Johnson & Krol, LLC

Taft-Hartley Report

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Supreme Court Upholds Patient Protection and Affordable Care Act

On June 28, 2012, the United States Supreme Court, in a 5-4 decision, upheld most of the Patient Protection and Affordable Care Act ("ACA").

Although the case presented several constitutional challenges, the main argument revolved around the individual mandate – the requirement that almost all Americans buy health insurance by 2014 or pay a "shared responsibility payment." Before the Court could decide the constitutionality of the individual mandate, however, it had to determine whether the Anti-Injunction Act, a federal tax law, barred any challenge to the mandate prior to its effective date in 2014.

During oral arguments, opponents of the individual mandate and the Obama administration argued that the individual mandate is not the type of tax provision to which the Anti-Injunction Act applies. Accordingly, both parties urged the Court to address the merits of the constitutional challenge now, rather than deferring a decision until 2014.

Chief Justice Roberts, writing for the majority, held that the Anti-Injunction Act did not bar the suit because the ACA actually describes the shared responsibility payment as a "penalty," not a "tax."[1] Because the Anti-Injunction Act generally prohibits lawsuits that challenge a "tax" until the tax has actually been assessed, the Anti-Injunction Act does not prevent the Court from deciding the constitutionality of the ACA.

The main constitutional challenge to the ACA focused on the individual mandate. Defending the constitutionality of the mandate, the government argued that Congress can require everyone to buy health insurance using its power under the Commerce Clause of the Constitution.[2] Five Justices – Chief Justice Roberts, Kennedy, Scalia, Thomas, and Alito – all rejected this argument.

Chief Justice Roberts, writing for the majority, acknowledged that Congress has a broad power under the Commerce Clause, but Congress's power to regulate commerce assumes that there is commercial activity to regulate.[3] "The individual mandate, however, does not regulate existing commercial activity. It instead compels individuals to *become* active in commerce by purchasing a product, on the grounds that their failure to do so affects interstate commerce."[4] The Court held that "construing the Commerce Clause to permit Congress to regulate individuals precisely *because* they are doing nothing would open a new and potentially vast domain to congressional authority."[5]

Even though Chief Justice Roberts rejected the government's Commerce Clause argument, he agreed with one of the government's alternative arguments: the mandate imposes a "tax" on people who do not buy health insurance. Accordingly, the Court upheld the individual mandate under the Taxing Clause of the Constitution because the shared responsibly payment looks like a tax in many respects.[6] Specifically, the payment is paid into the Treasury by "taxpayers" when they file their tax returns and the payment is found in the Internal Revenue Code and enforced by the IRS.[7]

Chief Justice Roberts did, however, acknowledge that the ACA describes the payment as a "penalty," not a "tax." While that label is fatal to the application of the Anti-Injunction Act, the Court held that it does not determine whether the shared responsibility payment may be viewed as an exercise of Congress's taxing power.[8] Accordingly, Chief Justice Roberts held that "because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."[9]

Because a majority of the Court upheld the individual mandate, the Court did not consider whether other parts of the health care law were unconstitutional. The Supreme Court did however address the final constitutional challenge – the ACA's Medicaid expansion. The Medicaid provisions of the ACA require states to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line.[10] Under the ACA, if states do not expand their Medicaid programs, they would risk losing all Medicaid funding provided by the federal government. The states argued that the Medicaid expansion was unconstitutional because it was coercive.

Chief Justice Roberts, again writing for the majority, held that the Medicaid expansion is constitutional, but it is unconstitutional for the federal government to withhold existing Medicaid funding for states that do not comply. The Court declared that nothing in its opinion "precludes Congress from offering funds under the ACA to expand the availability of health care, and requiring that states accepting such funds comply with the conditions on their use."[11] However, the Court also held that Congress was not free to penalize states that choose not to participate in the Medicaid expansion program by taking away their existing Medicaid funding.[12]

For more information on the Supreme Court's decision, please contact our office.

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Fiduciaries Must Consider All Plans When Making Investment Decisions, says District Court

Kraft Foods Global, Inc. employees ("Employees") filed a lawsuit in 2008 against Kraft and its affiliated companies alleging that Kraft and Altria Corporate Services, Inc. (collectively referred to as "Kraft") breached their fiduciary duties by investing in two actively managed mutual funds: (1) the Balanced Fund and (2) the Growth Equity Fund. Specifically, the Employees argued that Kraft should have eliminated these actively-managed funds from its Section 401(k) plan since they have eliminated actively-managed funds from their defined contribution plans.

