May 5, 2014, the United States Supreme Court announced that it will resolve a circuit split about how courts should interpret collective bargaining agreements (CBAs) that provide retiree health insurance benefits in *M&G Polymers USA, LLC v. Tackett*, 733 F.3d 589 (6th Cir. 2013). The case asks the Court to consider what is known as the "Yard-Man inference," a judicial presumption that union retiree health benefits are intended to vest for life in the absence of any specific plan or collective bargaining agreement language to the contrary.

In *M&G Polymers*, a group of retirees brought a class action against their employer asserting claims under ERISA and the Labor Management Relations Act. The retirees argued that certain CBA provisions granted them lifetime contribution-free health care benefits. The CBA at issue promised a "full Company contribution towards the cost of health care benefits" to employees who met certain age and service requirements. However, the CBA was silent on the duration of those benefits.

The district court initially dismissed the case, but the Sixth Circuit reversed that decision based on the "Yard-Man inference" and sent the case back down to the district court. After a trial, the district court ruled in favor of the retirees and barred the employer from collecting any retiree contributions. The employer appealed, but the Sixth Circuit upheld the district court's decision. The Sixth Circuit relied heavily on its prior decision in *United Auto Workers v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir. 1983), and confirmed its position that a court may presume retiree health care benefits are intended to vest for life when the CBA is silent on the duration of those benefits. Following the Sixth Circuit's decision, M&G petitioned the Supreme Court for review.

Federal appellate courts are split over how to interpret CBAs that provide for retiree health insurance benefits, but do not explicitly include language on the duration of those benefits. The Sixth Circuit's Yard-Man approach differs from decisions of other appellate courts, which generally hold that retiree benefits are not vested absent language explicitly providing for lifetime benefits. For example, the Third Circuit stands in stark contrast to the Sixth Circuit, holding that benefits are not vested absent clear and unambiguous language to that effect. The Second and Seventh Circuits have adopted a more middle ground approach, requiring some language in a CBA that can reasonably support a finding of lifetime health insurance benefits.

Application of the Yard-Man presumption to CBAs has resulted in uncertainty for employers and retirees and inconsistent outcomes for CBAs covering employees in different circuits. Accordingly, a Supreme Court decision will finally resolve this uncertainty for employers and retirees alike. The Court will hear the case during its October 2014 term and a decision is expected by June 2015.

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(312) 372-8587

www.johnsonkrol.com

Employer Responsibility under the Affordable Care Act – Reporting & Disclosure

With the approach of the 2015 tax year, many employers and group health plans are beginning to gear up for what industry professionals are referring to as the 6055 (minimum essential coverage reporting) and 6056 (employer responsibility reporting) reporting requirements under the Patient Protection and Affordable Care Act of 2010 (ACA). While the corresponding Internal Revenue Service (IRS) Forms (1094-B, 1094-C, 1095-B and 1095-C) are not due until March of 2016, getting ready for reporting will be no small undertaking.[1]

The draft Forms and instructions were recently released and as the compliance date approaches, plans and employers will need to work together to gather all of the necessary data required in the filings (demographic and coverage information). However, the primary issue for employers and plan sponsors is to determine what filings are required and who is responsible for filing them.

Filing under Section 6055 – Minimum Essential Coverage Reporting

The purpose of the 6055 filing is to assist the government in determining whether or not an individual is covered under a minimum essential health plan and is therefore exempt from the individual penalty (tax) assessed if the individual does not maintain coverage during each month of the calendar year.

Filing under section 6055 is required of ***all*** providers of minimum essential coverage, including insurers and employers who offer self-funded health benefits. Originally, the intention was that each employer would be required to file under 6055 regardless of size. However, many employers expressed concerns about possessing the information necessary to accurately file the returns. In response, the draft instructions clarified the filing responsibilities.

Where an employer offers its group health benefits through an insured arrangement or under a multi-employer trust, the employer does not have an individual responsibility to file under section 6055 with regards to those employees.[2] The plan sponsor (board of trustees) is responsible for the filing where the coverage is provided through a self-insured multi-employer arrangement and the insurer is responsible for filing where the coverage is provided through an insured arrangement.

Filing under Section 6056 – Employer Shared Responsibility Reporting

The purpose of the 6056 filing is to assist the government in determining an employer's liability under the employer shared responsibility provisions and determining eligibility of employees for premium tax credits.

