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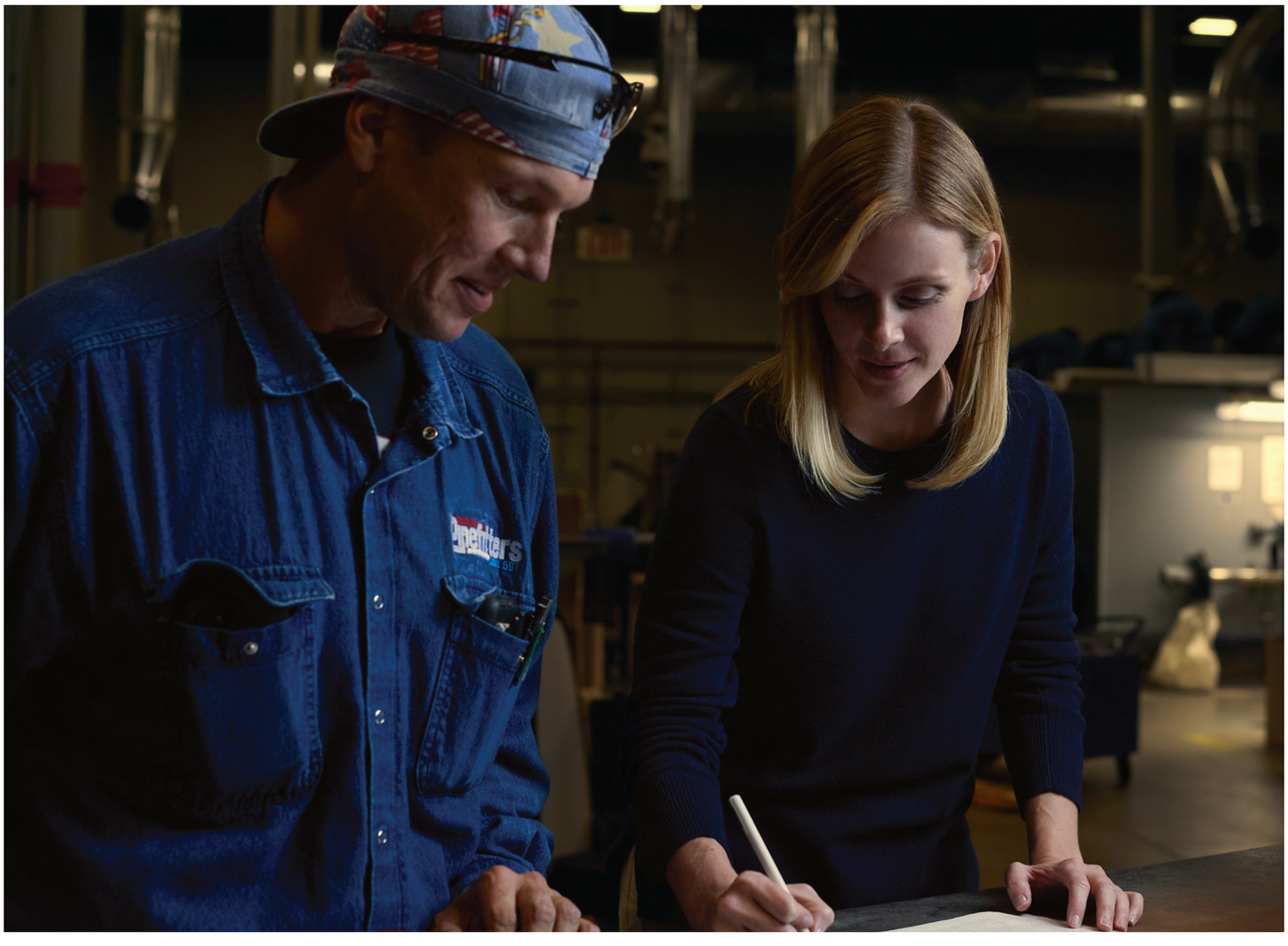

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LEGAL AND PRACTICAL CONSIDERATIONS FOR VACCINE POLICIES

As of July of 2021, more than half of all people in the United States (53.8%) have been vaccinated, according to the Centers for Disease Control and Prevention (CDC).

For workplaces, some thorny questions are emerging: Should employees who have not yet been vaccinated be asked, or required, to return to the workplace? Should employers require employees to be vaccinated in order to return to work? As this newsletter has periodically highlighted, the guidance on questions of this nature is evolving. Existing laws and regulations have provided incomplete answers to important questions. Unfortunately, each set of updated regulatory guidance that has come forth solves some questions but also raises new questions. Regardless, the correct answer as to the proper vaccine policy for an individual employer will involve an interactive assessment between its legal options and its legal needs. In other words, what an employer can do legally may not be what it really needs to do.

CAN AN EMPLOYER LEGALLY MANDATE EMPLOYEES BE VACCINATED?

Yes. The Equal Employment Opportunity Commission (EEOC) initially issued guidance implying that employers may lawfully require employees to be vaccinated before returning to work, subject to exceptions. It did not directly address the question of whether employers may mandate vaccines authorized only for emergency use (such as the COVID-19 vaccines) as opposed to those receiving full approval under the U.S. Food and Drug Administration (FDA) process. On June 28, 2021, the EEOC again issued guidance which punted resolution of this question to the FDA. The FDA has already strongly signaled that the vaccines are likely to receive full clearance based on what is presently known about their efficacy. But as the last year has shown, scientific consensus today might not be the same tomorrow. Nevertheless, some employers are adopting a more cautious legal approach to requiring vaccines by encouraging employees to get vaccinated on a voluntary basis in light of the emergency use issue.

There are a couple notable clear exceptions to required vaccination policies. First, under the American with Disabilities Act (ADA), employers may require employees to meet qualification standards that are "job-related and consistent with business necessity," which encompasses COVID-19 vaccinations. Generally, asking employees for proof of vaccination status does not constitute a medical examination. However, under the ADA, any vaccination-related information, regardless of whether the employee divulged it by mandate or voluntarily, must be treated as a confidential medical record. On a national level, the EEOC's guidance allows employers to obtain "proof of receipt" of vaccination but does not lay out what that proof should look like.

