JOHNSON & KROL, LLC

Taft-Hartley Report

JUNE 2014 ISSUE

NLRB's Proposed Rulemaking on Union Elections

On February 6, 2014, the National Labor Relations Board issued a notice of proposed rulemaking to amend its rules related to the processing of petitions for union elections. The proposed changes are largely the same as those previously proposed by the Board in June 2011, which many employers referred to as "quickie union elections" or "ambush election rules." A handful of the proposed rules were adopted in December 2011, but were later struck down by a federal district court judge who determined that the rule changes were adopted in the absence of a Board quorum, which is required by statute.

The proposed rule changes are intended to speed up and modernize the union election process. The Board explained in a statement released with the notice of proposed rulemaking that the new reforms would: 1) allow for electronic filing and transmission of election petitions and other documents; 2) require a pre-election hearing within seven days from the filing of a petition; 3) require the exchange timely information needed by the union and/or employees to understand and participate in the representation case process; 4) streamline pre- and post-election procedures to facilitate agreement and eliminate unnecessary litigation; 5) include telephone numbers and email addresses in voter lists to enable parties to the election to be able to communicate with voters using modern technology; and 6) consolidate all election-related appeals to the Board into a single post-election appeals process.

If adopted, these new changes would be a great victory for unions, which often deal with lengthy legal battles and other pre-election challenges that are used by employers as a tactic to delay union elections. These new changes would defer legal challenges until after the election occurs. Some legal experts have estimated that, under the proposed rules, some elections could occur within three weeks of the filing of an election petition. Additionally, under this proposal, employers would also be required to provide the union with email addresses of eligible employees which could be used by the Union to communicate directly with the employees they seek to represent.

The proposal has drawn wide criticism from employers and other business associations with many employers claiming that an expedited election process would deny employees the right to make a fully informed decision regarding the election. In contrast, Richard Trumka, president of the AFL-CIO, called these rule changes "an important step in the right direction that will help improve…and reduce delay in the NLRB election process."

There is a good chance that the proposed rule changes will be adopted because the proposal is backed by the Board's three Democrats, Board Chairman Mark Gaston Pearce and Members Kent Y. Hirozawa and Nancy Schiffer. Board Members Philip A. Miscimarra and Harry I. Johnson III dissented.

The proposed rule changes were open to public comment through April 7, 2014. The Board will also hold a public hearing in early April 2014. The NLRB has not released the final rule.

PPA Sunset Rules

The Pension Protection Act of 2006 (PPA) imposed certain requirements on multiemployer defined benefit pension plans. Some of these requirements will apply regardless of the sunset provisions, some requirements will sunset for Green Zone plans for plan years beginning after December 31, 2014, and some requirements will continue to apply to Red Zone and Yellow Zone plans.

The PPA requirements that will continue regardless of the sunset provisions include the 15 year amortization rule and the annual funding notice that must be sent to participants each year. In addition, the annual funding notice will need to be revised based on the sunset provisions.

The sunset provisions generally apply to Green Zone plans. Accordingly, plans in the Green Zone for the 2014 plan year will no longer be subject to the funding zone rules. For such plans, the 2014 plan year is the last for which an actuarial zone certification is required. In addition, if such a Green Zone plan subsequently runs into funding problems, the protection against the funding deficiency excise tax afforded by the zone rules will no longer apply.

Plans in the Yellow or Red Zones that are "operating under" a funding improvement plan or rehabilitation plan for the 2014 plan year will continue to operate as such until the end of the funding improvement or rehabilitation period.

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PPA Sunset (*continued from previous page)*

There are unanswered questions as to whether a plan that is first certified as Yellow or Red for the 2014 plan year is considered "operating under" a funding improvement or rehabilitation plan. Also, there are questions as to how the zone rules apply to a plan that moves between the Yellow and Red Zones and how they apply to a Red Zone plan that is not expected to emerge from the Red Zone by the end of the rehabilitation period.

These questions may be moot if Congress passes legislation to address the sunset provisions. If not, there may be regulatory guidance. Otherwise, plans will need to rely on the advice of Fund Counsel in grappling with these unanswered questions.

