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THE JOHNSON + KROL NEWSPAPER

BILLING FOR BILLIONS: HOW MEDICARE FRAUDSTERS GAMED THE SYSTEM

Four of the five largest private health insurers have either settled or are currently facing lawsuits claiming fraudulent coding.

A recent analysis of Medicare records conducted by the Wall Street Journal ("Journal") found that between 2018 to 2021, private insurance companies involved in Medicare Advantage made hundreds of thousands of diagnoses that were unsubstantiated by actual medical treatment, costing American taxpayers approximately $50 billion.[1]

WHAT IS MEDICARE ADVANTAGE?

Medicare Advantage, also referred to as Medicare Part C, is an alternative to the original Medicare system, a federally funded health insurance program for people age 65 or older and for younger people with disabilities. Original Medicare includes only Part A—hospital insurance (i.e., inpatient hospital stays, skilled nursing facility care, hospice care, etc.), and Part B—medical insurance (i.e., doctor visits, outpatient care, preventive services, medical equipment, etc.). Individuals also have the option to enroll in Part D—prescription drug coverage—to help cover the cost of prescription drugs.

Medicare Advantage plans must cover all services that Original Medicare provides, and many plans offer additional benefits not included in Original Medicare, such as prescription drug coverage (eliminating the need for a separate plan), vision, hearing, dental, and fitness benefits.

HOW DOES IT WORK?

The intent behind Medicare Advantage was to provide more options for Medicare beneficiaries, including private plans with more comprehensive benefits than traditional Medicare and improve the quality of their care while streamlining patient costs.[2] Most plans are structured as Health Maintenance Options ("HMOs"), Preferred Provider Organizations ("PPOs"), and Special Needs Plans ("SNPs").

Medicare Advantage combines Parts A and B into one plan, often includes Part D, and may offer extra benefits—all while being managed by a private insurance company. The plans are often cheaper for patients than paying for a Medicare supplement (sometimes referred to as Medigap) and may include an annual out-of-pocket maximum, which Original Medicare does not offer. However, there can be higher out-of-pocket costs for certain services, and network restrictions limit the number of providers available to patients.

The private insurers receive a lump-sum from the federal government for every person they sign up for health benefits, which amount can increase based on the health status of the individuals they cover. In addition, private insurers receive extra federal funding for patients based on the severity of reported conditions (a practice referred to as "risk adjustment"), which has led to private insurers

encouraging providers to document patient diagnoses comprehensively to ensure maximum funding is provided. In 2023, approximately $400 billion in taxpayer money went to private insurers of Medicare Advantage plans.[3]

MORE DIAGNOSES = MORE MONEY

Insurers are permitted to add diagnoses to those submitted by doctors on behalf of patients. While private insurers cannot make medical diagnoses themselves, they can pay other doctors to review medical charts, which can give way for diagnoses to be added. In its analysis, the Wall Street Journal said it found doctors were unaware of some of the diagnoses that were made on their own patients, and that many of such diagnoses were apparently false. As an example, over 66,000 Medicare Advantage patients were diagnosed with diabetic cataracts even though they already had gotten cataract surgery. "It's anatomically impossible," Dr. Hogan Knox, an eye specialist at University of Alabama at Birmingham, told the Journal. "Once a lens is removed, the cataract never comes back."

Meanwhile, another 36,000 diabetic cataract patients didn't receive any treatment related to diabetes.

Similarly, around 18,000 Medicare Advantage patients were diagnosed with HIV through their insurers, but weren't receiving treatment from their doctors. Each HIV diagnosis generated about $3,000 a year in added payments to insurers. According to the Journal's analysis, insurer-driven diagnoses by UnitedHealth in 2021 for conditions that were not treated amounted to additional payments to the tune of $8.7 billion.

Insurers are also allowed to offer financial benefits to patients as an incentive to agree to home visits. These hourlong home visits are conducted by nurses sent to gather health information and identify new diagnoses. The home-visit findings are sent to primary care physicians, who may prescribe additional treatment.[4] Insurers claim at-home visits can help catch diseases early and ensure patients take their medications properly. However, the Journal's investigation found that some home visit companies push their nurses to run screening tests and add unwarranted diagnoses during patient visits based on inaccurate diagnostic tests or misinterpretation of questionnaires. For example, more than 700,000 peripheral artery disease diagnoses were made only during home visits, netting insurers around $1.8 billion in payments in three years.

WHAT COMES NEXT?

