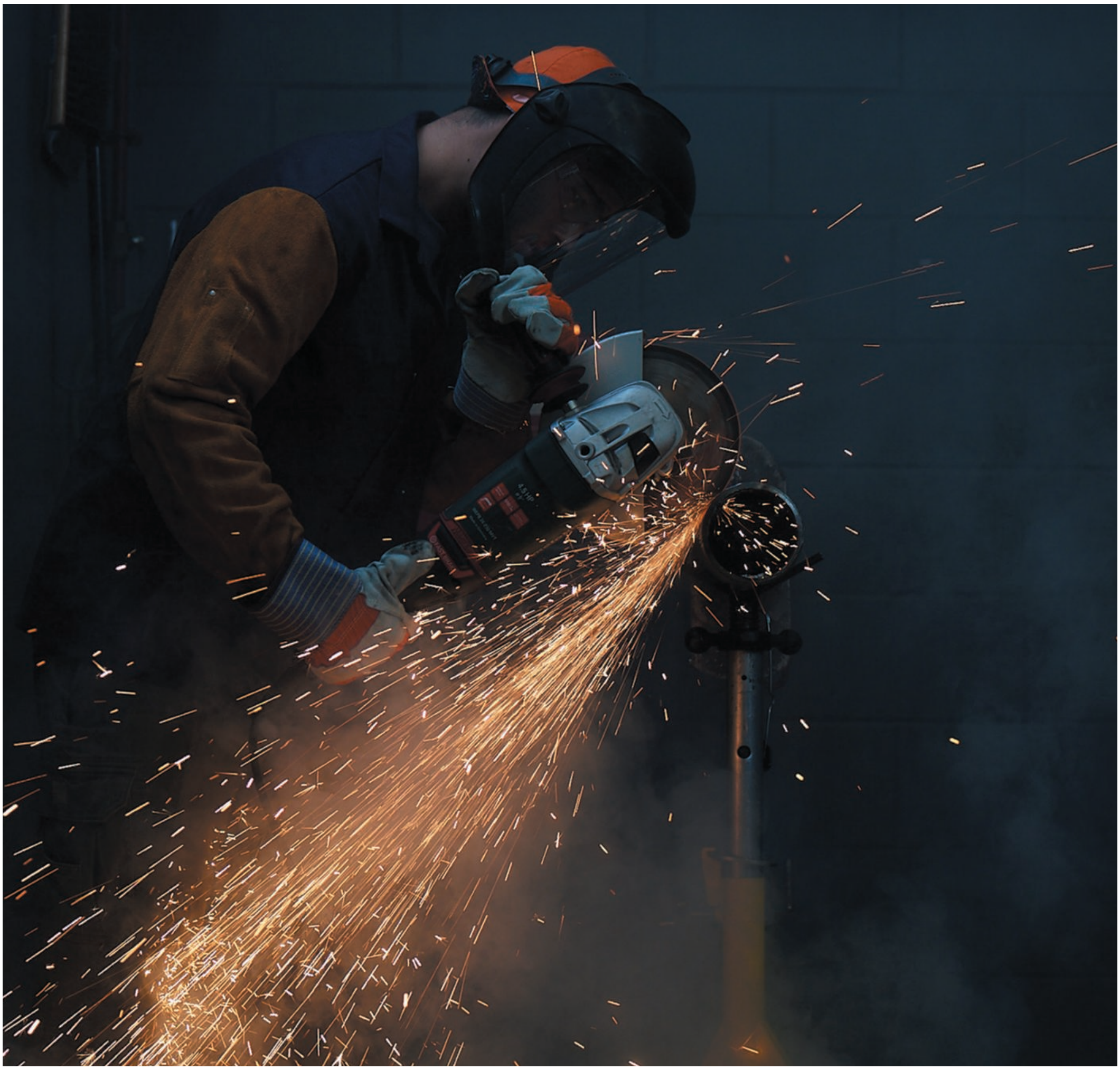
EDITION Nº TWENTY SEVEN

NEWS WITH PURPOSE, DECISIONS THAT COUNT

STATE OF THE UNION

THE JOHNSON + KROL NEWSPAPER



“Our look finally matches our working style–sleeves rolled up, heels dug in.