Heimeshoff's Impact on ERISA Plan Imposed Statute of Limitations

For a number of years, Employee Benefit Plans have been including a plan imposed statute of limitations directing when a claimant no longer will have a viable claim against the Plan. Courts around the nation were split on whether such an action was proper until December 16, 2013 when the Supreme Court held in *Heimeshoff* that a Plan imposed statutes of limitation were enforceable as long as they were "reasonable."[1]

The issue in *Heimeshoff* arose due to the fact that there was a split among the Circuit Courts as to whether a Plan could agree by contract to a limitations period for bringing claims against the Plan—specifically one that starts to run before the cause of action accrues. Historically, a court would simply borrow the applicable statute of limitations of the state in which it sits. However, as time went on, many parties chose to contractually agree to a different statute of limitations in the Plan itself. The Circuit Courts began to split on whether a contractual statute of limitations period shorter than that of the state in which the Court sits was allowable. The Supreme Court, in *Heimeshoff,* held that such limitations periods were allowed as long as they were reasonable. Additionally, the Supreme Court in *Heimeshoff* specifically analyzed what "was reasonable" for a Plan limitations period to be enforceable. Generally, a statutes of limitations period begins to run when a cause of action accrues (when the plaintiff can file suit and obtain relief).[2] The issue under ERISA is that courts "uniformly require that participants exhaust internal review before bringing a claim for judicial review under 502(a)(1)(B)."[3] Thus, generally, in order for an ERISA claim to accrue, the Plan must issue a final denial of benefits.[4] As a result of the unique ERISA internal review requirement, questions remained about limitations periods in Plans that began to run before the claimant's cause of action accrued. The Court in *Heimshoff* answered this question by holding that a Plan limitations period that starts to run before a cause of action accrues can be reasonable and enforceable.

One question that has come as a result of *Heimeshoff* is how long must a limitations period be, taking into account the requirement of exhausting internal review, to be reasonable.[5] Other cases prior to *Heimeshoff* have held that limitations period as short as 45 days after internal review was reasonable. Moreover, the 7th Circuit has opined that 30 to 60 days following the internal ERISA appeals process is enough time to bring suit for a claimant.[6] Lastly, a one year statute of limitations from the time the cause of action accrues has been held reasonable. The Court held in *Heimeshoff* that a three year statute was reasonable from the time proof of loss was due because it generally gave the claimant around 20 months to file a lawsuit after the internal review and appeals process required by ERISA are completed. However, questions remain as to shorter Plan limitations periods and what period is going to be considered reasonable. As a result, it is clear that a statute of limitations of at least 3 years from the time proof of loss is due will be reasonable, and from past case law, it seems that a statute of limitations as short as one year will be reasonable. The reasonableness of a Plan limitation is a question that will likely be asked more frequently in the wake of *Heimeshoff*, and because the case is so recent, courts have not yet reviewed the issue with the new guidance from the Supreme Court.

If you have any questions about *Heimeshoff* or its impact on your Plan, please contact J&K.

[1] *Order of United Commercial Travelers of America v. Wolfe*, 331 U.S. 586, 608 (1947).

[2] *Heimeishoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, 609-610 (2013).

[3] *Heimeshoff*, at 609-610.

[4] Because claim accrual is different in each case, under ERISA, a claim has been deemed to accrue when there has been "a clear repudiation by the plan that is known, or should be known to the plaintiff—regardless of whether the plaintiff has filed a formal application for benefits." *Carey*, 201 F.3d at 46-47; see, e.g., *Miller v. Fortis Benefits Insurance Co.*, 475 F.3d 516, 520-21 (3d Cir. 2007).

[5] *Davidson v. Wal-Mart Health and Welfare Plan,* 305 F. Supp. 2d 1059 (S.D. Iowa 2004). See also *Northlake Reg'l Med. Ctr. v. Waffle House Sys. Employee Benefit Plan,* 160 F.3d 1301 (11th Cir. 1998) (holding a 90 day limitation after the Plan Trustees decision on review was reasonable).