Unlike the section 6055 requirements, an employer (and its controlled group) that had less than 50 full time and full time equivalent employees during the taxable year (small employer)[3] is not currently required to report under section 6056. This means that a small employer that provides benefits to its employees through a multi-employer plan is not responsible for filing under 6055 or 6056 with regards to the employees covered under such plan.[4]

Where an employer is a large employer, the employer is responsible for filing under 6056. For such employers that offer more than one plan and/or offer benefits through a multi-employer arrangement, the coordination of information and filing under 6055 and 6056 is complicated.

The final regulations and recently released draft instructions indicate that a multi-employer plan will be able to assist large employers in complying with the filing requirements.[5] However, the instructions are unclear as to the logistics of this shared reporting. The IRS indicated that it is drafting a publication[6] to provide further guidance on the complicated filing requirements under 6056 for large employers who have multiple types of employees (multiple collective bargaining agreements or bargained and non-bargained employees covered under different plans).

Compliance Dates and Penalties for Non-Compliance

Both the 6055 and the 6056 filings must be filed with the IRS prior to March 31st after the end of each calendar year.[7] Additionally, the filing entity must mail statements[8] to all taxpayers included in the filing regarding minimum essential coverage and employer responsibility.

With penalties generally assessed at $200 per return with a maximum of $3 million per year[9] for a failure to timely or correctly file a return under the murky parameters currently set by the IRS, we suggest that employers and plan sponsors begin the discussion regarding options for 2015 and follow up with legal counsel and/or their welfare plan consultants to develop a game plan for compliance.

[1] Employers may voluntarily file in March of 2015 without penalty for filing errors.

[2] If the employer covers non-bargained employees under a self-insured arrangement, a 6055 filing is required on behalf of those employees.

[3] Based on actual hours of service during the prior taxable year.

[4] However, the W-2 reporting requirement regarding the cost of coverage still applies (optional for multi-employer plan coverage).

[5] The multi-employer plan would file a separate 6056 for each large employer that is a contributing employer with regards to the full time employees covered by the collective bargaining agreement who are eligible to participate in the plan and the employer would prepare and file with regards to all other employees, but the employer will remain liable for the filing and the administrator would need to become a tax return preparer under the Internal Revenue Code. However, the IRS indicated that it will address the requirement to file one return as the aggregate employer level data including the multiemployer plan participants on whose behalf the plan reported. Section XII(B) of the Preamble to the Final Regulations 26 U.S.C. 7805 Par.2. §301.6056.

[6] A guide for software developers and transmitters with details on communication procedures, transmission formats, business rules and validation procedures.

[7] February 28th if filing paper returns. The filing date requirement is the same for all plans, regardless of plan year start date.

[8] May be provided electronically if the individual consents to receive electronic notifications.

[9] Filing for 2014 is optional and no penalties will be assessed. The final rules also provide that there is a good faith effort standard for imposing 2015 reporting penalties for incorrect or incomplete filings.

Department of Labor Re-defining the meaning of "Fiduciary" and what it means for Plan Investment Consultants

Nearly four years ago, on October 22, 2010, the Employee Benefits Security Administration of the Department of Labor proposed a new rule that would re-define the meaning of a "fiduciary" for those who provide investment services to ERISA Plans.[1] However, on September 19, 2011, the DOL decided to postpone re-defining this rule at the urging of many investment advisers.[2] The DOL is now in the process of officially adopting this rule. The main purpose of the rule is to expand the definition of who a fiduciary is under ERISA and the Internal Revenue Code.