AGREEMENT WITH PAUL T. BERKOWITZ AND ASSOCIATES, LTD.

I am happy to announce that we have entered into a consulting agreement with Paul Berkowitz and Paul T. Berkowitz and Associates, Ltd. that became effective May 1, 2020. Pursuant to our agreement, Paul will work with J+K in a consulting capacity. We are very happy to add his wealth of knowledge to the pool of talent we can draw on.

Paul has been working with his clients to help transition them to J+K as he plans on retiring from the majority of his practice. Many of Paul’s former clients and two of his attorneys (Suzanne Dyer and Gary Gross—Of Counsel) have decided to move over to J+K. To Suzanne and Gary—welcome to our family. To our new clients—we will work very hard to earn the trust you have placed in us! To Paul—we are very excited to be working with you. We congratulate you on your pending retirement and look forward to our ongoing consulting arrangement.

NEW LOOK FOR J+K

As you can see by the new format for our newsletter, we are rolling out a new look for J+K. Our goal with our new website and branding is to communicate our mission and the passion we bring to our work. Please take a look at our new website at www.johnsonkrol.com. I also want to thank the folks at the Local 597 Training Center that made much of the photography possible!

Sincerely,

DENNIS R. JOHNSON
MANAGING MEMBER

THE NLRB TAKES AIM AT THE CONSTRUCTION INDUSTRY

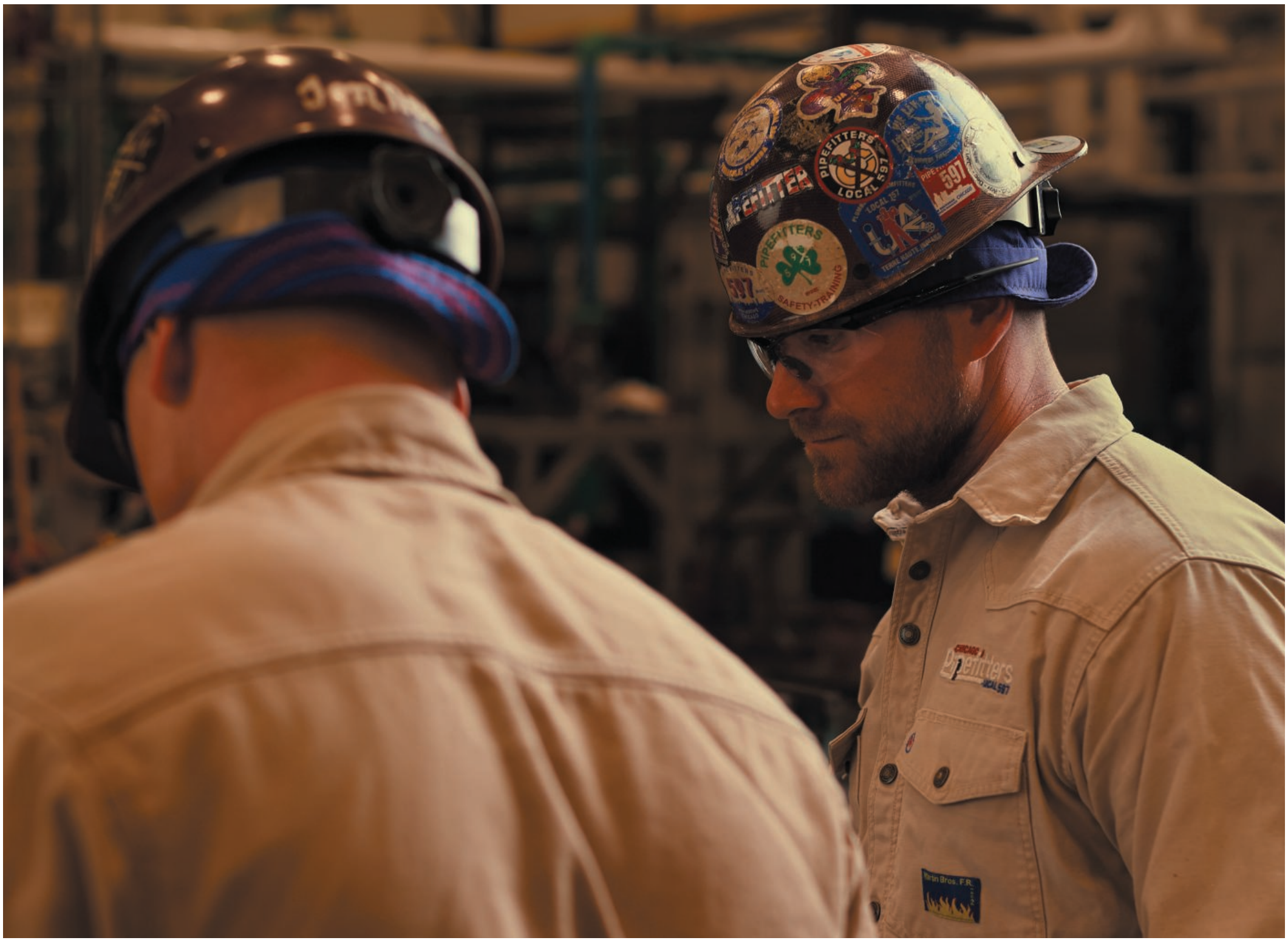
Since the NLRB ruled on *Staunton Fuel* in 2001, Unions and Employers in the construction industry have had a clear roadmap when it comes to voluntary recognition. In *Staunton Fuel*, the Board held that a Collective Bargaining Agreement between an Employer and a Union can be "independently sufficient to establish a union's 9(a) representation status where the [CBA's] language unequivocally indicates that (1) the union requested recognition as the majority or 9(a) representative of the unit employees; (2) the employer recognized the union as the majority or 9(a) bargaining representative; and (3) the employer's recognition was based on the union's having shown, or having offered to show, evidence of its majority support."[1] This language should be familiar, as it can be found in many of our mutually and successfully bargained for CBAs.