If an employee cannot be vaccinated because of a disability, the employer cannot require compliance without showing that the employee poses a "direct threat" to the health or safety of the employee or others in the workplace. Under the ADA, if an employer-mandated vaccination policy "screens out or tends to screen out an individual with a disability, the employer must show that an unvaccinated employee would pose a direct threat" that cannot be eliminated or reduced by a reasonable accommodation. If a reasonable accommodation exists, it must be implemented. The "direct threat" analysis revolves around the (1) duration of risk posed by the employee, (2) nature and severity of the potential harm caused by their physical presence at the work site, (3) likelihood of the potential harm, and (4) imminence of the potential harm.

Employers also must consider reasonable accommodations for those unable to get vaccinated because of a sincerely held religious belief. Title VII requires employers to reasonably accommodate employees who have a "sincerely held religious belief" or practice that prevents them from being vaccinated, unless the accommodation would cause an "undue hardship" for the employer. Accordingly—as with any other mandatory vaccination program, such as for influenza vaccines—employers must allow religious accommodations. According to the EEOC, employers should assume that a sincerely held belief underlies an employee's request for religious accommodation. However, if an objective basis exists for questioning the religious nature or sincerity of the belief or observance, the employer may request additional information from the employee. For instance, an employee's doubting the science behind the vaccines, without more, is not a sincerely held religious belief.

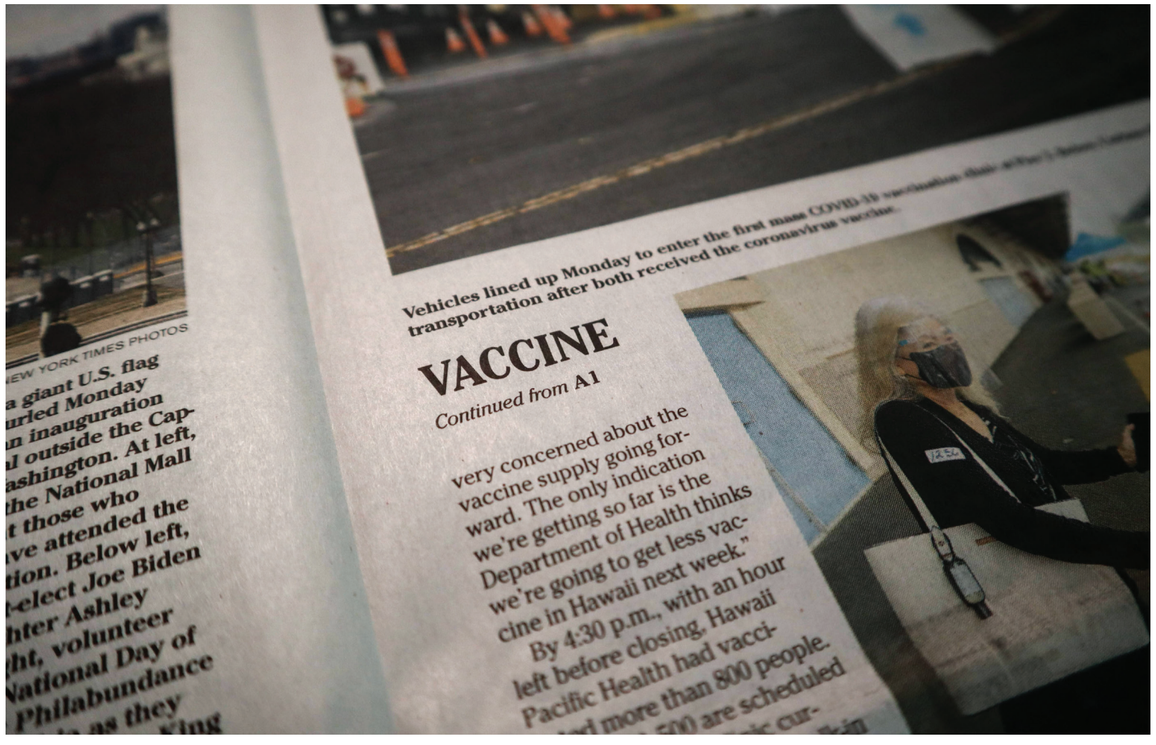
Reasonable accommodations for disabilities or religious belief may involve logistical measures, such as installing plexiglass or other barriers to reduce potential COVID-19 exposure or instituting temporary job restructuring or rescheduling. Employers may also implement reasonable accommodations by modifying already-existing workplace policies or procedures.

Thus far, strict vaccinations policies have passed legal scrutiny. Houston Methodist Hospital suspended 178 unvaccinated employees for two weeks without pay for refusing to comply with the hospital's vaccine mandate. Furthermore, on June 12, 2021, a federal court in Texas dismissed the case filed by 117 unvaccinated employees at the hospital, challenging the vaccine mandate. The federal court, citing the EEOC's guidance, held that employers may require employees to be vaccinated against COVID-19. Some employers, such as United Airlines, Delta Airlines, and Blackrock, have adopted strict vaccination policies as well.

SHOULD AN EMPLOYER MANDATE THAT ALL EMPLOYEES BE VACCINATED?

There is no "one size fits all" approach to vaccine-related considerations, and employers will need to consider their unique situations, where they are located, the state of the virus in their area, the demographic nature of their workforce, the customers they serve, and more as they navigate the uncertainty of bringing employees back to work before vaccines have been fully approved. But the goal is for employers to adopt vaccination policies that serve client, employee, and legitimate business needs.

As with any workplace consideration or policy, communication is going to be critical as employees return and employers develop policies around vaccination. Employee and customer opinions need to be evaluated, and employers will need to remain flexible as they address varying sentiments and concerns around their own health and safety. Opening lines of communication and gathering input from employees and customers can help employers determine the best steps to take. This process must occur before an employer can identify the solution that will be appropriate for their situation.



“It is worth looking at how Cedar Point Nursery might impact other areas of law about union access to private property.