Under ERISA, a person is considered to be a fiduciary if he provides investment advice for a fee to an employee benefit plan. In 1975, the DOL issued a five part regulatory test for defining what constituted "investment advice for a fee."[3] The test states that a person qualifies as a fiduciary when: (1) they make recommendations on investing in purchasing or selling securities or other property or give advice to their value, (2) on a regular basis, (3) pursuant to a mutual understanding that the advice, (4) serves as a primary basis for investment decisions, and (5) the advice given is individualized to the particular needs of the plan.[4] All five elements must be present for an individual to be deemed a fiduciary.[5] As a result, an investment advisor who provides one-time advice on a complex transaction to a Plan may not be responsible as a fiduciary for his or her action, even if such action was determined to be imprudent. Moreover, "the 1975 regulation contains technicalities and loopholes that allow advisers to easily dodge fiduciary status."[6] The proposed rule would first, replace the five part test with a broader definition of fiduciary (described below), and also lay out clear exceptions for conduct that should not result in fiduciary status.[7] Specifically, the DOL's new rule defines a fiduciary as: (1) a person who represents to a Plan, participant or beneficiary that he is an ERISA fiduciary, (2) a person who already is a fiduciary by having control over management of Plan assets, (3) a person who is an investment adviser under the Investment Advisers Act, or (4) a person who provides advice pursuant to an agreement or understanding that the advice may be considered in connection with investment or management decisions with respect to plan assets and will be individualized to the needs of the plan. The individual must also receive a fee to be an ERISA fiduciary.[8] Any one of the above qualifications will make a person a fiduciary under the new rule.

One of the main differences with this rule is that it "eliminate[s] the existing bright line regulatory test and replac[es] it with a regulatory structure that presumes persons to be an ERISA fiduciary."[9] Moreover, the new test does not include the regular basis requirement. Therefore, one time advice can qualify a person as a fiduciary. Finally, the advice need not be the primary basis for investment decisions under the new test. Therefore, the scope of who can be a fiduciary for a single client is drastically widened. It is not certain when the DOL will officially move forward with this new rule, but ERISA Plans should keep an eye on the DOL's actions with regard to this rule and make sure to periodically review any agreements with their investment advisers.

[1] *Testimony of Phyllis C. Borzi, Assistant Secretary of Labor Employee Benefits Security Administration before the House Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions United States House of Representatives (July 26, 2011), available at http://www.dol.gov/ebsa/newsroom/ty072611.html.*

[2] *Id. Department of Labor Could Ban Earning on Commission on IRA Advice, Financial Services Institute, https://www.financialservices.org/uploadedFiles/FSI_Content/The_Issues/DOL_Redefinition_of_%E2%80%98Fiduciary%E2%80%99/Briefing-DOL_Fiduciary-05-12-2014.pdf.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] *Id. "Examples of advice that would be covered under the new regulation are: (1) appraisals or fairness opinions concerning the value of securities or other property, (2) recommendations about investing in, purchasing or selling securities or other property, or (3) recommendations as to the management of securities or other property." Id.*

[8] *Id.*

[9] *Department of Labor Could Ban Earning on Commission on IRA Advice, Financial Services Institute, https://www.financialservices.org/uploadedFiles/FSI_Content/The_Issues/DOL_Redefinition_of_%E2%80%98Fiduciary%E2%80%99/Briefing-DOL_Fiduciary-05-12-2014.pdf*

Supreme Court Holds ACA Contraceptive Mandate Infringes on Religious Rights of Closely Held For-Profit Employer

Recently, the United States Supreme Court issued a landmark decision in *Burwell v. Hobby Lobby Store, Inc.* The Supreme Court, in a 5-to-4 ruling, held that it is unlawful to require small, closely held corporations to pay for insurance coverage for contraception, as mandated by the Affordable Care Act. In *Hobby Lobby*, the Court stated that it was a violation of a federal law protecting religious freedom to require closely held companies to fund insurance plans which provide birth control for female employees, when there are alternative means which do not interfere with the religious beliefs of the company.

Hobby Lobby Stores, Inc. ("Hobby Lobby") is a nationwide arts and crafts store with approximately 13,000 employees. The Hobby Lobby's owners have operated and managed the store based upon their strong Christian beliefs. Notably, the company owners do not believe in the use of birth control or contraception. However, pursuant to the recently passed Affordable Care Act ("ACA"), for-profit employers must provide contraception coverage to their female employees. Following the ACA mandate, Hobby Lobby filed a lawsuit in the United States District Court for the Western District of Oklahoma against the Secretary of Health and Human Services. In the suit, Hobby Lobby claimed that the ACA requirement to provide coverage for contraception in their health plan was a violation of their religious freedoms under the Religious Freedom Restoration Act of 1993 ("RFRA"). On November 26, 2013, the United States Supreme Court granted certiorari to hear the case.