In 2018, the NLRB made its intention clear that it wanted to overrule *Staunton Fuel*. When considering *Loshaw Thermal Technology*, the Board invited amicus briefs on whether it should overrule *Staunton Fue*l. But *Loshaw* settled and so the Board turned to its now questionable, but go-to move, legislating via rule making. Earlier this year, the Board issued a rule that for CBAs entered into after August 1, 2020, contract language alone **will not** be sufficient to establish majority status. As we all know, the biggest implication here is whether Employers can simply walk away at the end of a CBA and what impact that might have on pension funding for Employers and Unions alike.

However, the Board did not stop at overruling *Staunton Fuel*, it went back another eight years and overruled *Casale Industries*.[2] Since 1993, the Board has not allowed an Employer to challenge whether a Union had majority status at the time of recognition if the Company waited more than six months after the recognition to file a challenge. Again, through rulemaking, the Board summarily threw out twenty-seven years of precedent. This is especially surprising given the Taft-Hartley Act's well-known six-month statute of limitations, upon which both Unions and Employers rely. In theory, this means that an Employer could make a Union prove it had majority status at the time of recognition, no matter how long ago that was.[3]

These Rules are currently being challenged in Court by the AFL-CIO and Baltimore-D.C. Metro Building and Construction Trades Council.[4] The AFL-CIO has had some success challenging the Board's rulemaking process in the past, so what effect these rules will have long-term effects remains to be seen. In the meantime, unions will need to keep their representation cards up-to-date and organized.

[1] *Staunton Fuel,* 335 NLRB 717 (2001).
[2] *Casale Industries,* 311 NLRB 951 (1993).
[3] See Federal Register / Vol. 85, No. 63 / Wednesday, April 1, 2020 / Rules and Regulations at 18389-18391.
[4] *ALF-CIO and Baltimore-D.C. Metro Building and Construction Trades Council v. National Labor Relations Board* (Case No. 20-cv-1909, D.C. for the District of Colombia).