ACCESS BY UNION BUSINESS AGENTS TO PRIVATE PROPERTY: *CEDAR POINT NURSERY V. HASSID*

On June 23, 2021, the Supreme Court issued its decision in *Cedar Point Nursery v. Hassid*, 594 U.S.____, 131 S. Ct. 2063 (2021). In a 6-3 ruling, the Court ruled that a California regulation which gave union organizers access to migrant farm workers on their employer’s property amounted to an unconstitutional governmental “per se” taking of private property. The 1975 California law, a product of the United Farm Workers and Cesar Chavez, gave union organizers access to private property for three hours a day for no more than four thirty-day periods in a calendar year.[1] The reasoning behind the law was that many farm workers are migratory and live on the employer’s property for the few weeks/months of a particular harvesting season. While the Decision is a narrow one, as California is the only state with this type of law, it could have an impact in other areas going forward.

WHERE THE LAW STANDS NOW:

On the face of the decision, *Cedar Point Nursery* did not change anything outside of invalidating the California law. But given the Court’s history and reasoning for the ruling, it is worth looking at how it might impact other areas of law about union access to private property.

1. Access by Business Agents to the union’s own bargaining unit members:

Many CBAs have language that permits union business agents to access the employer’s property. There may be caveats about notice or time limitations, but if the Employer owns the property and this is agreed to in the contract, it would not be impacted by *Cedar Point Nursery*.

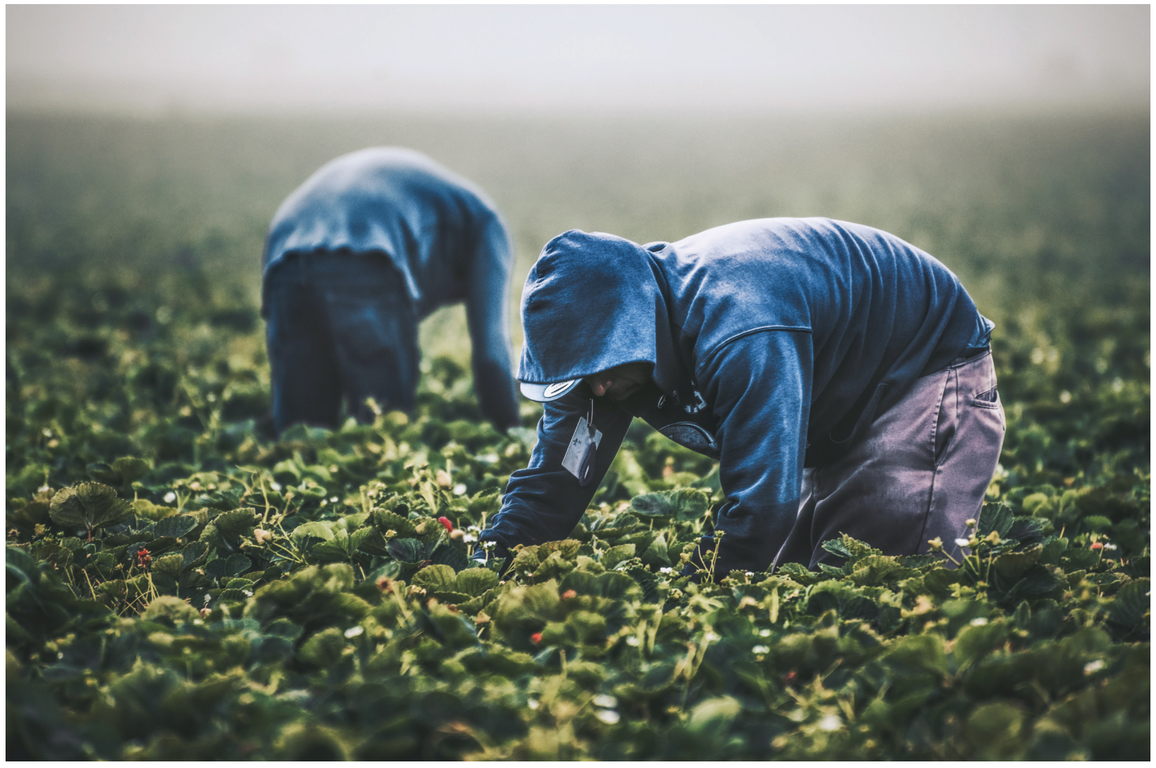
For construction unions, it can be trickier because the employer rarely owns the property/construction site. As of now, the law says that by virtue of the members’ Section 7 rights, union business agents have the right to access the property on which bargaining unit members are employed in order to monitor and enforce the parties’ CBAs. Any property owner who allows union represented employees to work on their property is deemed to have waived the right to protest the access. See *CDK Contracting Company*, 308 NLRB 1117 (1992). There are a few caveats to this–the property owner can require reasonable notice or if there is an overriding property or security concern, for instance if members are working at a nuclear power plant. It is possible to see that *Cedar Point Nursery* might invite challenges to this line of cases given that it pertains to allowing access on private property.

2. Access for “non-employee organizers”:

A property owner is not required to allow non-union employee organizers on its property for the purpose of organizing its employees unless there is no other way to access the employees (for instance employees who live and work on an oil rig). See *NLRB v. Babcock & Wilcox*, 351 U.S. 105 (1956). While this is a very rare occurrence, this is the area most likely to be impacted by *Cedar Point Nursery*. Indeed, Justice Roberts mentioned Babcock & Wilcox in passing in his majority Decision stating, “Whatever specific takings issues may be presented by the highly contingent access right we recognized under the NLRA, California’s access regulation effects a per se physical taking under our precedents.” *Cedar Point Nursery*, 141 S. Ct. at 2077. It is unclear from his decision if Justice Roberts and the majority believe there is any amount of mandated access that would not constitute an unconstitutional “taking” of private property. Justice Kavanaugh, in a concurring opinion, wrote that he believed *Babcock & Wilcox* actually supported the *Cedar Point Nursery* decision, but that the California law far exceeded the minimal access that is allowed by *Babcock*. *Id*. at 2077.