Profits on Medicare Advantage plans are at least double what insurers earn from other kinds of policies, so it is no wonder that Medicare Advantage plans now cover about half of the U.S. government's health program for older Americans.[5] Yet, evidence uncovered in lawsuits and audits over the last decade reveals this is largely due to Medicare Advantage insurers' systematic overbilling of the government. Four of the five largest private health insurers have either settled or are currently facing lawsuits claiming fraudulent coding.[6] Smaller health insurers have fared similarly; in September 2023, Cigna Group agreed to pay $172 million to settle a lawsuit filed by the Justice Department over its alleged practices of increasing payments by using in-home health risk assessments and having medical coders conduct chart reviews on its Medicare Advantage patients.[7]

Medicare officials and experts are reviewing and adjusting policies to address these issues, but there are fears that abuses may persist as long as the system relies heavily on diagnosis codes for payment incentives. Such fears are well justified, as a study recently conducted by the University of Southern California found dementia diagnoses among Medicare Advantage members increased 7.8% in 2019, the same year such diagnosis was added to the list of approved risk adjustments.[8]

Nevertheless, the Medicare Payment Advisory Commission ("MPAC") recommends reducing the number of diagnoses that incur extra payments. Accordingly, beginning in 2026, diagnoses such as diabetic cataracts will pay less or nothing to insurers. Further, the MPAC proposed eliminating more than 2,000 specific diagnosis codes from the Medicare Advantage payment formula, including peripheral artery disease. In addition, a spokesperson from the Centers for Medicare and Medicaid Services ("CMS") advised that CMS is ramping up audits to verify diagnoses. Whether or not these steps succeed remains to be seen. For more information, please contact our office.

[1] https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d
[2] https://www.pgpf.org/budget-basics/what-is-medicare-advantage#:~:text=The%20program%20was%20created%20with,half%20of%20all%20Medicare%20enrollment.
[3] https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/
[4] https://www.beckershospitalreview.com/care-coordination/insurers-push-diagnoses-during-at-home-visits-bringing-in-billions-wsj.html#:~:text=Specialties-,Insurers%20push%20diagnoses%20during%20at,visits%2C%20bringing%20in%20billions%3A%20WSJ&text=Home%20visit%20companies%2-0pushed%20nurses,Wall%20Street%20Journal%20reported%20Aug
[5] https://www.nytimes.com/2023/03/22/health/medicare-insurance-fraud.html
[6] https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html
[7] *Medicare Advantage Fraud*, HHS-OIG Impact Brief, July 2024 chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://oig.hhs.gov/documents/impact-briefs/9930/Medicare%20Advantage%20Fraud%20Impact%20Brief.pdf
[8] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812968

SLIMMER WAISTLINES, SLIMMER WALLETS: THE HIGH COST OF SEMAGLUTIDE SOLUTIONS

Semaglutide-based drugs sold under the brand names Ozempic and Wegovy have the potential to be a game-changer for the millions of Americans struggling with Type 2 diabetes and obesity. Ozempic is generally marketed as a diabetes medication, whereas Wegovy is promoted as a weight-loss solution. The CDC estimates that approximately one in ten Americans has diabetes, with 90-96% of those cases being Type 2. Some estimates show that more than 40,000 lives per year could be saved if these products were affordable and accessible in the U.S.

The number of people living with diabetes worldwide is on pace to more than double in the next three decades, according to a recent study published in The Lancet. This increase will bring the total number of diabetic patients worldwide to a staggering 1.3 billion by 2025, making diabetes one of the top 10 leading causes of death and disability globally. If the promise of these drugs is real, they could reverse this trend.

Despite their apparent effectiveness, these drugs remain out of reach for those who need them—particularly Americans. NovoNordisk, a pharmaceutical manufacturer based in Denmark, holds multiple U.S. patents for Ozempic and Wegovy, both brand names for the compound semaglutide. The current price of Ozempic in the United States is $969 per month, while Wegovy is priced at $1,349 per month. According to a letter from the nonprofit consumer advocacy organization Public Citizen to the Department of Health and Human Services (HHS) dated August 5, 2024, Ozempic costs up to 15 times more in the United States than in Canada, Japan, and Europe. Yet a recent study conducted by Yale researchers found that semaglutide could be sustainably priced between $0.89 and $5.00 per month. Additionally, a report by the Senate Health, Education, Labor, and Pensions ("HELP") Committee stated that there are subcontractors in the U.S. prepared to immediately begin manufacturing a generic Ozempic for the U.S. government at approximately $100 per month, if given consent. The high price has caused many insurers and employer-provided plans to exclude coverage for these drugs, placing them almost completely out of reach for the average American. There are common-sense solutions to this disparity, yet none of them can be implemented.