JOINING THE FIGHT

SARAH E. BALAS
ASSOCIATE

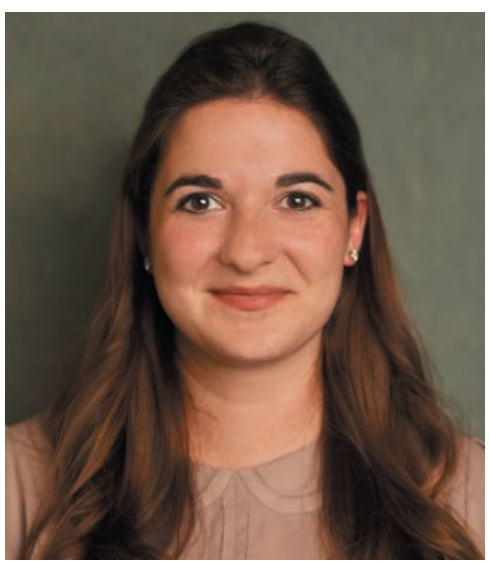
EDUCATION

- **Juris Doctor** (2017)
  DePaul College of Law
- **Bachelor of Arts in English** (2014)
  Loyola University Chicago

Sarah Joined Johnson & Krol in January of 2020 as an Associate Attorney. Sarah is a part of the firm's Employee Benefits practice. Her practice focuses on handling subrogation matters and Qualified Domestic Relations Orders (QDROs) for pension and annuity fund clients. Sarah has experience drafting plan documents, amendments, and participant communications. She is also well versed in regulatory research and assessing regulatory impact.

Prior to joining the firm, Sarah worked as a Regulatory Compliance and Research Attorney for AIM Specialty Health. As a member of the Legal and Compliance teams, Sarah reviewed and analyzed new and upcoming legislation across all 50 states to assess impact to the company.

After graduating law school, Sarah was a judicial law clerk to the Honorable Gerald Cleary in the mortgages/foreclosures sector of the Cook County Circuit Court Chancery Division. She also has experience clerking in Chicago's Liberty Mutual insurance defense firm and Rush University Medical Center's Office of Risk Management. During law school, Sarah was an active member of the Michael and Mary Jaharis Health Law Institute's student board.



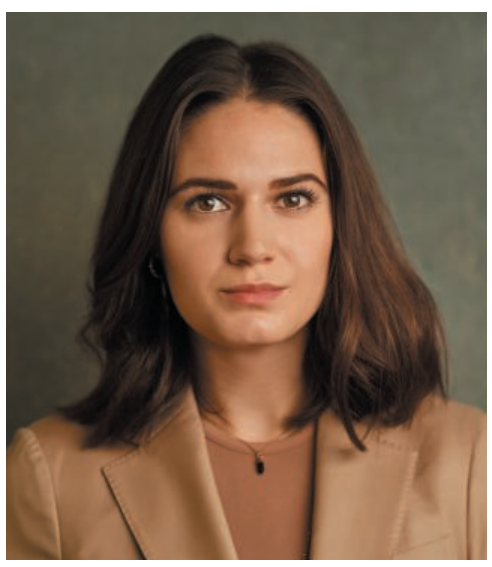
OLIVIA N. USTUPSKI
ASSOCIATE

EDUCATION

- **Juris Doctor** (2019)
  Chicago-Kent College of Law
- **Bachelor of Business Administration in Business Management** (2016)
  Loyola University Quinlan School of Business

Olivia joined Johnson & Krol in January of 2020 as an Associate Attorney. Olivia is a part of the firm's Employee Benefits practice. Her practice concentrates on plan management, including subrogation and reimbursement matters, as well as Qualified Domestic Relations Order (QDRO) administration. She assists clients on plan design issues, drafting plan documents and participant communications. She also has experience advising clients on benefits claims and disputes.

During law school, Olivia served as a judicial extern to the Honorable Franklin U. Valderrama in the Chancery Division of the Circuit Court of Cook County where she was able to further develop her legal research and writing skills. Olivia served as a legal extern at the C-K Law Group Entrepreneurial Law Clinic as well. She also gained valuable experience as a tax intern, where she researched legislative changes and analyzed the implications on clients.



"There are plenty of competent attorneys out there. But truly passionate defenders– they are rare.