The far more common situation occurs when non-employee organizers attempt to meet with employees on the employer’s property in areas that are open to the public. For forty years, the NLRB’s interpretation was that if an area was open to the public, the property owner had to allow non-employee union organizers into that area open to the public for the purpose of organizing as long as they were non-distributive. In 2019, the NLRB changed this and now union organizers can be barred in areas open to the public if the property owner/employer has a valid no-solicitation policy that has been evenly applied. *UPMC* and *SEIU*, 368 NLRB No. 2 (2019). Given this change in 2019, it is unlikely that *Cedar Point Nursery* will have an immediate impact in this area.

[1] California Code of Regulations, Title 8, § 20900(e).



CYBERSECURITY PRACTICES FOR ERISA-COVERED PLANS

ERISA-covered plans can be prime targets for cyber-attacks.

ERISA-covered plans can be prime targets for cyber-attacks. As holders of various assets and personal participant data, it is important for plan fiduciaries to ensure the proper mitigation of cybersecurity risks. For that reason, the Employee Benefits Security Administration (EBSA) issued guidelines for retirement plans. Here are some of the best practices EBSA provides to prevent, identify and respond to cyber-attacks:

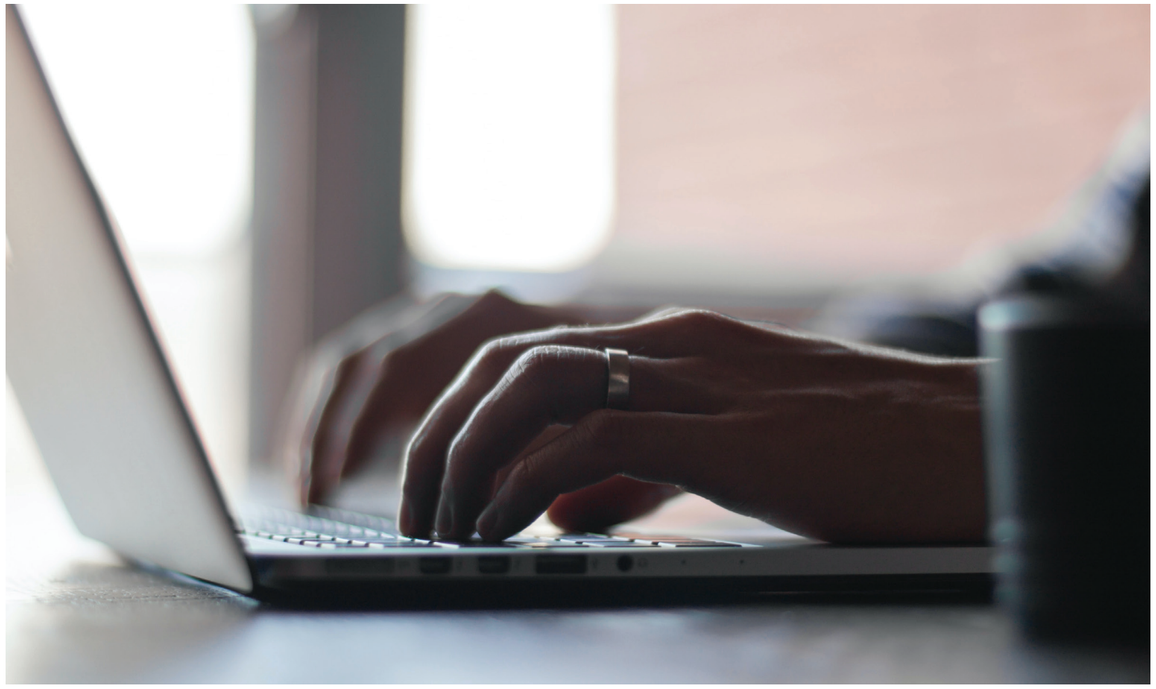
A WELL DOCUMENTED CYBERSECURITY PROGRAM

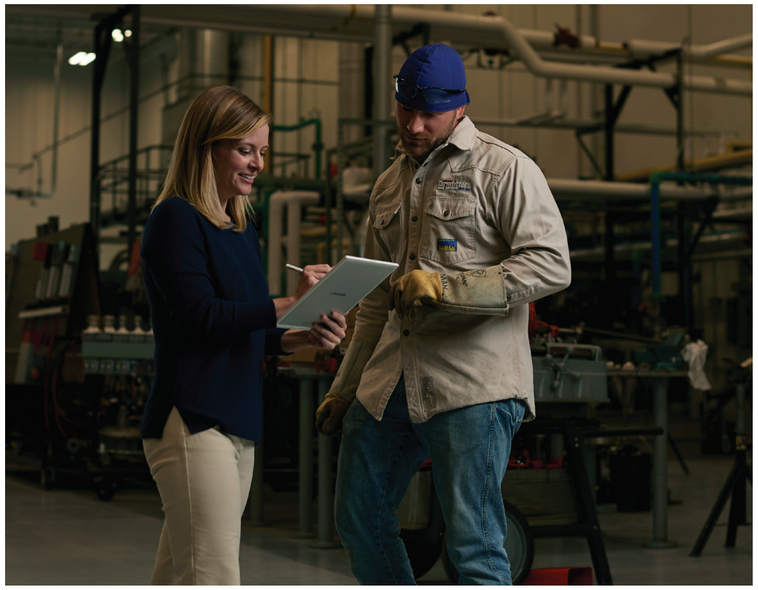
First and foremost, establishing a cybersecurity program is necessary to assess internal and external cybersecurity risks. With a formal cybersecurity program, plans can protect themselves from factors threatening the security of infrastructure and data stored in the system. A well formatted program will:

- Protect the infrastructure of information systems by identifying/detecting cybersecurity threats.
- Establish strong security policies, procedures, and guidelines approved by senior leadership and an independent third party, reviewed annually with updates, and explain terms to users.
- Formulate effective policies and procedures that govern all internal systems, such as data disposal and asset management.

RISK ASSESSMENTS AND THIRD PARTY AUDITS

Annual risk assessments and third party audits are key to the identification, estimation, and prioritization of information system risks. A risk assessment should identify, assess, and document how cybersecurity risks are evaluated and categorized. It needs to establish criteria to evaluate the confidentiality and integrity of the information system being assessed. It also needs to describe how the identified risks will be mitigated or accepted. Risk assessments should be conducted annually to keep up with the constantly changing field of information technology. Third party audits allow for an independent auditor to assess an organization's security controls in a clear and unbiased way. Effective third party audits will document any existing risks, vulnerabilities and weaknesses of an organization's information system.





