EDITION Nº THIRTY-TWO

NEWS WITH PURPOSE, DECISIONS THAT COUNT

STATE OF THE UNION

THE JOHNSON + KROL NEWSPAPER

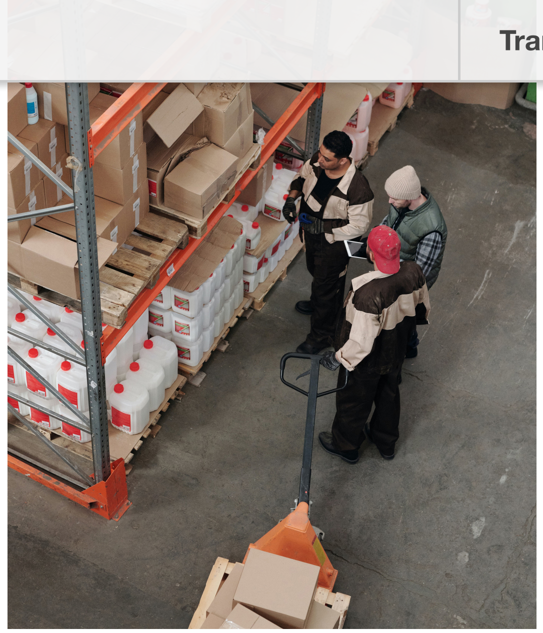
AMAZON WORKERS' UNIONIZATION EFFORTS PAY OFF IN HISTORIC NEW YORK VICTORY

The Amazon Labor Union (ALU), an independent union led by current and former members of the Amazon workforce, is the first American union to successfully organize employees for the e-commerce giant.

Workers at a Staten Island, New York Amazon warehouse clinched a historic victory as they voted 2,654 to 2,131 in favor of unionizing. The Amazon Labor Union (ALU), an independent union led by current and former members of the Amazon workforce, is the first American union to successfully organize employees for the e-commerce giant. Despite Amazon's attempts to resist the ALU's unionization efforts, the victory in New York could open the door to the unionization of more Amazon facilities.

On April 25th, workers at another Amazon warehouse in Staten Island will also begin voting on whether to join the ALU. A successful vote in that election could have a ripple effect throughout New York as the ALU is also planning to force elections at two other facilities within the state. Growing the ALU's presence and credibility in the state of New York could allow the homegrown collective of workers to expand their unionization efforts to Amazon sites in other states. It will be interesting to see whether other locations are more inclined to follow the grassroots blueprint laid out by the ALU or whether they will turn to more traditional and larger labor organizers. The International Brotherhood of Teamsters and the American Federation of Labor and Congress of Industrial Organizations could be options for employees as both indicated their desire to take on Amazon as well.

Although the ALU may have won the election, Amazon is likely to put up quite the battle against the results. The company has already indicated that it will explore its options into filing objections, as it alleges the National Labor Relations Board ("NLRB") had an inappropriate and undue influence on the election. Even if the election does survive Amazon's appeals and is certified by the NLRB, the ALU will have to undergo the considerable challenge of negotiating a first collective bargaining agreement with the company. However, the ALU will receive some support from Section 8(d) of the National Labor Relations Act as the statute requires employers to bargain in good faith with their employees' representative.



There was also a recent election that took place at the Amazon facility in Bessemer, Alabama. As the results currently stand, 875 workers voted in favor of joining the Retail, Wholesale and Department Store Union and 993 workers voted against it. An additional 416 ballots were challenged by either Amazon or the union. Because these challenged ballots could ultimately be the deciding factor in the final tally of the votes, this election is too close to call at this point in time. It will likely be another month before the result of this election is finalized and then certified by the NLRB.

SEVENTH CIRCUIT: ARBITRATION CLAUSES THAT WAIVE ERISA REMEDIES ARE INVALID

In September of 2021, a class action lawsuit was brought before the United States Court of Appeals for the Seventh Circuit, in which participants sued fiduciaries and sponsors of their employer's defined contribution retirement plan ("Plan").[1] The participants alleged that the employer's board violated the Employer Retirement Income Security Act ("ERISA") by breaching their fiduciary duties and engaging in financial misconduct.[2] The Plan included an arbitration provision with a class action waiver.[3] Subsection (b) No Group, Class, or Representative Arbitrations of the Plan requires, in relevant part, that:

Each arbitration shall be limited solely to one Claimant's Covered Claims, and that Claimant may not seek or receive any remedy

Affirming the lower court's ruling, the Seventh Circuit concluded that because the arbitration provision prospectively waived remedies available under ERISA, the provision was incompatible with the remedies provided by statute and was therefore unenforceable.[7] The primary issue with the arbitration provision in this case was "its prohibition on certain plan-wide remedies, not plan-wide representation."[8] Under ERISA, the participants had a statutory right to seek such equitable or remedial relief as the court may deem appropriate, including the removal of a fiduciary for breaches of fiduciary duty. Because the terms of the Plan's arbitration provision expressly denied the participants this right, the Court determined that the provision was invalid.