The Supreme Court focused in on the issue of whether the RFRA permitted the United States Department of Health and Human Services to require that closely held corporations provide insurance coverage for contraception, even when the use of contraception violates the company owners' religious values and beliefs.[2]

Justice Alito delivered the opinion of the Supreme Court, holding that the requirement to provide contraception, when company owners found contraception to be against their religious values, was a violation of the RFRA. First, the Court determined that a corporation is afforded protection of religious beliefs under the law as the corporation is an extension of the people within the corporation and their beliefs.[3] Yet, the Court noted the religious rights under the RFRA should not be extended to for-profit publically traded companies as such companies are too large to hold unified religious beliefs.[4] In this case, Hobby Lobby is owned by only one family that holds an undisputed, unified religious belief.

Next, the Supreme Court had to determine whether the requirement to provide contraceptive coverage was a substantial burden to Hobby Lobby. The RFRA protects religious beliefs when a law substantially burdens the free exercise of one's religious beliefs.[5] The Court reasoned that the mandate is a substantial burden to Hobby Lobby as the ACA mandate would impose a fine of almost $475 million dollars per year for not providing contraception, which violated their religious beliefs.[6] Further, the Supreme Court reasoned that although there is a substantial interest in providing contraception to female employees, the mandate requiring Hobby Lobby to do so is not the least burdensome or restrictive method to provide contraceptive coverage to female employees.[7] Justice Alito states that there are other alternatives to ensure female employees have access to cost -free FDA approved contraceptives. For example, prior to this case, there were accommodations under the RFRA made for religious non -profit organizations.[8] Such accommodations include a program that ensures employees of such religious non-profits have access to contraception, but the employer is exempt from having to pay for the ACA mandated contraception.[9] Additionally, the Court noted that the Government can provide separate programs which would cover the cost of contraception coverage.

In summary, this case issues a narrow ruling that allows only closely held corporations and entities to be exempt from the ACA requirements to provide contraception - which is against their religious beliefs – where there are less restrictive means of advancing the government interest of providing cost free access to contraception. It is important to note, that this ruling does not allow for for-profit corporations and other businesses to simply opt-out of any law that they may argue is a violation of their religious beliefs.

[1] *Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014)*
[2] *Id. at 2751*
[3] *Id.*
[4] *Id.*
[5] *Id.* at 2759
[6] *Id.*
[7] *Id* at 2777
[8] *Id* at 2758
[9] *Id.* at 2781

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Fax: 312.255.0449
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Does the Illinois Supreme Court's Decision Regarding Health Insurance Premium Subsidies Mean Doomsday for Pension Reform?

The Illinois Supreme Court recently ruled that the State Employees Group Insurance Act of 2012 ("SEGIA"), which required former state employee retirees to pay premiums towards the cost of their healthcare, was unconstitutional. *Kanerva v. Weems*, Ill., No. 2014 IL 115811, 7/3/2014. SEGIA forced retirees in three state retirement systems to pay medical premiums to participate in the healthcare plans. Prior to the adoption of SEGIA, the state of Illinois did not require the retirees to pay any medical premiums.

The plaintiffs included members of the State Employees' Retirement System, the State Universities Retirement System, and the Teachers' Retirement System of the State of Illinois. The plaintiffs argued that the obligation to pay a premium towards their healthcare was unconstitutional under the pension protection clause of the Illinois Constitution of 1970 (Ill. Const. 1970, art. XIII, § 5). The pension protection clause states that:

> Membership in any pension or retirement system of the State, any unit of local government or school district, or any agency or instrumentality thereof, shall be an enforceable contractual relationship, the benefits of which ***shall not be diminished or impaired.***

The state argued that the clause was created to protect retirement benefits, but not other post-employment benefits like the healthcare subsidies. The Illinois Supreme Court agreed with the retirees and held that the subsidized healthcare was a retirement benefit that could not be diminished.

The Court's ruling is likely to have broad repercussions for pending suits challenging the recent pension reforms enacted by Governor Quinn in 2013. The pension reforms imposed numerous reductions and changes to pension benefits of current and future public-sector retirees. Specifically, the pension reforms include a combination of retirement-age increases and caps on inflation adjustments for public -sector employees.

Presently, there are a number of cases pending in the lower courts challenging the validity of the pension reform. Based on the Illinois Supreme Court's ruling, public pension reform may not be possible without amending the Illinois Constitution.