ASSIGNED INFORMATION SECURITY ROLE

Assigning this role to a qualified individual to oversee the cybersecurity program is important for effectiveness. This person should initiate and maintain the vision, strategy, and operation of the cybersecurity program. They will need to have sufficient experience, necessary certification, and knowledge of cybersecurity threats and countermeasures. They must also participate in regular training to keep up with current cybersecurity risks.

ACCESS CONTROL

Access control is guaranteeing that users are who they say they are. It consists of two components, authentication and authorization. The best practices for access control are to establish multi-factor authentication, have all personnel use unique-complex passwords, and limit access to authorized users, processes, devices, activities, and transactions.

THE CLOUD

Cloud computing is a data storing system. In the cloud, data is stored with a third-party provider and is accessed over the internet. This presents many challenges because control and visibility over that data is limited. Organizations should conduct a risk assessment of the third-party service provider and ensure that the guidelines and contractual protections address policies and procedures.

ENCRYPTION

Data encryption is a form of protecting nonpublic information. This practice should be implemented for all data within an organization's information system. Ways to ensure the protection of the confidentiality and integrity of data can be through encryption keys and message authentication.

CYBERSECURITY TRAINING

All personnel of an organization should participate in annual cybersecurity awareness training. This program should set clear cybersecurity expectations for employees and provide education on recognizing signs of potential threats, preventing incidents, and responding to incidents. For benefit plans in particular, identity theft should be a key topic of training because it is the leading cause of fraudulent distributions. Personnel should be on the lookout for individuals falsely posing as authorized plan officials, fiduciaries, participants or beneficiaries.

RESPONSIVENESS AND BUSINESS RESILIENCY

A response to a cybersecurity incident or breach is as important as preventing one. Appropriate actions should be taken to protect the plan and its participants, including informing law enforcement, notifying the proper insurers, providing affected plans and participants with the necessary information to prevent/reduce injury, complying with any contractual or legal obligations with respect to the breach, and fixing the problems to prevent their recurrence.

It is important to maintain business resilience in the midst of a cybersecurity incident. A business resiliency program should be in place to ensure that an organization can quickly adapt to disruptions while maintaining continuous business operations and safeguarding data. A plan should be made that highlights the proper procedures to allow for an organization to recover, resume and maintain business functions.

Cybersecurity is vital to the success of ERISA-covered plans. As technology progresses, so will the unique challenges that come with cybersecurity. Implementing these strategies can limit the risk of cyber threats. If you'd like more information on how to implement these practices, please contact our office.

NO SURPRISES ACT AIMS TO COMBAT SURPRISE BILLING WITH FIRST INTERIM FINAL RULE

On July 1, 2021, the Departments of Health and Human Services, Labor and Treasury issued its first Interim Final Rule ("IFR"), which implements some parts of the Act.

The Consolidated Appropriations Act, 2021 ("CAA") was signed into law by President Trump on December 27, 2020. The CAA contains the "No Surprises Act" (the "Act"), which aims to prohibit balance billing in certain situations. The provisions of the Act take effect for plan years beginning on or after January 1, 2022 and have significant implications on group health plans and their participants. On July 1, 2021, the Departments of Health and Human Services, Labor and Treasury issued its first Interim Final Rule ("IFR"), which implements some parts of the Act. More rules are expected to be released later this year.

I FIRST, WHAT IS BALANCE BILLING?

Balance billing occurs when a provider bills a patient for the difference between the amount the provider charges and the amount the patient's insurance pays. This regularly occurs when a patient selects an out-of-network provider, understanding that his out-of-pocket costs will be much higher than if he had seen an in-network provider. However, balance billing has become an increasingly problematic issue for patients in two situations: (1) when patients receive treatment at an in-network facility and then later discover that part of their treatment was done by an out-of-network provider; and (2) when patients receive emergency care and do not have a choice when it comes to the facility or provider. In these two scenarios, the patients are usually unaware they will be balance billed and are surprised when they receive a large bill from the provider in the mail.

II HOW DOES THE ACT PROTECT AGAINST BALANCE BILLING?

Under the Act, patients will only be responsible for paying their in-network cost sharing, and out-of-network providers (including air ambulance providers) in these situations cannot balance bill patients for more than the in-network cost sharing amount. The Act also requires health plans to make an initial payment or notice of denial within 30 days after the bill is submitted by the provider or facility. If a provider or facility disagrees with the initial payment or notice of denial, the parties have 30 days to engage in voluntary negotiations to try and resolve the payment dispute.

If the parties cannot agree on a payment during the open negotiation period, then either party may initiate the independent dispute resolution ("IDR") process within four days. The arbitration process will be administered by IDR entities approved by the federal government. The IDR process sets forth "baseball style" arbitration rules, meaning each party submits a final offer for consideration and the arbiter will select one of the offers. There are a number of factors the arbitrator may consider, including the median contracted in-network rate and the provider's training and experience. The IDR process must conclude within 30 days, and the losing side will be required to pay all fees associated with participating in the arbitration process. More details on the IDR process are expected to be released in future guidance.

III WHAT ELSE DOES THE ACT DO TO HELP PREVENT SURPRISE MEDICAL BILLING?

EXTERNAL REVIEW.
The Affordable Care Act's (ACA) current external review process was extended for adverse benefit determinations under the surprise billing provisions. In other words, external review options, which previously were limited to adverse benefit determinations relating to medical necessity determination or recission of coverage, will be extended to patients who believe that surprise billing and surprise air ambulance provisions apply.

ID CARD INFORMATION.
Group health plans and issuers must include, in clear writing, the deductible, out-of-pocket maximums, telephone number and website address on physical or electronic identification cards.

ADVANCED EXPLANATION OF BENEFITS.
Group health plans must provide an advanced explanation of benefits before scheduled care or upon a patient's request prior to scheduling such services.

COST-SHARING TOOL.
Group health plans must offer price comparison guidance via phone and make available on the plan's website a price comparison tool.