Pensioner Sues After Plan Miscalculated Her Benefit

In a recent Sixth Circuit case, the Court of Appeals denied a claim of equitable estoppel to a pension plan participant.[1]

Plaintiff Virginia Stark was an employee of Mars, Inc. for over twenty years and retired in 2004.[2] Before Stark retired in 2004, she elected to change retirement plans from the "Mars Retirement Plan" to the "Associate Retirement Plan (ARP)."[3] One of the benefits of the ARP was that participants were guaranteed to receive the higher of either their new ARP benefits or their previous Mars Retirement Plan Benefit.[4]

In 2008, Stark was informed by the plan that her pension plan balance was $378,763.58, which she was entitled to withdraw at any point.[5] After telephone and written correspondence, Stark elected to receive a five year annuity in which she would receive an estimated benefit of $5,364.63 per month. Stark collected this benefit from March 2009 through July 2009.[6]

In July 2009, the benefits management company contacted Stark and informed her that there had been a programming error which over-calculated her pension benefit and her corrected benefit should have been in the amount of $2,303.18.[7] Stark filed a claim with the Mars Benefit Plans Committee ("Committee") to continue paying the over-calculated monthly payment.[8] After the Committee denied her claim, Stark filed a law suit against Mars, Inc. and sought summary judgment on her claims of equitable estoppel and breach of fiduciary duty. The District Court for the Southern District for Ohio denied summary judgment on both of her claims and granted summary judgment in favor of Mars Inc. and the Committee. Thereafter, Stark filed an appeal.[9]

In this case, the Sixth Circuit Court held that Stark's equitable estoppel claim could not proceed because she did not provide evidence of fraud. In particular, the court said that the equitable estoppel requirements were not met due to the fact that the Committee made an honest mistake in miscalculating Stark's pension benefit and did not have knowledge of the mistake. In addition, the court also stated that Stark did not detrimentally rely upon or dramatically change her lifestyle based upon the benefit calculation. As such, the court denied Stark's claim of equitable estoppel.

Further, the court held that the District Court was also proper in granting summary judgment to the Committee on the claim for breach of fiduciary duty. The Sixth Circuit Court held there was no breach of fiduciary duty by the Committee because the misrepresentation of the pension benefit amount was neither intentional nor negligent.

In light of *Stark v. Mars*, plans should always be careful when calculating a participant's pension benefits. Disclaimers and limiting language should accompany any benefit representations and if an error is discovered, remedial measures should be promptly taken.

[1] *Stark v. Mars, Inc.*, 518 Fed. Appx. 477 (6th Cir. Ohio 2013)

[2] *Id* at *478*.

[3] *Id*.

[4] *Id*.

[5] *Id*.

[6] *Id* at *479*.

[7] *Id* at *480*.

[8] *Id*.

[9] *Id*.

We encourage you to contact

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if you have any questions regarding the content within this newsletter.

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Sixth Circuit to Revisit Decision in ERISA Disgorgement Case

On December 6, 2013, the U.S. Court of Appeals for the Sixth Circuit issued its opinion in *Rochow v. Life Insurance Company of North America,* 737 F.3d 415, (6th Cir. 2013) and affirmed an unusually large award of $3.8 million in a case involving the denial of long-term disability benefits.

In *Rochow*, the plaintiff was covered by a disability plan sponsored by his employer, Arthur J. Gallagher & Co., and administered by defendant, Life Insurance Company of North America (LINA). In 2001, the plaintiff, President of Arthur J. Gallagher & Co., began experiencing short term memory loss. A few months later, Gallagher demoted the plaintiff from President to sales executive-account manager because he could no longer perform his duties as President. The plaintiff continued to have difficulties, and as a result of his inability to perform his job, Gallagher forced the plaintiff to resign in 2002.[1]

Shortly thereafter, the plaintiff was diagnosed with HSV-Encephalitis, a rare and severely debilitating brain infection. The plaintiff eventually applied for long term long term disability benefits. LINA denied the plaintiff's claim stating that his employment ended before his disability began.[2] The plaintiff filed suit and the district court ruled that LINA's decision was arbitrary and capricious. The Sixth Circuit affirmed the finding that LINA's denial of the plaintiff's claim was arbitrary and capricious, and the court remanded the case for further proceedings.[3]

The plaintiff died shortly thereafter and his estate pursued the claim. On remand, the plaintiff's estate, in addition to benefits due, sought an equitable accounting and disgorgement of profits obtained by LINA on the benefits that it had withheld. The plaintiff argued that disgorgement was necessary to prevent LINA's unjust enrichment resulting from profits it earned on the wrongfully retained benefits. In other words, the plaintiff wanted LINA to pay back any interest LINA earned by retaining the plaintiff's benefits.

At its core, ERISA is a remedial statute. The purpose of ERISA is to make claimants whole, not to give them a windfall. Here, the plaintiff's argument for disgorgement of profits seems to undermine ERISA's remedial scheme.