ELECTRONIC DISCLOSURES FOR RETIREMENT PLANS

On May 21, 2020, the U.S. Department of Labor ("DOL") issued a new rule allowing the administrators of retirement plans to post retirement plan disclosures online or deliver them by email as a default method of delivery. This expands previous rules, which first allowed plans to issue some disclosures through electronic media in 2002. Now, plans may satisfy notice requirements by utilizing two new optional methods of electronic delivery: a) posting documents on the plan website and/or b) email delivery directly to eligible individuals. While only available to retirement plans such as pension plans, profit-sharing plans, and 401(k) plans at this time, the DOL stated it may expand the new electronic disclosure guidelines to welfare plans in the future.

To construct the new rule for electronic disclosure, the DOL relied on research concerning present day access to and use of electronic media. Their primary concern was whether allowing retirement plans to rely on methods of electronic delivery for plan disclosures would effectively and properly reach the intended recipients—specifically, ensuring plan participants and beneficiaries who lacked regular access to electronic means would be reached. However, the research findings gave the DOL reason to believe that participants were more likely to welcome and benefit from allowing plans to issue notices via email or other electronic delivery due to the rising trend of access to and reliance upon technology in the United States today.

Especially in light of the COVID-19 pandemic, the DOL recognized the value of removing burdens to administrators and significantly reducing costs associated with complying with ERISA's disclosure requirements. Adopting the new electronic disclosure rule will allow plan administrators to utilize the tools and systems already in place to electronically deliver notices and mitigate the significant costs associated with continually mailing and furnishing reccurring plan disclosures. And because the electronic delivery methods remain optional, plans are afforded the flexibility to select the delivery method that best suits their needs.

The rules established in 2002 have allowed plans to provide electronic disclosures to individuals who gave their affirmative consent to receive documents electronically and to individuals who are "wired at work," meaning they have the ability to access plan disclosures electronically at their workplace. The DOL's new rule creates a third category of eligible individuals for whom plan disclosures may be furnished electronically: individuals who have provided the plan with an electronic address. Under the new rule, retirement plans may now elect to utilize electronic delivery as the default method of delivery for individuals who have provided the plan with an electronic address, either by making required disclosures available on the plan's website or by delivering disclosures directly to the individual via email.

However, in order to protect the rights of individuals who would prefer to opt out of receiving plan disclosures electronically, prior to issuing notices electronically a plan must send a notice on paper to each eligible individual advising of their right to opt out of default electronic delivery options. The notice must inform the individual that some or all documents will be furnished electronically to the electronic address provided unless the individual requests that those documents not be sent electronically. The notice must also specifically identify the electronic address that will be used for delivery of plan disclosures and include instructions on how to access plan documents that will be posted on the plan's website. While this initial notice only needs to be issued once, it must be issued before a retirement plan may begin utilizing the new electronic disclosure options.

In addition to the initial notification of default electronic delivery, plans that choose to post disclosures on their website must issue a Notice of Internet Availability ("NOIA"). The NOIA must be issued each time a covered document is posted or otherwise made available on the plan's website. As opposed to the initial notification of default electronic disclosure, the NOIA is sent electronically. This is to support the DOL's goal of advancing the use of electronic tools associated with ERISA disclosures, as well as significantly reducing the cost associated with posting these disclosures. The NOIA also includes instructions on where the published disclosures are located and how individuals may access them, as well as a cautionary statement that documents are not required to be available on the website for longer than one year.

The DOL believes these new procedures will prove an effective balance to enhance the use of electronic disclosures while respecting and honoring the preferences of some individuals that documents be mailed or delivered on paper. The new electronic disclosure options became available for retirement plans to begin utilizing as of July 27, 2020.

WHAT THE NEW ACA NONDISCRIMINATION PROVISION MEANS TO GROUP HEALTH PLANS

On June 12, 2020, the U.S. Department of Health and Human Services ("HHS") finalized a rule under the nondiscrimination provision of Section 1557 of the Affordable Care Act ("Final Rule"). The Final Rule is effective August 18, 2020, and scales back the reach of the previous rule issued by the Obama administration ("2016 Rule").