CONTINUITY OF CARE.
Group health plans must provide up to 90 days of continued care for certain individuals at in-network cost sharing rates when their provider leaves the network. This requirement does not apply to for-cause terminations of a provider.

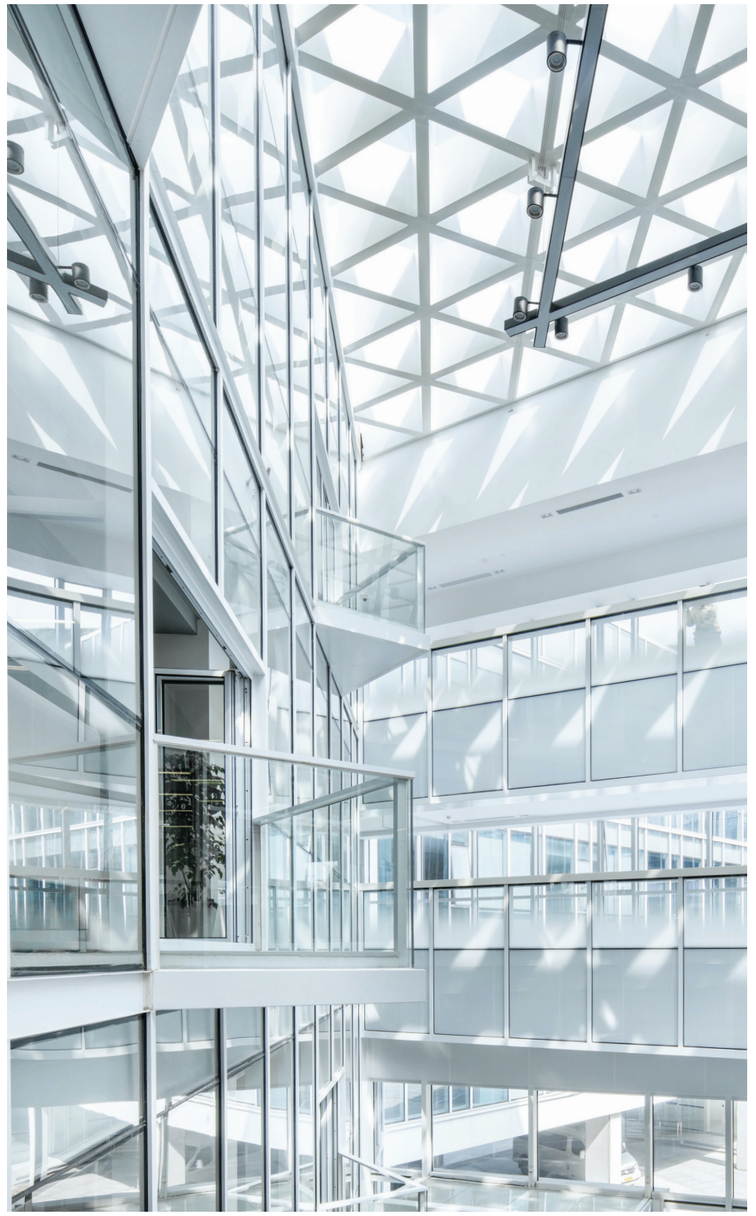
PROVIDER DIRECTORIES.
Group health plans must verify and update provider directories at least once every 90 days. An individual that relies on inaccurate information will only be responsible for the in-network cost sharing amounts for the services received from that provider.

PROVIDER NON-DISCRIMINATION.
The Act requires the Department of Health and Human Services, Treasury and Labor to issue proposed regulations on the ACA's provider non-discrimination provision.

IV WHAT ARE SOME OF THE PROTECTIONS IMPLEMENTED BY THE INTERIM FINAL RULE?

EMERGENCY SERVICES.
The IFR includes additional patient protections for emergency services. It defined "emergency services" broadly to include medical screening provided in the emergency room and services provided in any department of the facility to screen, treat and stabilize the patient. The IFR clarified that group health plans cannot place restrictions on emergency care such as the following: limit the coverage of emergency services based on plan terms, impose limits on out-of-network emergency providers that are more restrictive than in-network emergency providers, deny emergency coverage based solely on diagnostic codes, require a time limit between the onset of symptoms and when the patient sought emergency treatment or deny emergency services based on general plan exclusions.

PATIENT-COST SHARING PROTECTIONS FOR OUT-OF-NETWORK EMERGENCY SERVICES AND SOME IN-NETWORK EMERGENCY SERVICES.
The IFR also clarified how payment for emergency and some non-emergency services (such as services provided by an out-of-network provider at an in-network facility) will change for out-of-network providers. Under the IFR, the cost-sharing amount for emergency and some non-emergency services must be equal to the recognized amount. The recognized amount can be determined in three ways; however, for the purposes of self-insured group health plans, the recognized amount would be "the lesser of the billed charges or the Qualifying Payment Amount ("QPA")." The QPA is the median of the contracted rates of the plan for the item or service in the geographic region. In other words, patients will not have to pay higher cost-sharing when a provider bills less than the median in-network rate. Instead, the patient's cost-sharing amount will be based on the lower billed charges, not the higher QPA.



V WHAT ARE THE NEXT STEPS?

Group health plans should work closely with their plan professional to implement these new provisions. More guidance is expected to be released on this matter, including but not limited to, the IDR process and price comparison rules. If you have any questions, please contact our office.