One reason is the monopoly power granted to drug companies by U.S. patent laws. Patent laws in the United States play a crucial role in shaping the pharmaceutical industry, particularly when it comes to the pricing of prescription drugs. Pharma companies file for a patent soon after the discovery of a drug with a novel mechanism of action. Patents give drug companies exclusive rights to manufacture and sell their products for a set period of time, typically 20 years from the filing date, without competition. Once the 20-year exclusivity period is up, generic competitors can enter the market and compete with the branded drug on price. But until that point, the monopoly allows drug companies to sell their product essentially without competition.

Compounding this issue, there are no meaningful controls over the prices pharmaceutical companies charge for their drugs in the U.S. In some countries, the approval of new drugs is tied to their cost-effectiveness, meaning a drug is only approved for public reimbursement if it delivers sufficient value for its price. In the U.S., however, the Food and Drug Administration evaluates drugs based on safety and efficacy but not on cost, which means that once a drug is approved, companies can charge what the market will bear, regardless of its value relative to its cost. In wealthier countries with higher disposable income and weaker price controls—such as the U.S.—drugmakers can set prices higher, whereas in countries with lower incomes or stronger pricing regulations, they adjust prices downward. Unchecked pricing coupled with the monopoly power granted to pharmaceutical companies has led to abuse.

To extend the initial 20-year patent period, pharmaceutical companies have developed several strategies. One involves filing dozens or even hundreds of patents on the same drug based on dubious differences, known as patent thickets. One of the oft-cited examples of abuse involves AbbVie, which managed to extend its patent protection on its arthritis drug Humira for an additional seven years beyond the original twenty. AbbVie filed 312 patents on the drug, 94% of which were filed after it had already received FDA approval, and secured 166 of those patents. The point was to create a massive legal deterrent to any generic competitors who might attempt to enter the market when the

original patent expired. And it worked. In the seven years it took to resolve these after-the-fact patents, AbbVie generated an additional $75 billion in profits from Humira. If the past is any predictor of the future, NovoNordisk's website states that the company holds 29 U.S. patents related to the manufactur e and delivery of Ozempic and Wegovy, and owns an additional 12 patents for semaglutide tablets marketed under the name Rybelsus. NovoNordisk's patent is currently set to expire in 2032.

Ozempic, Wegovy, and other semaglutide-based drugs could be effective weapons in the war on diabetes and obesity, but they remain largely out of reach for most people who need them. This dynamic reflects a broader debate over how patent laws—while designed to encourage innovation—can also restrict access to affordable healthcare. Until a drug's patent expires, which for Ozempic could take years, U.S. consumers will continue to face significantly higher prices than those in other countries, unless systemic reforms are made to either the patent system or drug pricing regulations. Patent laws grant drug companies the exclusive right to profit from their innovations, but this protection results in higher prescription costs, especially in the U.S., where patent enforcement is strong and drug price regulation is relatively weak.

“SB3649 represents a significant step toward protecting workers' rights in Illinois by preventing employers from using captive audience meetings to influence employees on unionization efforts.”

ILLINOIS’ NEW CAPTIVE AUDIENCE LEGISLATION

Governor J.B. Pritzker signed into law SB3649, which aims to limit an employer’s ability to hold captive audience meetings. SB 3649 is known as the Worker Freedom of Speech Act (the “Act”). Specifically, the Act forbids employers from disciplining, firing, penalizing, or threatening employees for declining to attend mandatory company meetings where the employer shares its views on religious or political topics. Captive Audience Meetings are defined as mandatory meetings held by employers during working hours to dissuade employees from joining a labor union.

SB3649 states that an employer or the employer's agent, representative, or designee may not discharge, discipline, or otherwise penalize, threaten to discharge, discipline, or otherwise penalize, or take any adverse employment action against an employee:

(1) because the employee declines to attend or participate in an employer-sponsored meeting or declines to receive or listen to communications from the employer or the agent, representative, or designee of the employer if the meeting or communication is to communicate the opinion of the employer about religious or political matters;

(2) as a means of inducing an employee to attend or participate in meetings or receive or listen to communications; or

(3) because the employee, or a person acting on behalf of the employee, makes a good faith report, orally or in writing, of a violation or a suspected violation of the Act.

Employers in Illinois will be required to post and maintain a notice of employee rights provided in SB3649. These notices have to be posted in locations where other employee notices are typically displayed. Employers will be required to post within thirty days of SB3649 enactment. SB3649 is set to go in effect on January 1, 2025. If an

employer is found to violate any part of this Act, the employer will be assessed $1,000.00 for each violation. An employee or interested party may file a Complaint with the Illinois Department of Labor or bring an action for violation of this Act in the county where the violation is alleged to have occurred or where the principal office of the employer is located. The Act defines an interested party as "an organization that monitors or is attentive to compliance with public or worker safety laws, wage and hour requirements, or other statutory requirements[.]" Therefore, a Union could file a Complaint with the Illinois Department of Labor for an alleged violation of this Act.