Recently, the U.S. District Court for the Northern District of Illinois decided that Kraft Employees may continue in their suit against Kraft with regard to the Employees' imprudent investment theory, but they may not proceed on their improper monitoring theory.[13] The court also found that ERISA's six-year statute of limitations time-barred some of the Employees' fiduciary breach claims, however, the court refused to apply the shorter three-year limitations period sought by Kraft and its affiliated companies.[14]

In its argument against the continuation of the Employees' claims, Kraft claimed that the Employees' imprudent investment theory failed because the Employees were judging Kraft's actions with regard to a defined contribution plan in light of actions taken with respect to a defined benefit plan. The court, however, rejected this argument, stating that a jury could conclude that a reasonable prudent business person would not have retained actively managed investments in the plan after 1999 given that Kraft had decided to eliminate active investments from defined pension plans in 1999. Specifically, a reasonable jury could conclude that, despite the differences between defined contribution and defined benefit plans, a prudent fiduciary would have offered indexed (i.e., passive) investments rather than actively managed investments as plan investment options in the market segments covered by the funds. A reasonable jury, the court maintained, could therefore conclude that Kraft's decision to retain the funds (or failure to make a decision to remove them) constituted a breach of fiduciary duty. It is for this reason that the court allowed the Employees to continue with their claims based on a theory of imprudent investment.

It appears from this ruling that the investment decision making processes of one plan can be applicable to other plans. If a fiduciary makes what it believes to be a prudent investment decision, it must also apply that decision to other plans or be prepared to defend it against an imprudent investment theory. Plan fiduciaries are encouraged to maintain a complete record of the review process and the way in which investment decisions are made in the event that one day they must defend the decisions they make for one plan and not another.

After five years of litigation and in light of this court's recent decision, Kraft and the Employees are currently in the process of reaching a settlement agreement and this case has been dismissed. However, it is important to note that the court's decision to allow the Employees to continue on with their lawsuit based on claims of imprudent investment could mean that fiduciaries who reject certain investment options as undesirable (such as active management in this case) in a defined benefit plan, yet retain those options in a Section 401(k) plan, are risking fiduciary breaches. The decision making process involved in the investment strategy of one plan does not simply end with that plan; rather, fiduciaries must examine the process globally and as a whole.

When is Exhaustion of Administrative Remedies Required?

The United States District Court for the District of Colorado ruled in *Sample v. City of Sheridan*,[15] that a plan participant did not need to exhaust his administrative remedies under the terms of the plan before bringing a claim for denial of COBRA benefits.

In *Sample*, a plan participant sued his former employer alleging that it unlawfully denied him COBRA benefits. The City of Sheridan argued that the plan participant was precluded from bringing his claim for COBRA benefits because he did not first exhaust his administrative remedies as provided for in the plan document. The district court disagreed with the city's argument, noting that exhaustion of administrative remedies is not always required.

The district court relied on the reasoning in *Morales-Cotte v. Cooperativa de Ahorro y Credito Yabucoena*.[16] In *Morales-Cotte*, the United States District Court for the District of Puerto Rico examined a similar denial of COBRA benefits and found that the exhaustion requirement applies only where the issue concerns an interpretation of the *plan* terms – not the statute itself.[17]

To support its conclusion, the *Morales-Cotte* court discussed the theory of administrative exhaustion, which distinguishes between plan-based and statutory-based claims, and acknowledged that the theory has caused a split among the circuit courts.[18] The majority of circuit courts, including the Sixth Circuit,[19] have similarly held that "administrative remedies must be exhausted for plan-based claims, but not where a plaintiff brings suit based on a violation of the terms of the ERISA statute itself."[20] These courts reasoned that while a plan fiduciary may have expertise in interpreting the terms of the plan itself, statutory interpretation is the province of the judiciary.[21]

The *Morales-Cotte* court also discussed the minority position, noting that the law of the Seventh Circuit[22] gives district courts the discretion to require administrative exhaustion of statute-based claims.[23] The Seventh Circuit has reasoned that, regardless of the nature of the ERISA claim, administrative review enables plan administrators to apply their expertise and assemble a factual record that will assist in resolving their actions.[24]

Following the reasoning of the *Morales-Cotte* decision, the *Sample* court sided with the majority view. As a result, the *Sample* court determined that neither party offered any argument regarding a *plan-based* denial of COBRA benefits. As a result, the court held that the participant did not need to exhaust his administrative remedies before bringing his claim for denial of COBRA benefits because the claim was based on the *statute* itself.