SUPREME COURT EXPANDS EDUCATION-RELATED BENEFITS FOR NCAA STUDENT ATHLETES

According to the United States Supreme Court, an 1852 boat race at Lake Winnipesaukee, New Hampshire between Harvard and Yale is widely regarded as the first intercollegiate athletic competition. *NCAA v. Alston*, 141 S. Ct. 2141 (2021). The event was sponsored by a railroad executive in order to promote travel to the lake by train, and the competitors were offered an all-expenses paid vacation, lavish prizes, and unlimited alcohol. *Id.*

While college sports may have started with a boat race, football was the principal reason college sports expanded the way they did, and colleges began offering "all manner of compensation to talented athletes." *Alston*, 141 S. Ct. at 2148. And prior to the existence of the NCAA and its rules, college athletes were treated more like today's professional athletes than amateur student-athletes. According to the Court, Yale was allegedly able to entice a prominent tackle to play for the school by offering him a trip to Cuba, the exclusive right to sell scorecards from his games, and a job with the American Tobacco Company, along with free meals and tuition. *Id.* In addition, without residency requirements, athletes would transfer from team to team, like professional free-agents. In 1896, a law student at West Virginia University, Fielding H. Yost, transferred to Lafayette to lead the school's team to victory over arch-rival Penn, and then returned to West Virginia's law school the following week. *Id.*

In 1906, the Intercollegiate Athletics Association of the United States, which would ultimately become the NCAA, was formed to set rules of amateur sports. At the time of its founding, the organization expressed its view about compensating college athletes by stating, "[n]o student shall represent a College or University in any intercollegiate game or contest who is paid or receives, directly or indirectly, any money, or financial concession." Intercollegiate Athletic Association of the United States Constitution By-Laws, Art. VII § 3 (1906). Yet for many years, student-athletes continued to be compensated. In 1939, freshman football players at the University of Pittsburgh went on strike because upperclassmen were reportedly earning more money. *Id.* at 2149. In the 1940s, a football player at the University of Washington became known as the first college football player ever to take a cut in salary to play professionally. *Id.*

It was not until 1948, when the NCAA adopted its "Sanity Code" and created an enforcement mechanism, allowing for suspension or expulsion of offenders, that the outright payments to student athletes stopped. The Sanity Code also authorized colleges and universities to pay athletes' tuition. *Id.* In 1956, this was expanded to allow payments for room, board, books, fees, and incidental expenses. *Id.* Since then, the NCAA has placed limits on education-related benefits that schools can provide to student-athletes. In other words, what can be provided to college athletes as a part of their scholarships. The NCAA has done so through rules that it claims were aimed at preserving amateurism in college sports, which in turn "widens consumer choice by providing a unique product–amateur college sports as distinct from professional sports." *Id.* at 2152.

In recent years, the NCAA has created the "Student Assistance Fund" and the "Academic Enhancement Fund" to assist college athletes in meeting their financial needs. These funds have provided money to student-athletes for post-graduate scholarships, school supplies, loss-of-value insurance premiums, travel expenses, clothing, and magazine subscriptions. The assistance can be provided in cash or in kind without limits as to what any particular student-athlete may receive. The Supreme Court found that since 2015, these disbursements have sometimes been tens of thousands of dollars above the full cost of attending college.

In addition, the NCAA allows student-athletes to receive payments "incidental to athletics participation," including the funding of travel for the student-athletes' family members to attend certain events; awards for certain athletic achievements or participation, such as qualifying for a bowl game; certain payments from outside entities for things like participating in the Olympics; and NCAA member schools can award up to two "Senior Scholar Awards" of $10,000 for students to attend graduate school after their athletic eligibility expires.

Like the rules governing payments to athletes, the NCAA has also continued to grow and evolve. Today, the NCAA is a colossal enterprise with roughly 1,100 member colleges and universities. *Id.* These schools are broken up into three divisions, with nearly 350 Division I teams divided into 32 conferences sitting at the top. *Id.* at 2150. This is a far cry from the humble beginnings of intercollegiate athletic competition in the United States.

In 2014, a former West Virginia football player, Shawn Alston, filed suit against the NCAA. It was later joined by other current and former student-athletes in Division I FBS football and men's and women's Division I basketball. The lawsuit alleged a violation of Section 1 of the Sherman Antitrust Act of 1890, which states "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is declared to be illegal." 15 U.S.C. § 1. Alston argued that any restrictions the NCAA implements regarding what schools can offer to their student-athletes as compensation were illegal violations of the Sherman Act.

In 2019, the district court judge upheld the NCAA's rules limiting undergraduate athletic scholarships and payments related to athletic performance. At the same time, the judge found certain rules limiting education-related benefits available to student-athletes to be unlawful. The judge ruled that schools should be able to provide their student athletes with educational equipment, study abroad programs, internships, and monetary rewards for academic accomplishments. Both sides appealed and the Ninth Circuit Court of Appeals upheld the lower court's decision. *Alston v. NCAA*, 958 F.3d 1239, 1263 (9th Cir. 2020).

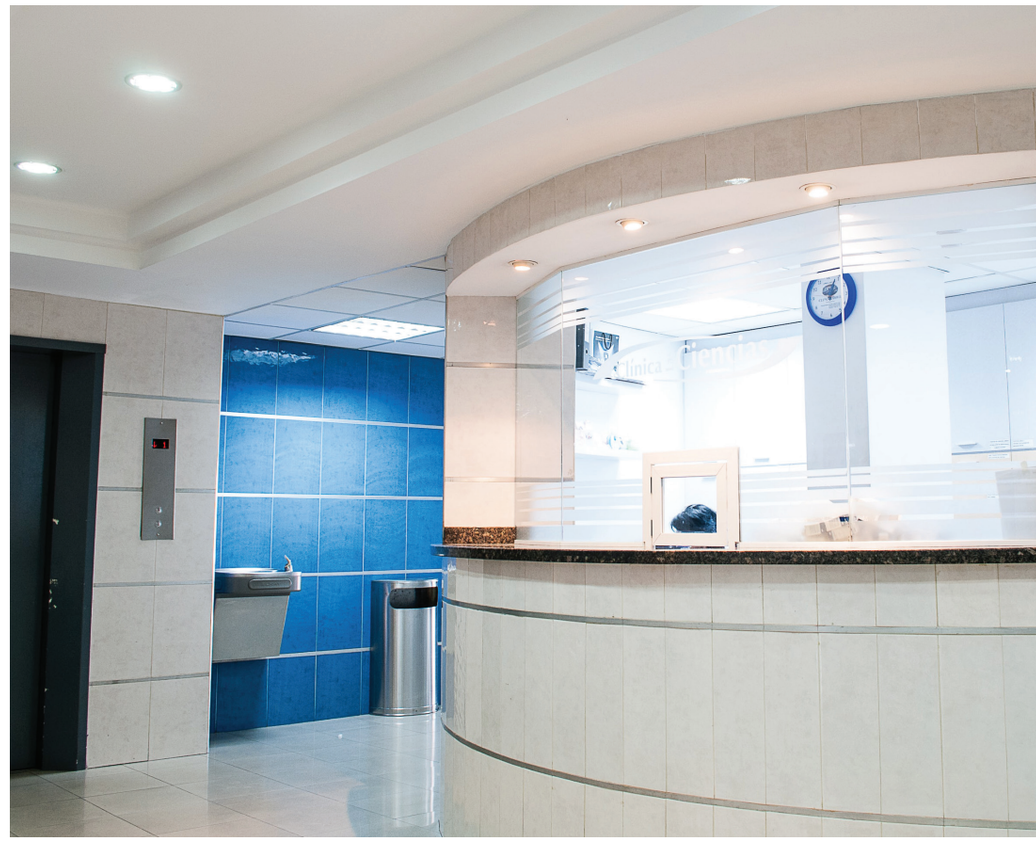
The NCAA appealed the Ninth Circuit's decision to the United States Supreme Court. In its decision, the Court stated that in enacting the Sherman Act, Congress tasked the courts with enforcing an antitrust policy of competition "predicated on one assumption alone—'competition is the best method of allocating resources' in the Nation's economy." *Alston*, 141 S. Ct. at 2160. And despite the NCAA's arguments to the contrary, the Supreme Court found that the trial court and appellate court properly subjected the NCAA's compensation restrictions to the "rule of reason" analysis. *Id.* at 2155-2162. The Court also rejected a number of the NCAA's other arguments, including arguments that the lower courts had applied the wrong level of scrutiny, overstepped their authority by redefining the NCAA's definition of amateurism, and that the decision will micromanage the NCAA's business. *Id.* at 2162-2164.