Once a Complaint has been filed, the Department of Labor will then send Notice of the Complaint to the employer and the interested party. The employer will then have the option to contest or cure the violation within thirty days of receiving the Notice. If the Employer fails to respond to the Notice, the Department of Labor will then issue a Notice of Right to Sue to the interested party.

If, within 180 days after serving the Notice of Complaint to the parties, the Department has not (i) resolved the dispute and cure period, (ii) mutually agreed with the parties to extend the time for the named party to remedy the violation and settle the Complaint, or (iii) issued a right-to-sue letter, the interested party may file a civil action for penalties. The parties can mutually agree to extend the 180-day period. The statute of limitations for the interested party to bring an action under this Act will be tolled during the 180-day period and any agreed-upon extensions. At the end of this period, or any extensions, the Department must issue a right-to-sue letter to the employee or interested party.

A Complaint must be brought within three years after the alleged conduct plus any period for which the limitations period has been tolled. An interested party that prevails in an action under this Act shall be awarded ten percent of any statutory penalties and all attorney's fees and costs in bringing the lawsuit.

Critics of the bill claim that this will hinder an employer's right to hold a meeting with employees regarding unionization and limits an employer's freedom of speech. However, SB3649 still allows employers to hold a meeting regarding unionization but stops them from penalizing or threatening employees from not attending these meetings. Legal challenges have already been filed.

SB3649 represents a significant step toward protecting workers' rights in Illinois by preventing employers from using captive audience meetings to influence employees on unionization efforts. Illinois becomes the eighth state to pass such legislation, including Connecticut, Minnesota and New York. This law ensures that employees can decline participation in such meetings without fear of retaliation, and also establishes penalties for violations. By requiring employers to post notices of employee rights and providing clear avenues for legal recourse, SB3649 promotes a fairer and more transparent workplace environment. The law's implementation on January 1, 2025, marks a critical milestone in safeguarding employee freedom of choice. If you should have any questions on SB3649, please feel free to give our office a call.

FIRST ESG CASE HEARD POST-CHEVRON

On July 18, 2024, the U.S. 5th Circuit Court of Appeals decided to send a case, *Utah v. Su*, Case No. 23-11097, back to the District Court to rehear a challenge to the Department of Labor's environmental, social and governance rule ("ESG Rule") for investing by defined contribution retirement plans. The ESG Rule allows fiduciaries to consider environmental, social and governance factors when making investment decisions and went into effect February 1, 2023. While an appellate court remanding (or sending back) a case in and of itself is not significant, the remand reflects the current legal landscape after the U.S. Supreme Court overturned the *Chevron* doctrine.

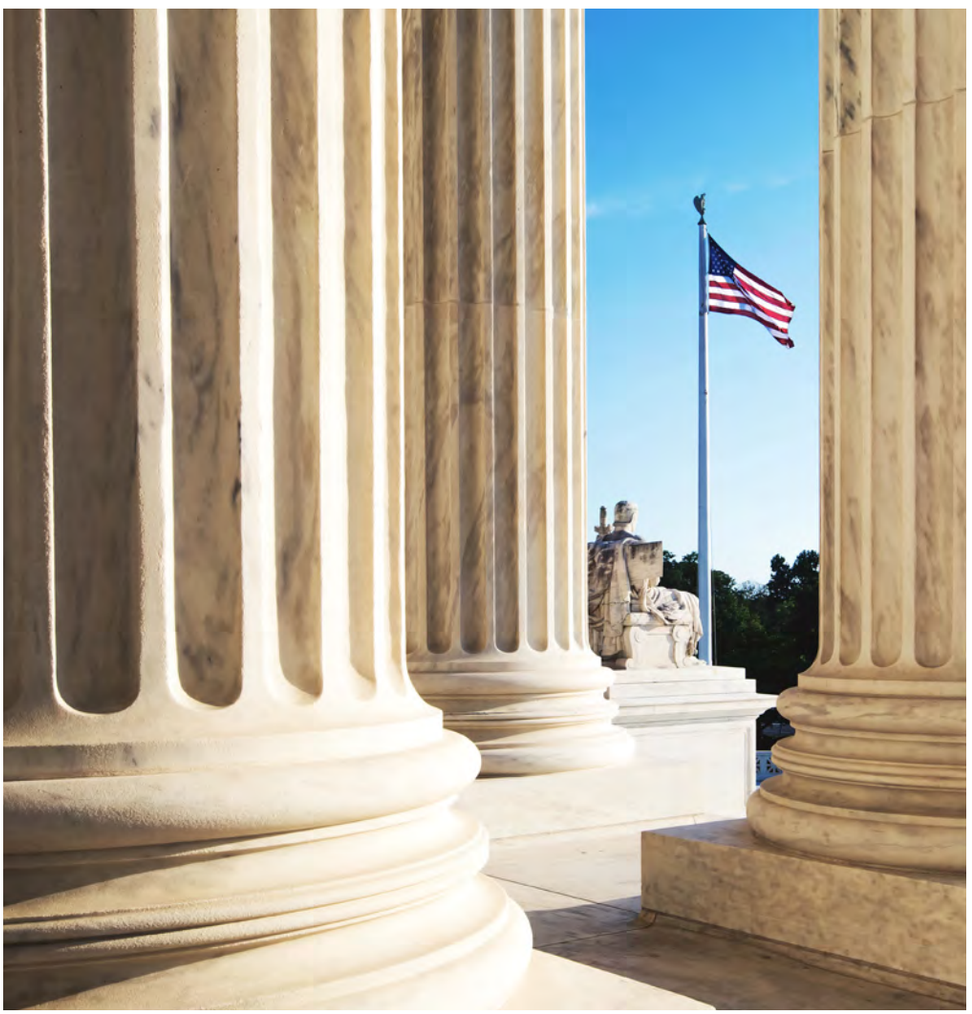
So, what is the *Chevron* doctrine? The *Chevron* doctrine, named after the 1984 Supreme Court Decision, required federal courts to be deferential to federal agencies' interpretations of ambiguous language. In other words, courts used to be required to defer to an agency's interpretation of a vaguely written law if the agency did not act in an arbitrary or capricious way.