DOL Sets Guidelines for Use of Plan Assets for Graduation Ceremonies, Advertising

Recently, the U.S. Department of Labor (DOL) issued a bulletin which addressed questions that have risen throughout the course of the Employee Benefits Security Administration (EBSA)'s investigations of apprenticeship and training plans. These questions are primarily concerned with whether the use of plan assets to pay for graduation ceremonies and advertising expenses violates ERISA's exclusive purpose and fiduciary duty requirements. In its response, the DOL set guidelines intended to encourage consistency among the Regional Offices in their enforcement positions on these issues.

The DOL first explains that, although apprenticeship and training plans are operationally different than other ERISA plans, the plan fiduciaries are still subject to and must abide by the general fiduciary standards set by Part 4 of ERISA. These standards require: (1) the plan to be established and maintained pursuant to a written instrument which provides for one or more named fiduciaries who jointly or severally have authority to control and manage the plan; (2) the assets must be held in trust by one or more trustees; and (3) the trustees and other plan fiduciaries must perform their duties solely in the interests of the plan's participants and for the exclusive purpose of providing apprenticeship or training benefits to participants.

Several apprenticeship and training plan payments have been questioned by the EBSA as part of recent routine investigations because the plan payments do not qualify as payments for plan training benefits. Typically, the payments in question fall into two categories: (1) payments for meals, gifts, entertainment, or other expenses related to graduation ceremonies; and (2) payments to market, advertise, or promote the apprenticeship or training program. The DOL will not unconditionally classify all payments as automatically impermissible; instead, it suggests that investigators examine expenses on a case-by-case basis all the while being guided by ERISA's exclusive purpose rule.

When applying ERISA's exclusive purpose rule to apprenticeship and training plans, the rule requires plan fiduciaries to ensure the reasonableness of plan expenses in light of the education objectives of the apprenticeship or training program. Without exception, apprenticeship and training plan fiduciaries must be able to justify plan expenses as appropriate means of furthering the plan's goal of training workers. If a plan fiduciary uses plan assets without reasonably deciding that the expenditures are likely to promote legitimate plan purposes, the fiduciary breaches its core obligations under ERISA and will be held personally liable for the resulting loss of plan assets.

As with other educational programs, apprenticeships and training programs frequently award graduates of the program with certificates of completion at graduation ceremonies. These ceremonies are generally open to family members, plan officials, school instructors, and administrators. Graduation ceremonies can support the training goals of the plan by creating an incentive and objective for participants to successfully complete the program. Furthermore, apprenticeships and training programs, like other educational programs, must maintain some sort of outreach program to increase awareness of the program and encourage enrollment. Examples of such outreach efforts include distributing information about the program requirements and opportunities, publishing advertisements in local newspapers, and attending employment fairs with local vocational programs.

Given the plans' unique characteristics, the DOL will not treat modest graduation ceremonies or outreach expenses paid for by apprenticeship and training plans as an impermissible use of the plans' assets provided that the expenses are reasonable. Specifically, the amount of the expense must be modest in relationship to the plan's assets and the expenses must be approved by internal accounting and other methods of control to prevent excessive expenditures. Furthermore, the expenses must be for the cost of the graduation ceremony or marketing of the apprenticeship or training program itself. The expenses must not be for industry advancement or for sponsoring employers or employee organizations. Ultimately, the fiduciaries of apprenticeship and training plans must always utilize plan payments in a manner consistent with the fiduciaries' obligation to be prudent and economical in the use of plan assets.

Fee Disclosure Regulations

The Department of Labor (DOL) recently released a final set of regulations that are aimed to help America's workers manage and invest the money they contribute to their multiemployer benefit plans. The purpose of this set of rules is to ensure that participants of specific types of plans are given, or have access to, the information they need to make informed decisions.