As a background, the 2016 rule prohibits discrimination on grounds of race, color, national origin, sex, age, or disability so that an individual cannot be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any health program. Ultimately, the 2016 Rule required health plans that received financial assistance from HHS to (1) amend their health plans to remove exclusions for transgender services, (2) post notices of discrimination and taglines in the top 15 non-English languages, and (3) establish a grievance procedure.

The Final Rule eliminated certain provisions of the 2016 Rule. Most notably, HHS significantly reduced the scope of the rule itself by limiting the entities to which it applies by clarifying, among other things, that a health insurer's operations are subject to the Final Rule only to the extent any of its operations receive federal financial assistance directly from HHS. Entities that receive federal funding through Medicare Part C, Medicare Part D, or Medicaid would be subject to the rule—including Medicare Advantage Plans, Medicare Managed Care Plans, Employer Group Waiver Plan (EGWP), or Retiree Drug Subsidy Plans—to the extent that they receive direct federal financial assistance. In other words, plans that have self-insured Medicare Advantage and Prescription Drug Plans or EGWPs would not be considered covered entities because they do not have a contract directly with HHS and thus do not receive federal financial assistance directly.

If a plan is still determined to be a covered entity under the Final Rule, the following provisions apply:

- Plans are permitted to categorically exclude coverage for services related to gender transition and may exclude related treatment as experimental or cosmetic.
- Plans are no longer required to post notices of discrimination or include taglines with "significant" communications. The Final Rule maintains the requirement that plans provide taglines whenever such taglines are necessary to ensure meaningful access to a health program. Keep in mind that plans are still mandated under other federal laws to provide nondiscrimination notices and taglines, such as the Summary of Benefits and Coverage. The Final Rule retains many of the same language access requirements, namely plans must continue to provide access to translation and interpretation services to individuals at no cost.
- Plans are no longer required to establish a grievance procedure or designate a compliance coordinator.

On June 15, 2020, three days after the issuance of the Final Rule, the U.S Supreme Court held that Title VII of the Civil Rights Act of 1964 prohibits employment discrimination against lesbian, bisexual, and transgender people. Thereafter, relying in part on the Supreme Court case, two federal district courts issued nationwide preliminary injunctions preventing HHS from implementing parts of the Final Rule, specifically the exclusion of sex stereotyping from the definition of sex discrimination and the inclusion of a blanket religious exemption from sex discrimination claims. The courts in both cases denied the request to eliminate other parts of the Final Rule, namely the elimination of the prohibition on categorical exclusions for transgender services. Recently, several other cases have been filed challenging other parts of the Final Rule as it pertains to gender identity. Group health plans that are considered covered entities under the Final Rule should follow these new cases, as they will likely alter the impact of the Final Rule on their plan.

Group health plans that are no longer considered covered entities under the Final Rule, and thus are not required to follow the provisions of Section 1557, should still be wary that reincorporating certain exclusions, namely blanket exclusions for transgender services, may run afoul of other federal laws such as the discrimination provisions of the Health Insurance Portability and Accountability Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008.

If you have questions about the applicability of the Final Rule or the impact of litigation involving the Final Rule on your welfare plan, please contact our office.

CALIFORNIA V. TEXAS

The future of the ACA remains in limbo pending Supreme Court decision

The constitutionality of the Affordable Care Act (ACA) remains uncertain as *California v. Texas* makes its way to the U.S. Supreme Court.

In 2017, the Tax Cuts and Jobs Act (TCJA) eliminated from the ACA the individual mandate requirement that created a tax penalty for uninsured Americans. A group of 20 states and two individuals sued the federal government seeking to strike down the ACA as an unconstitutional exercise of Congress' taxing power. A Texas federal district court held that the TCJA rendered the mandate unconstitutional and declared the entire ACA invalid.[1] The U.S. Court of Appeals for the Fifth Circuit partially affirmed the district court decision but remanded the case for additional analysis.[2] However, a California-led coalition of attorneys general and governors intervened and appealed the Fifth Circuit's decision to the Supreme Court. The Supreme Court granted California's petition for review and Texas' cross-petition for review.