On July 28, 2024, *Chevron* was overturned by the Supreme Court's decision in *Loper Bright Enterprises v. Raimondo*, 603 U.S.____(2024). In *Loper Bright*, the Supreme Court held that the "Administrative Procedure Act requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority, and courts may not defer to an agency interpretation of the law simply because a statute is ambiguous; *Chevron* is overruled." The end of *Chevron* deference marks a significant shift in administrative law, with great implications for federal agencies, including the Department of Labor.

Now, the Department of Labor's ESG Rule is the first case involving ESG's to be heard before a court after the *Chevron* deference was eliminated. In *Utah v. Su*, the Court was tasked with hearing whether the DOL exceeded its powers under federal benefits law when it issued the ESG Rule, which is what the plaintiff group of 29 Republican attorneys general argued.

The ESG Rule states that a fiduciary must consider financial factors when determining what investments to include in a 401(k) Plan, and the rate of return needs to be the primary factory when deciding on an investment, but if there are two investments that are essentially equal in terms of rate of return, a plan sponsor can consider the ESG as a tiebreaker. ERISA is silent on whether plans can consider factors other than rate of return for investment decisions, but courts were previously required to defer to the DOL or similar agencies directing fiduciaries to consider the ESG as a tiebreaker under the *Chevron* doctrine.

Now that the *Chevron* doctrine is no more, the Court sent the case back to the District Court to be examined under the new legal landscape where the *Chevron* deference is eliminated, and the District Court has the freedom to examine the rule and decide if it was within the authority of the DOL to issue the rule.



NEW SPACEX OPINION IN NLRB CASE HAS OMINOUS HINTS FOR FEDERAL AGENCIES

In January 2024, SpaceX filed a lawsuit ("Brownsville Case") challenging the constitutionality of the National Labor Relations Board ("NLRB"). The lawsuit stemmed from Unfair Labor Practices charges filed against SpaceX in 2022. The Charges alleged that eight former employees were terminated for engaging in protected conduct. After initial rounds of investigation, the NLRB found merit to the Charges and filed an official Complaint against SpaceX, setting a hearing date for consideration of the Charges. This prompted SpaceX to file a lawsuit challenging the constitutionality of NLRB's administrative law judges ("ALJ") and members of the NLRB.

SpaceX argues the NLRB violates the United States Constitution in three ways. First, ALJs may only be removed from their positions for cause by officials who may also be removed only for cause. This, SpaceX argues, infringes Presidential removal powers under Article II. Second, ALJs were recently permitted to award remedies beyond backpay, which SpaceX alleges violates an offender's right to a jury trial. And third, the NLRB's exercise of prosecutorial, legislative, and adjudicatory authority in the same proceeding violates separation of powers and due process rights. SpaceX seeks an order declaring the NLRB unconstitutional and requests the Court to stop its proceedings before the agency.