I. Background

The Employee Retirement Income Security Act of 1974 (ERISA) generally prohibits the provision of goods, services, or facilities between an employee benefit plan and a party in interest. However, Section 408(b)(2) exempts certain contracts or arrangements for essential services between service providers and plans if the arrangement and the compensation for services are deemed "reasonable." In 2007, the DOL issued proposed rules on what constitutes a "reasonable arrangement," but in 2010, the DOL published interim regulations that made substantial changes to the 2007 proposed regulations. These interim regulations required covered service providers to provide detailed disclosures of certain direct and indirect compensation they accepted directly from the plan. Indirect compensation is defined as any compensation received from any source other than the plan, the plan sponsor, a covered service provider, or a covered service provider's affiliates or subcontractors. Recently, the DOL issued the final regulations, which succeed the 2010 interim regulations. These final regulations maintain the basic structure of the proposed and interim regulations, however, there are a few changes discussed below. Although intended to keep participants more informed, these regulations mandate specific disclosure requirements on three different levels which can lead to more confusion for the administrators of multiemployer benefit plans.

There are potentially three levels of DOL disclosure requirements that apply to multiemployer benefit plans: (1) reporting plan fees on the Form 5500 Schedule C; (2) service provider fee disclosure regulations; and (3) participant fee disclosure regulations.

II. Form 5500 Schedule C Obligations

The reporting of plan fees on the Form 5500 Schedule C applies to welfare, defined benefit pension plans, and defined contribution retirement plans. This requirement first applied to the 2009 plan year and required that all plans request information on indirect compensation received by plan service providers for the prior plan year. Specifically, the service provider must give the plan sponsor four pieces of information: (1) the existence of direct compensation; (2) the services provided for the indirect compensation or the purpose for payment of the indirect compensations; (3) the amount (or estimate) of the compensation or a description of the formula used to calculate or determine the compensation; and (4) the identity of the party(ies) paying and receiving the compensation. Typically, these requests to plan service providers are monitored by the plan in order to complete the Form 5500. Additionally, if a service provider receives more than $5,000.00 or more in compensation for the plan year, it must be reported on the Form 5500.

III. Service Provider Disclosure Obligations

Service provider disclosure obligations, which became effective July 1, 2012, apply to covered service providers of defined benefit and defined contribution plans. Specifically, the rule applies to service providers who enter into a contract or an arrangement with a covered plan for certain services and to those providers that reasonably expect to receive $1,000.00 or more in direct or indirect compensation. Covered service providers include fiduciary and investment adviser services, recordkeeping and brokerage services, and services for which indirect or related party compensation is expected, such as accounting, actuarial, and custodial.

Service provider disclosure obligations require disclosure of three main pieces of information: (1) the description of the services to be provided; (2) the disclosure of fiduciary or investment adviser status; and (3) disclosure of compensation and how it will be received. Direct compensation includes compensation received directly from the plan, whereas, indirect compensation is compensation received from any source other than the plan, sponsor, covered service provider, affiliate, or subcontractor.

Service provider disclosure obligations were due on July 1, 2012, and before any contract or agreement is entered into, extended, or renewed. After the initial round of compliance and once a provider has learned of a change to information, it must disclose the change within sixty (60) days. However, disclosure of changes to investment-related information must be disclosed "at least annually." Monitoring these disclosures can dovetail with the Form 5500 disclosure requirements. The list of plan vendors can then be monitored to determine if covered service providers have submitted the necessary disclosures by the July 1, 2012 effective date. On July 1, 2012, the plans should have requested any missing information in writing and if the covered service provider does not respond within ninety (90) days, the plans must notify the DOL and terminate the contract as expeditiously as possible, taking into account early termination or other similar fees.

IV. Participant Fee Disclosure Obligations

Participant fee disclosure obligations apply to individual account plans, such as participant-directed 401(k) plans. The obligations require that the plans disclose: (1) a new notice of general plan and investment information; and (2) a revised quarterly statement with certain fee information. General plan information, which includes identifying information such as the name and category of investments, performance data, and benchmark information, must be disclosed up front and annually.