This case raises three issues being considered by the Supreme Court: (1) whether the individual and state plaintiffs in this case have established legal standing to challenge the law; (2) whether the TCJA rendered the ACA's individual insurance mandate unconstitutional by eliminating the tax penalty; and (3) whether the minimum-coverage provision is severable from the rest of the ACA. Opening briefs were filed on June 25, 2020 and oral arguments are scheduled for Tuesday, November 10, 2020. The Supreme Court lengthened the amount of time for oral arguments to 40 minutes for each side.[3] California will argue for 30 minutes, with the House arguing the remaining 10 minutes. The federal government and Texas will equally split their 40 minutes.

While the litigation is pending, the ACA remains in effect. The Supreme Court will first determine whether the individual and state plaintiffs have standing. If so, the Court will determine whether the TCJA rendered the individual mandate unconstitutional. If the Supreme Court finds that the ACA's individual mandate is unconstitutional but holds that the individual mandate is not essential to and can be severed from the remaining provisions of the ACA, then the ACA will continue to be enforced without the individual mandate. If, however, the entire ACA is struck down, there will be significant effects on the nation's healthcare system. Specifically, provisions that protect people with pre-existing conditions, provide subsidies for people with low incomes, expand eligibility, and increase taxes to fund the Act would be struck down.

It's likely the Supreme Court will not issue a decision until June 2021. Until then, the ACA will continue to be enforced.

[1] *Texas v. U.S.*, Civil Act No. 4:18-cv-00167-O (N.D. Tex. Dec. 30, 2018).
[2] *Texas v. U.S.*, 945 F.3d 355 (5th Cir. 2019).
[3] James Romoser, *Court adds extra argument time in Affordable Care Act case*, SCOTUSblog (Aug. 24, 2020)

NEW SUMMARY OF BENEFITS AND COVERAGE (SBC) TEMPLATES

Under the Affordable Care Act, group health plans and health insurance issuers offering group health insurance coverage are required to provide a written summary of benefits and coverage (SBC) without charge to applicants and enrollees. The SBC must "accurately summarize benefits and coverage available under the plan or coverage." The purpose of the SBC is to provide employees information related to their health plan coverage and costs in a concise and understandable way.

Most group health plans comply with this requirement by using the SBC template, instructions, and related materials provided by the Department of Labor (DOL). On November 8, 2019, the DOL and Health and Human Services (HHS) issued a new template for the SBC. Beginning on the first day of the first open enrollment period for any plan years that begin on or after January 1, 2021, group health plans and insurance issuers will be required to use the updated materials.

The updated template is similar to the 2017 version, with key changes in the entries regarding *minimum essential coverage, minimum value, and coverage examples.*

MINIMUM ESSENTIAL COVERAGE (MEC)

The new template revises this section by eliminating reference to the individual mandate payment. Also, prior templates indicated that individuals without MEC would be taxed. However, the updated template revises the language, indicating that individuals eligible for certain types of MEC may not be eligible for a premium tax credit. It also incorporates an explanation of what MEC includes.

MINIMUM VALUE

This section of the template inquires whether the plan meets Minimum Value Standards. It provides that if one's plan doesn't meet the Minimum Value Standards, he or she may be eligible for a premium tax credit to help pay for a plan. Because the concept of minimum value is not relevant to individual market coverage and issuers of individual market coverage, the new templates revises this section by including a third answer option ("not applicable") in addition to "yes" and "no."

COVERAGE EXAMPLES

The new template includes updated, standardized data provided by HHS to be inserted in the "Total Example Cost" section for the coverage examples. The revised template also includes examples of the interaction between cost sharing amounts and out of pocket limits when applying the suggested rounding rules for dollar values. Finally, the revised template provides a list of the updates made to the SBC Calculator and examples of medical scenarios.

It's critical for group health plans to be prepared to use the updated templates beginning January 1, 2021. Plans should verify that their insurance carriers or third-party administrators are implementing the most recent template.

The updated template is similar to the 2017 version, with key changes in the entries regarding minimum essential coverage, minimum value, and coverage examples.

JOHNSON +KROL
ATTORNEYS AT LAW