Since the initial filing, the parties have been fighting over the appropriate venue. The Brownsville Case was filed in Texas, but the NLRB sought to have the matter moved to Los Angeles, where SpaceX is based. While it was originally ordered to move, a Fifth Circuit Court of Appeal's Panel denied the transfer. Then in April, SpaceX filed a second lawsuit ("Waco Case") in a different district of Texas also against the NLRB challenging constitutionality along the same grounds as the Brownsville Case in a charge related to mandatory arbitration and dispute resolution provisions in severance agreements.

In July, Judge Alan Albright, the presiding judge in the Waco Case, granted a preliminary injunction for SpaceX stopping administrative hearings pending the outcome of the lawsuit. In so ordering, the Judge Albright made the finding SpaceX was likely to succeed on the merits of its lawsuit. His reasoning followed an analogous case, *Jarkesy v. Sec. & Exch. Comm'n.* 34 F.4th 446, 465–66 (5th Cir. 2022), *aff'd and remanded*, 144 S. Ct. 2117 (2024). There, Securities and Exchange Commission ALJ removal restrictions were deemed unconstitutional because ALJs had two or more layers of for-cause protection from Presidential removal. *Id*. at 463.

Judge Albright declined to sever the unconstitutional removal provisions, in lieu of staying the hearings, during the preliminary injunction stage as he deemed it premature. Traditionally, where a portion of a statute is deemed unconstitutional, that portion is severed from the legislation and the otherwise constitutional portions remain in place thereby affording continued action. Judge Albright explained the preliminary injunction is a temporary measure meant to preserve the status quo and even if it were appropriate, he wrote, "[h]ere there is no appropriate way to sever any of the removal protections to remedy the constitutional problems with the NLRB's structure." *SpaceX v. NLRB*, No. W-24-CV-00203-ADA (W.D. TX July 23, 2024). The administrative hearings in the Brownsville Case had previously been stayed, pending appeals.

The lawsuits with SpaceX are two of nearly twenty the agency is presently facing that challenge the NLRB's constitutionality. The NLRB has similar lawsuits from companies like Amazon, Starbucks, and Trader Joe's. More recently, Amazon filed in early September seeking an injunction to stop agency proceedings regarding a refusal to bargain case. The injunction was granted and proceedings were stayed in late September.

NEXT STEPS IN THE SAGA OF NCAA STUDENT ATHLETES

The Third Circuit Court of Appeals ruled that student athletes are not barred from being considered as "employees" under the Fair Labor Standards Act.

In 2021, the U.S. Supreme Court issued an opinion, *NCAA v. Alston*, 594 U.S._____(2021), in which it unanimously ruled that restricting student athletes from profiting on their own likenesses was a violation of the Sherman Antitrust Act. The NCAA reacted by creating a policy called Name Image Likeness or "NIL". The interim policy adopted by the NCAA consisted of three parts:

1. Athletes can engage in NIL activities if they follow their state's laws where their school is located. Schools must ensure these activities comply with state law.
2. Athletes in states without NIL laws can still participate in NIL activities without breaking NCAA rules.
3. Athletes are allowed to seek professional service providers for their NIL activities.[1]

Many student athletes began operating under this interim policy, including sponsorships on social media for stars like LSU's Olivia Dunne, to selling autographed memorabilia, blogging, podcasting and merchandising.

However, there was still the question of all the lost revenue to athletes for years past. In 2020, Grant House, a former Arizona State swimmer and Sedona Prince, who had previously played basketball at Oregon University and was then playing at TCU, filed a lawsuit against the NCAA and its "Power Five"[2] conferences alleging that the NCAA had violated anti-trust rules prior to 2021. A second lawsuit, filed by former University of Illinois football player, Tyler Oliver, was later consolidated into *House v. NCAA*. In November of 2023, the District Court in the Northern District of California granted class action certification to three additional classes of athletes.

On May 23, 2024, the parties announced that they had reached a proposed settlement. The settlement includes $2.8 billion in back pay over a 10-year period. The NCAA would cover 41% of damages, the Power 5 would cover 24%, the Football Championship Subdivision will be responsible for 13%, the Group 5[3] would cover 10% and any Division 1 school that did not have a football team will jointly be responsible for 12%.

The Settlement also includes an optional revenue sharing program for the power conferences in which 22% of the school's annual revenue, which the settlement estimates to be approximately $20 million per school, would be distributed directly to

student athletes and would increase annually.