The district court, however, agreed with the plaintiff and held that the proper remedy was both the award of benefits and the equitable remedy of "disgorgement of profits," and the district court ordered LINA to disgorge or pay back $3.8 million. LINA appealed.

On appeal, LINA argued that disgorgement was inappropriate because equitable relief under ERISA §502(a)(3) is available only where §502(a) does not otherwise provide an adequate remedy.[4] The plaintiff argued that disgorgement is an appropriate remedy because it is a remedy in addition to the award of benefits under §502(a)(1)(B), not a repackaged benefits claim; it provides a different type of remedy than benefits and was appropriately awarded to remedy the defendant's breach.[5]

Specifically, LINA argued that the award for fiduciary breach, in addition to the award of the disability benefits, was inconsistent with the U.S. Supreme Court's decision in *Varity Corporation v. Howe*, 516 U.S. 489 (1996), and Sixth Circuit precedent. In *Varity Corp.*, the Supreme Court held that equitable relief under §502(a)(3) normally would not be appropriate where the plaintiff already had an adequate remedy under another applicable ERISA provision.[6] Accordingly, LINA argued that §502(a)(1)(B) provides a remedy for benefits due under the plan, and this was sufficient to make the plaintiff whole for the denial of his disability claim.

The majority of the Sixth Circuit panel disagreed and held that where a plan administrator acts arbitrarily and capriciously, the equitable remedy of disgorgement of profits could be appropriate equitable relief under §502(a)(3), in addition to the award of benefits under §502(a)(1)(B).[7] Judge McKeague, in his stinging dissent, argued that the majority's ruling was an "unprecedented and extraordinary step to expand the scope of ERISA coverage" and contrary to clear Supreme Court and Sixth Circuit precedent."

After that decision, LINA sought a rehearing and review of the majority's ruling en banc, which involves a rehearing by all active Sixth Circuit judges. On February 19, 2014, a majority of the Sixth Circuit's judges granted the motion for rehearing en banc, which serves to vacate the earlier panel's December 6, 2013 decision. The parties were expected to file briefs by May 2014, and an argument to the en banc panel is expected sometime this summer. This decision will be important in determining whether ERISA's equitable remedies are available in traditional denial of benefit cases. For more information or questions regarding this case, please contact our office.

[1] *Rochow v. Life Insurance Company of North America*, 737 F.3d 415, 417 (6th Cir. 2013).
[2] *Id.*
[3] *Rochow v. LINA (Rochow I)*, 482 F.3d 860, 865 (6th Cir. 2007).
[4] 737 F.3d at 423.
[5] *Id.*
[6] *Varity Corporation v. Howe*, 516 U.S. 489, 513-15 (1996).
[7] 737 F.3d at 426-27.
[8] *Id.* at 431.

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Possible Fiduciary Breach Claim When Insurer Representative Gives Inaccurate Information

The Seventh Circuit recently found in *Killian v. Concert Health Plan* that an employer and its group health plan may have breached their fiduciary duty when they failed to inform the participant that her proposed hospital where treatment for emergency cancer surgery was to occur was not included in the plan's network of providers in her group health plan.[1]

Last year, when the Plaintiff, James Killian, was told by his wife's physician that his wife needed emergency brain surgery, her husband contacted their insurer for pre-admission approval. Mrs. Killian's health insurance was through her employer, Royal Management Corporation which had contracted with Concert Health Plan Insurance for coverage.[2] Although Royal Management failed to provide the Killians with a Summary Plan Description (SPD), Concert did provide them with an insurance card which contained several telephone numbers to call "to confirm that the provider is a current participant."[3] When Mr. Killian called, the customer service representative authorized him to have his wife admitted to the hospital for the surgery. Mr. Killian then made a second phone call to a "utilization review" the same day and was told it was "okay" to admit his wife.[4] Mrs. Killian underwent the surgery, passed away several months later and Concert refused to reimburse the treatment.[5]

Mr. Killian initiated the lawsuit after Concert refused to reimburse the treatment his wife received at the hospital, which left Mr. Killian liable for approximately $80,000 in unpaid medical bills that he believed would be covered after Concert's representative confirmed the surgery. Mr. Killian sued Concert for a claim for breach of fiduciary duty based on two theories: (1) Concert failed to provide Mrs. Killian with an SPD and (2) Concert failed to inform him that Mrs. Killian's providers were out of network during the two telephone conversations.[6] In its defense, Concert argued that it did not breach its fiduciary duty because Mr. Killian could not show that the lack of an SPD caused him harm when he knew that he could determine the provider's network status by calling the numbers on the insurance card. The Northern District of Illinois granted summary judgment in favor of Concert on the breach of fiduciary duty claim.