In the end, the Court agreed with the lower court, making it clear that the Sherman Act applies to the NCAA, and holding that not only does the NCAA have power over the market for student-athlete services, but that its rules can (and actually do) harm competition. *Id.* at 2156, 2159. The decision in *Alston* means that the NCAA is prohibited from limiting education-related compensation or benefits that conferences or schools may provide to student-athletes playing Division I football or basketball and is allowed to continue limiting cash awards for academic achievement, but only so long as the limits are no lower than for cash awards allowed for athletic achievement. *Id.* at 2164. And while a wider array of education-related benefits, such as scholarships for graduate or vocational school, payments for tutoring, and paid post-eligibility internships are now available, the NCAA is still free to propose rules imposing limits on these benefits. *Id.* at 2164-2165. Moreover, individual conferences may impose stricter restrictions on these benefits than the NCAA. *Id.*

The Supreme Court's ruling is narrow, yet many, including Justice Kavanaugh, believe that the Court's decision underscores the point that the NCAA's remaining compensation rules may run afoul of antitrust laws. A point which seems to have been clearly understood by the NCAA, which adopted a name, image, and likeness policy within ten days of the Court's decision. The NCAA's decision, to change course and allow student-athletes the opportunity to profit from their name, image, and likeness, suggests that the NCAA recognizes that it no longer has *carte blanche* when it comes to student-athletes.

"The Court agreed, making it clear that the Sherman Act applies to the NCAA.

BCBS SETTLEMENT



In October of 2020, Blue Cross Blue Shield ("BCBS") reached a $2.67 billion settlement ("Settlement") in a class-action antitrust lawsuit (*In re: Blue Cross Blue Shield Antitrust Litigation MDL 2406*, N.D. Ala. Master File No. 2:13-cv-20000-RDP). The Settlement received preliminary approval, with the final hearing set for October 20, 2021. If approved, this would become one of the largest health care settlements in U.S. history.

The Plaintiffs in this matter alleged that BCBS and its 35 member companies violated antitrust laws by agreeing not to compete in selling health insurance and administration of commercial health benefit products in the United States and Puerto Rico and agreeing to other means of limiting competition in the market. The parties agreed to a Settlement in the amount of $2.67 billion. Taking into account attorney's fees and administrative expenses, the total settlement amount that will be distributed to authorized claimants is approximately $1.9 billion.

Pursuant to the court order, Unique IDs should have been distributed to known claimants by May 31, 2021. Accordingly, by now, many have received a postcard or e-mail informing them of the Settlement. The damages classes include individuals, insured groups, and self-funded accounts that purchased or were enrolled in a BCBS health insurance or administrative services plan during the relevant period. For self-funded plans, the relevant period is between September 1, 2015 and October 16, 2020.

The $1.9 billion net settlement amount will be split into two funds, with $1.78 billion allocated to individuals and insured groups and $120 million allocated to self-funded accounts. Payment eligibility is based on premiums paid during the relevant period. The amount of each claim submitted by any given self-funded claimant will be determined by the following formula,

$$\frac{A}{B} \times C$$

where "A" equals total administrative fees paid between September 1, 2015 and October 16, 2020, "B" equals total administrative fees paid during this period by all self-funded claimants who submit claims, and "C" equals the total dollars in the self-funded net settlement fund.

In determining the percentage of administrative fees paid during the relevant period, the Claim Form allows claimants to choose between two options: the *Default Option* or the *Alternative Option*.

The *Default Option* provides pre-set percentages to be applied to the claim. The self-funded default allocations are as follows: (1) 18% of a member's premium for single coverage is deemed to have been paid by the member, with the remaining 82% allocated to the Fund; and (2) 25% of a member's premium for family coverage is deemed to have been paid by the member, with the remaining 75% allocated to the Fund. If the Fund elects the *Default Option*, no additional documentation needs to be provided to validate the Fund's contribution percentage.

On the other hand, the *Alternative Option* would allow the Fund to submit data or records supporting a contribution higher than the Default and maximize the potential payout from the Settlement proceeds. Accordingly, if the *Alternative Option* is elected, the Fund would need to submit documentation showing the percentage of premiums paid by the Fund.

In order to receive payment from the Settlement, a valid claim needs to be submitted by November 5, 2021. Additional information regarding the Settlement can be found on the BCBS Settlement website, www.bcbssettlement.com.

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