There are objections to the settlement including the fact that an estimated 95% of backpay will go exclusively to former men's football and basketball players. The remaining 5% or $140 million will be split between every other former Division 1 athlete. According to Michele Simpson Tuegel, an attorney who represents a group of female athletes, "[t]he proposed NIL settlement is far cry from the fair and equitable belief it promises to former collegiate athletes."[4] Whether this has changed between the original proposed settlement and the eventually approved preliminary settlement, remains to be seen.

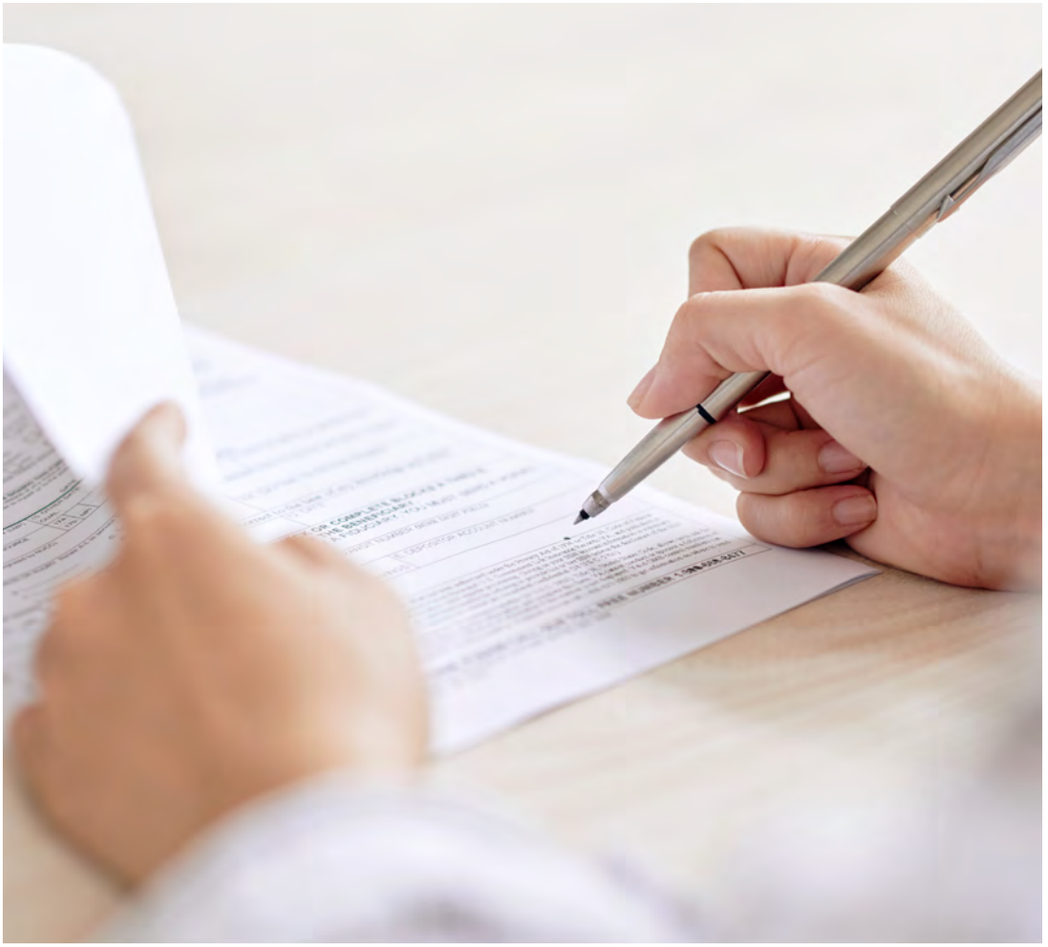
On October 7, 2024, after initially raising several concerns, Judge Claudia Wilkens granted preliminary approval to the settlement. Judge Wilkens gave impacted athletes until January 31, 2025 in which to file objections and a final hearing to approve the settlement has been set for April 7, 2025.

On a separate front, on July 11, 2024, the Third Circuit Court of Appeals ruled that student athletes are not barred from being considered as "employees" under the Fair Labor Standards Act. In the case of *Johnson v. NCAA*, the Third Circuit ruled that the appropriate test to consider whether or not they were employees was the "economic realities test" holding the following: "college athletes may be employees under the FLSA when they (a) perform services for another party, (b) 'necessarily and primarily for the other party's benefit,' (c) under that party's control or right of control, and (d) in return for 'express' or 'implied' compensation or 'in-kind benefits'."[5] In the Decision, the Third Circuit was clear in exposing some of the inherent unfairness in the NCAA, noting "...by far the most obvious beneficiaries of college sports are a select few administrators, athletic directors, and coaches. The recently retired Alabama football coach, Nick Saban, earned over $11.4 million in his last year leading the Crimson Tide, making him the highest-paid coach in college sports..."[6] The Third Circuit remanded the case to the District Court for reconsideration under the economic realities test.