The Seventh Circuit agreed with the District Court's finding that Mr. Killian did not show adequate harm; however, the Seventh Circuit remanded to permit the District Court to determine (1) whether the telephone calls put Concert on adequate notice, thus giving rise to a duty to disclose material information related to the Killians' situation, (2) whether Concert breached its duty, and (3) whether the breach harmed Mr. Killian.

The main focus of the Court's analysis was directed towards the Plan Document. Specifically, the Court found that the Plan Document was unclear because the Participant had no documentation that would identify what providers fell within the preferred provider network.[7] Instead, Participants were advised to call the phone number on their insurance cards to verify coverage. After examining the phone records, the Court found that the communications from the insurer's representative were unclear and misleading.

Specifically, the Court noted that "once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire."[8]

Does this mean that fiduciaries are always liable for the mistaken advice given to an insured by a ministerial non-fiduciary agent? No. The Court made a note that as long as the Plan documents are clear and the fiduciary has exercised appropriate oversight over what its agents advise participants, there would be no breach.[9] However, if the fiduciary "supplies participants and beneficiaries with plan documents that are silent or ambiguous on a reoccurring topic, the fiduciary exposes itself to liability for the mistakes that plan representatives might make in answering questions on that subject."[10] Here, the Killians never received an SPD, which ERISA requires must contain the composition of the provider network. Instead, Concert only gave Mr. Killian a list of numbers to call, which activated Concert's affirmative obligation to inform Mr. Killian that the providers Mrs. Killian was about to see were out of network.[11]

This case illustrates the salient point that a fiduciary's duty to provide complete and accurate information, even if the beneficiary does not specifically inquire, is triggered when the beneficiary makes the ERISA fiduciary "aware of the beneficiary's status and situation."[12] However, ERISA does not require that a fiduciary set out on a journey to reveal any kind of harm that might befall a beneficiary - it merely requires an application of the rule that a provider cannot defeat a breach of fiduciary duty claim by arguing that it was unaware that an insured was seeking material plan information when the insured called two different numbers that the insurance company itself established to provide the type of information in question.[13]

As highlighted by the facts in this case, it is important for Plans to provide its participants and beneficiaries with clear and unambiguous plan documents. If a Plan fails to provide these documents, it risks exposing itself to liability for mistakes that Fund representatives might make in relaying information to participants and beneficiaries. For more information or questions regarding fiduciary responsibilities, please contact our office.

[1] *Killian v. Concert Health Plan*, 2013 U.S. App. LEXIS 22657 (7th Cir. 2013).
[2] *Killian*, 2013 U.S. App. LEXIS at *4.
[3] *Id.* at 5.
[4] Debofsky, Mark, *Court Recognizes Fiduciary Breach Claim When Health Insurer Gives Erroneous Information*; Debofsky & Associates, http://www.debofsky.com/author/mdebofsky (November 11, 2013).
[5] *Id.*
[6] *Killian,* 2013 U.S. App. LEXIS at *15.
[7] Debofsky, Mark, *Court Recognizes Fiduciary Breach Claim When Health Insurer Gives Erroneous Information*; Debofsky & Associates, http://www.debofsky.com/author/mdebofsky (November 11, 2013).
[8] *Killian*, 2013 U.S. App. LEXIS at *34, quoting *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452 (7th Cir. 2010).
[9] *Id.* at 35.
[10] *Id.*
[11] *Id.* at 44.
[12] *Id.* at 46, *quoting* quoting *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452, 456 (7th Cir. 2010).
[13] *Id.* at 51.

Affordable Care Act Employer Mandate Delay

The Affordable Care Act's ("ACA") employer mandate, outlined in Internal Revenue Code §4980H, imposes excise taxes on large employers that do not provide certain health plan coverage to their full-time employees. Generally, the employer mandate provides that applicable large employers with more than 50 full-time employees may face penalties if (1) they do not offer full-time employees affordable health care coverage that meets minimum standards and (2) if at least one of their employees receives a premium tax credit or reduced cost health insurance through one of the ACA health insurance marketplaces.