Participant fee disclosures are typically made through Summary Plan Descriptions (SPDs), quarterly statements and materials regarding voting, tender or similar rights. The DOL also provided a model which allows the participant fee disclosures to be put in a comparative format for investment-related information. For calendar year plans, the first notice of general plan and investment information must be distributed by August 30, 2012, and the first participant quarterly statement applies to the calendar quarter ending September 30, 2012, and must be distributed by November 14, 2012. For further information on the recent changes in disclosure requirements, please contact our office.

Satisfaction of Monetary Judgments: The Search for Alternative Assets

The first step in collecting contributions from a delinquent employer is obtaining a monetary judgment against the company, and in some cases, against the company's owner. In straightforward collection actions, there is often very little dispute as to the company and/or the owner's personal liability. However, once the trust funds obtain a monetary judgment, the next step involves searching for corporate and/or personal assets to seize in order to satisfy the funds' monetary judgment. But what should the funds do in the event the company has no money to pay off the judgment? There may be alternative assets that could be recovered and sold in order to satisfy all or a portion of the judgment.

In a majority of collection cases, there is often little or no money available to satisfy a monetary judgment against a delinquent company. However, do not overlook other assets that can be seized and sold to satisfy a monetary judgment in favor of the funds. For example, cars, trucks, boats, jet skis, trailers and other titled property, if unencumbered, can be seized and sold by the funds with the proceeds applied towards the outstanding judgment amount. While locating these alternative assets requires diligence on the part of the fund counsel, once found, the process for obtaining a court order to turn over these assets is fairly simple and straightforward. The proceeds garnered from the sale of these assets can sometimes go a long way towards satisfying all, or a portion of, the funds' monetary judgment.

Another benefit of finding alternative assets, such as titled vehicles, is that titled property is not typically covered under a blanket security agreement. For example, a bank may have a superior interest to the funds with respect to the company's general assets under a security agreement, but often times the company's vehicles are not covered under the agreement. Thus, while the funds may be unable to seize tools and other equipment from the delinquent company because of a superior security interest, there may be vehicles and other titled property available for seizure. As in most collection cases, time is the enemy. Consulting with fund counsel early on, as well as a diligent search for alternative assets will maximize the funds' ability to collect and ensure the funds are not leaving any money, or assets, on the table.

ACA Update – Final Regulations for Summary of Benefits and Coverage

Recently, the IRS, DOL, and HHS released additional guidance for the Summary of Benefits and Coverage ("SBC") required under the Patient Protection and Affordable Care Act ("ACA"). The purpose of the SBC is to provide participants and beneficiaries with a concise, uniform summary of coverage options.

The final regulations require plans to provide the SBCs in a uniform format to participants and beneficiaries 30 days prior to the first plan year beginning after September 23, 2012. After the initial compliance date, SBCs must be provided to participants and beneficiaries in the following situations: (1) within seven business days of application, enrollment or request; (2) at least 30 days prior to the first day of coverage under each new plan year; (3) within 90 days of a special enrollment under HIPAA; and (4) no later than 60 days prior to the date a material modification, as discussed below, becomes effective.[25]

Plans may provide the SBC to participants and beneficiaries as either a stand-alone document or in combination with other summary materials, such as a summary plan description ("SPD"), if the SBC information is intact and prominently displayed at the beginning of the materials.

The final regulations also allow plans to mail one SBC to all covered individuals residing at the same address unless the plan has a different last known address for any of the covered individuals. The penalty for failure to provide an SBC is $1,000 per participant and beneficiary as well as excise tax reporting requirements under Internal Revenue Code §4980(D).

Additionally, the final regulations require plans to issue the SBC in a "culturally and linguistically appropriate manner." This means that plans must provide foreign language assistance if the plan mails notices to participants in counties where 10% or more of the population is literate in the same non-English speaking language. Accordingly, plans must insert a one-sentence statement translated into the relevant non-English language on all SBCs sent to addresses in that county. Plans must also provide a completely translated SBC upon request and provide assistance with explaining the SBC.

For our Illinois clients, the foreign language requirement currently applies if the plan mails notices to participants residing in Kane County. For our clients in Indiana and Ohio, compliance with this requirement is not currently necessary. For copies of the recently issued regulations, further information on the recent changes or other ACA compliance and implementation issues, please contact our office.