This is certainly not the end of this topic. As former athletes from Michigan have also sued the Big Ten Network and the NLRB approved a Union election for the men's basketball team at Dartmouth.[7] The election was held in March and the team voted to unionize 13-2. However, Dartmouth has announced that is refusing to recognize the election and will not bargain with the SEIU, the Union the players had voted to represent them. All of these matters will likely end up in protracted litigation and possibly in front of the Supreme Court. If that is the case, the NCAA may be in trouble, as potential swing Justice Brett Kavanaugh was not sympathetic to the NCAA in his concurrence in *Alston*, stating, "[n]owhere else in America can businesses get away with agreeing not to pay their workers a fair market rate on the theory that their product is defined by not paying their workers a fair market rate...The NCAA is not above the law."[8]

[1] https://www.ncsasports.org/name-image-likeness
[2] The Power Five conferences at the time were the Atlantic Coast Conference ("ACC"), Big Ten Conference, Big 12 Conference, Southeastern Conference ("SEC") and Pac-12 Conference. As of 2024, the group is now known as the Power Four, with the Pac-12 no longer being considered part of the group.
[3] The "Group 5" is comprised of the American Athletic Conference, Conference USA, Mid-American Conference, Mountain West Conference and the Sun Belt Conference.
[4] https://www.si.com/college/gonzaga/basketball/current-and-former-college-athletes-claim-house-v-ncaa-settlement-undercompensates-female-athletes-01j71hrwngsn
[5] *Johnson v. NCAA*, Case No. 22-1223 at pg. 35 (3rd Cir. 204) (*internal citations omitted*).
[6] *Id.* at 13.
[7] Case No. 01-RC-325633
[8] *NCAA v. Alston*, 594 U.S. at pg. 5 (Kavanaugh, J. concurring).

THE FTC'S BAN ON NONCOMPETE AGREEMENTS ON HOLD FOLLOWING RULING IN TEXAS FEDERAL COURT



On April 23, 2024, the Federal Trade Commission ("FTC") issued a new rule that would ban workers and employers from entering into noncompete agreements. Originally, the FTC's final rule would go into effect on September 4, 2024. However, the new rule faced legal challenges almost immediately after the FTC issued it. Among these first legal challengers were: *Ryan, LLC v. FTC*, Case No. 3:24-cv-00986-E (N.D. Tex. Apr. 23, 2024); *ATS Tree Services, LLC v. FTC*, Case 2:24-cv-01743 (E.D. Pa. Apr. 25, 2024); and *Properties of the Villages, Inc. v. FTC*, Case No. 5:24CV00316 (M.D. Fla. June 21, 2024). Of the three cases against the FTC's new rule, the only case that has been decided is *Ryan, LLC v. FTC*. The other two cases are still in litigation.

On April 23, 2024, the same day the FTC issued its new rule, the U.S. Chamber of Commerce issued a statement declaring its intention to challenge the new rule in court. It followed through, and a few hours later the Chamber of Commerce filed the *Ryan, LLC* case in the United States District Court for the Northern District of Texas.

Following a heated legal battle, on August 20, 2024, the Court granted summary judgment in favor of the Chamber of Commerce. In its decision, the *Ryan* court concluded two things: (1) that the FTC does not have the authority to make substantive rules that regulate unfair competition, and (2) that the ban was arbitrary and capricious. For those two reasons, the *Ryan* court decided to block the ban as an unenforceable overreach of the FTC's authority.

The *Ryan* court wrote that its decision to set aside the Rule has a "nationwide effect," is "not party-restricted," and "affects persons in all judicial districts equally." The *Ryan* court's decision also states that the ban "shall not be enforced or otherwise take effect on September 4, 2024, or thereafter."

This decision means that the FTC's new rule banning noncompete agreements is now unenforceable nationwide. Employers do not need to comply with the FTC's new rule. However, employers should keep in mind that state-specific rules banning noncompete agreements have not been impacted by the *Ryan* decision.

Since the *Ryan* court has made its final decision, the FTC now has the option to appeal the decision to the U.S. Fifth Circuit Court of Appeals. It is not certain at this time if the FTC will take this option. If they do, then the Fifth Circuit may either agree or disagree with the *Ryan* court's ruling. Should the FTC file an appeal, the future of the rule banning noncompete agreements will be uncertain until the Fifth Circuit makes its ruling. If the FTC does not file an appeal, the *Ryan* court's decision will stand and the rule will remain unenforceable. The deadline for the FTC to file an appeal to the Fifth Circuit is October 20, 2024.

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