Under §4980H, employers with 50 or more full-time employees are considered "applicable large employers." A full-time employee is defined as an employee who averages 30 or more hours of service per week per month. Large employers generally become subject to the §4980H excise tax provisions beginning Jan. 1, 2015. However, the final regulations issued on February 10, 2014 provide large employers with permanent limited relief from the §4980H excise tax in certain circumstances. The recently issued final rules under the ACA have provided those employers with 50 to 99 full-time workers an additional year to comply with the employer mandate provisions under §4980H before they might face fees for failing to offer affordable health care.

In July 2013, the Obama administration delayed several provisions of the employer mandate for one year, pushing back the January 1, 2014 effective date under §4980H. As a result, the first delay postponed the start date for the employer mandate from January 1, 2014 to January 1, 2015. In 2015, large employers must offer coverage to at least 70% of its full-time employees to comply with the §4980H employer mandate regulations. However, starting in 2016, large employers must offer coverage to at least 95% or will face excise taxes. Beginning January 1, 2015, only employers with 100 or more full-time employees must comply with the final rules under the ACA's employer mandate. Importantly, the rules will not apply to businesses with 50 to 99 full-time workers until January 1, 2016. Please see the chart below for a brief summary of these provisions.

	EFFECTIVE DATE	
Employer Mandate Provisions	***Original***	***Delayed***
Employers with 100 or more employees must offer health insurance coverage to their full-time workers	January 1, 2014	January 1, 2015
Employers with 50 to 99 employees must offer health insurance coverage to their full-time workers	January 1, 2014	January 1, 2016

Court Rejects Claim for Breach of Fiduciary Duty Brought 17 Years After Plan Terminated

A recent decision of the Seventh Circuit reviewed some important aspects of the statute of limitations for bringing a breach of fiduciary liability claim against fiduciaries. *Laskin v. Siegel*, 728 F.3d 731 (7th Cir. 2013). In *Laskin v. Sigel*, the participant alleged that the plan administrator had breached his fiduciary duties by terminating a pension plan in 1991 and not paying the participant the account balance. According to the plan administrator, he attempted to pay out the balance but could not locate the participant. The participant finally contacted the plan administrator in 2008 – seventeen years after the plan terminated.

The plan administrator filed a motion to dismiss based on statute of limitations. In the decision, the court reviewed the statute of limitations for bringing a breach of fiduciary liability claim. Specifically, the court sited to 29 U.S.C. § 1113, which provides that no lawsuit may be commenced after the ***earlier*** of: (1) six years after the action or inaction occurred; or (2) three years after the earliest date that the participant had actual knowledge of the alleged breach. The court stressed that there is an absolute maximum of six years to bring a breach of fiduciary duty claim, regardless of when it is discovered. As a result, the court held that the claim for breach of fiduciary liability claim was time barred because the statute of limitations expired six years after the plan terminated – 1997.

Moreover, the participant argued that an exception to the statute of limitations should apply when the fiduciary commits fraud or concealment by delaying the participant's discovery of the alleged breach. However, the Court rejected this argument because there was no evidence of any fraud.

People v. Clark—For Now Assume Everyone is Listening

On March 20, 2014, the Illinois Supreme Court struck down the Illinois Eavesdropping Law (720 ILCS 5/14-(2)(a)(1)(A)) in *People v. Clark*. Prior to the Illinois Supreme Court hearing this case, it was against the law in Illinois to use an eavesdropping device for the purpose of recording a conversation with another without the consent of the other party. *In People v. Clark*, the Illinois Supreme Court held that the Illinois Eavesdropping Law was unconstitutional under the First Amendment and Fourteenth Amendment (substantive due process) of the United States Constitution.

As a result, for now, any conversation you have in Illinois, whether in public or in private, may be recorded. The fallout from this case is twofold: (1) as stated above, you should now assume that everything you say can be recorded and therefore it is of the utmost importance to be careful in situations where something you might say could be used against you in the future; and (2) you may now record your conversations with others. This could potentially be a very helpful tool for union organizers. The future of this law is uncertain, and it is likely the law will be revised to conform with the Illinois Supreme Court's ruling. For now, however, assume that someone may be listening. If you have any questions, please contact our office.

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