Health Care Providers, Balance Billing and Third Party Liability

Physician liens are a way for health care providers to recover money for services rendered when a third party caused the patient's injuries. Typically, a health care provider enters into a contract with a managed care organization to provide services to members of the organization at a negotiated rate. The healthcare provider then submits any claims for medical services to the managed care organization at the negotiated rate. Recently, however, health care providers are trying to recover the full amount for the provided medical treatment. Johnson & Krol is seeing this practice more frequently with subrogation and reimbursement cases when the provider knows a third party was at fault for the patient's injuries.

More and more health care providers are not accepting the negotiated rate and trying to recover the full amount directly from patients or liable parties. Only a few cases exist that address the issue. The South Dakota Supreme Court, however, provided some insight into the relationship between participants and health care providers. In *Jennings v. Rapid City Regional Hospital, Inc.,*[26] several plan participants sued a health care provider alleging, among other claims, breach of contract because the health care provider directly billed the plan participants for provided medical services. The participants argued that the managed care agreements prohibited the health care provider from collecting medical care charges directly from the participants because those charges were the plan's obligation.

The court agreed with the participants. Accordingly, the court held that the health care provider could not charge the participants for the cost of covered services because under the language and arrangement of the managed care agreements, the participants were not responsible for the cost of covered services.

Our office has noticed a trend in providers choosing to not submit claims related to a possible third party liability claim to the participant's health insurance and attempting to recover the full amount from the participant and/or his settlement amount. The provider holds off on accepting payment from the health and welfare fund with the hope that he will be able to collect a larger amount from the participant's settlement. Unfortunately, the settlement is often not sufficient to cover the provider's lien and the amount the health and welfare plans paid on behalf of the participant. Once the health care provider learns that the settlement is insufficient for payment of the medical bills, the provider turns back to the participant or the health insurance plan for payment. In many cases, the participant's plan cannot pay the medical bills because the time period for submitting claims has expired. If the participant's attorney cannot get the provider's lien reduced, this leaves the participant with the possibility of large medical bills.

[1] *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2583 (2012).
[2] *Id.* at 2585.
[3] *Id.* at 2586.
[4] *Id*. at 2587.
[5] *Id.*
[6] *Id.* at 2594.
[7] *Id.*
[8] *Id*.
[9] *Id.* at 2600.
[10] *Id.* at 2601.
[11] *Id.* at 2607.
[12] *Id.*
[13] Meredith Z. Maresca, *District Court Allows Employees to Pursue Breach Claims in Kraft Investment Action*, 38 BPR 1389 (7/26/2011) (*available at http://benefits.bna.com*).
[14] *Id.*
[15] *Sample v. City of Sheridan*, 2012 U.S. Dist. LEXIS 52037 (D. Colo. Apr. 13, 2012).
[16] *Morales-Cotte v. Cooperativa de Ahorro y Credito Yabucoena*, 73 F. Supp. 2d 153, 159-60 (D.P.R. 1999).
[17] *Id.* at 160.
[18] *Id.* at 159.
[19] The Sixth Circuit includes Kentucky, Michigan, Ohio and Tennessee.
[20] *Id. See Smith v. Syndor*, 184 F.3d 356, 364-65 (4th Cir. 1999); *Chailland v. Brown & Root, Inc.*, 45 F.3d 947 (5th Cir. 1995); *Richards v. General Motors Corp.*, 991 F.2d 1227 (6th Cir. 1993); *Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197 (10th Cir. 1990); *Zipf v. American Telephone & Telegraph Co.*, 799 F.2d 889, 891-92 (3d Cir. 1986); *Amaro v. Continental Can Co.*, 724 F.2d 747, 749-50 (9th Cir. 1984).
[21] *Id.*
[22] The Seventh Circuit includes Illinois, Wisconsin and Indiana.
[23] *Id.* at 160.
[24] *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996).
[25] A material modification is defined in ERISA §102 as any change to the coverage offered that independently or in conjunction with other contemporaneous changes would be considered by the average plan participant to be an important change, including changes that enhance or reduce benefits, increase premiums or cost-sharing or impose new referral requirements.
[26] *Jennings v. Rapid City Reg'l Hosp., Inc.*, 802 N.W.2d 918 (S.D. 2011).

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