Finally, in reaching its decision, the Seventh which has the purpose or effect of providing additional benefits or monetary or other relief to any Eligible Employee, Participant or Beneficiary other than the Claimant.[4]

Among other remedies, the participants in this case sought removal of one of the Plan's fiduciaries pursuant to 29 U.S.C. § 1109(a).[5] However, the arbitration provision clearly prevents participants from seeking relief that "has the purpose or effect of providing additional benefits or monetary or other relief to any" individual other than the claimant. Removing a fiduciary of the Plan would indisputably result in relief that extended to all participants of the Plan, not just the claimants that brought the class action lawsuit.

Based on the class action waiver above, the board filed a motion to compel arbitration, but their motion was ultimately denied by the district court for two main reasons: (1) the primary plaintiff in the lawsuit had retired before the arbitration provision went into effect; and (2) the arbitration provision was unenforceable as a "prospective waiver of a party's right to pursue statutory remedies."[6]

Circuit endorsed arbitration of ERISA claims for the very first time.[9] This should be considered by those whose plans have yet to incorporate an arbitration provision or those amending their arbitration provision's current language. Provisions that could be interpreted as precluding plan-wide relief may need to be amended.

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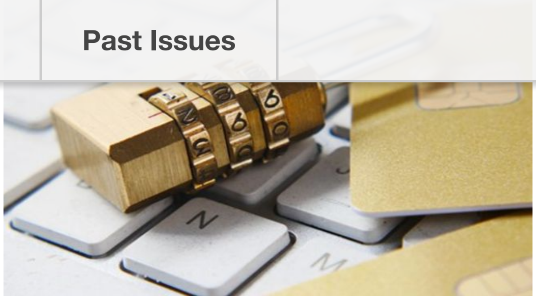
[1] *Smith v. Board of Directors of Triad Manufacturing, Inc.*, 13 F.4th 613, 615 (7th Cir. 2021).
[2] *Id.*
[3] *Id.* at 616.
[4] *Id.*
[5] *Id.* at 617.
[6] *Id.* at 621.
[7] *Id.*
[8] *Id.*
[9] *Id.* at 622.

COURT ENFORCES DOL SUBPOENA REGARDING CYBERSECURITY BREACHES

In the last year, The U.S. Department of Labor ("DOL") has made it very clear that it plans on taking ERISA plan's cybersecurity seriously when it issued its April 2021



guidance on cybersecurity for benefit plans and service providers. A recent federal district court's decision reinforces that stance.

On October 28, 2021, the U.S. District Court for the Northern District of Illinois sided with the DOL when it ordered a service provider, Alight Solutions, LLC ("Alight Solutions"), to comply with an administrative subpoena. Alight Solutions is a company that provides recordkeeping, administrative and consulting services to ERISA plan clients. The Employee Benefits Security Administration ("ESBA") of the DOL began an investigation of Alight Solutions in July 2019. Specifically, the DOL alleged that "Alight processed unauthorized distributions as a result of cybersecurity breaches relating to its ERISA plan clients' accounts. Further, in violation of its service provider agreements, Alight failed to immediately report the cybersecurity breach and the related unauthorized distributions to ERISA plan clients after its discoveries. In some instances, Alight failed to disclose cybersecurity breaches and unauthorized distributions to its ERISA plan clients for months, if at all. Alight also repeatedly failed to restore unauthorized distribution amounts to its ERISA plan clients' accounts."[1]

As part of its investigation, the DOL issued an administrative subpoena to Alight Solutions, calling for all documents relating to Alight's cybersecurity practices, procedures, assessment reports and training of its workforce, business continuity plans relating to information security and communications regarding any cybersecurity incidents. Alight argued that the DOL's subpoena power extends only to ERISA fiduciaries and since it is a non-fiduciary, it is not required to respond to the subpoena.[2] The Court rejected Alight's argument, stating this argument is not supported by the statute or case law, and citing the broad subpoena power of the DOL. Alight also argued that the requests were indefinite and unduly burdensome. The Court weighed the relevance of the document requests on Alight and determined that they were not unduly burdensome.

This decision is an example of how the DOL is making good on its promise to make cybersecurity of ERISA plans a top priority. Plans should expect the DOL to request documents similar to those in the above-referenced subpoena during investigations and regular plan audits. If you have any questions regarding your Plan's cybersecurity practices, please contact our office.

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[1] Case No. 1:20-CV-02138, *Martin Walsh v. Alight Solutions, LLC,* October 28, 2021.
[2] Tomasco, Jean. District Court Enforces DOL Investigative Subpoena Against Plan Service Provider Concerned Alleged Cybersecurity Breaches. ERISA Claims Defense Blog. November 24, 2021.

RECENT CHANGES TO ERISA VIA THE CONSOLIDATED APPROPRIATIONS ACT

Overview

Section 202 Disclosures in Detail:

The passage of the Consolidated Appropriations Act (CAA) amended section 408(b)(2) of ERISA to increase compensation disclosure requirements for service providers of ERISA group health plans. These increased disclosure requirements were designed to assist plan fiduciaries determine the reasonableness of an agreement while guarding against conflicts of interest, and largely mirror the disclosure rules already in place for retirement plan fees.

In general, ERISA prohibits plans from entering transactions with parties-in-interest, including service providers such as brokers or consultants. However, plans may enter contracts for various services, if plan fiduciaries determine that the terms of those contracts are reasonable.

Section 202 of the CAA, which contains the new disclosure requirements for service providers, greatly simplifies this task: as of December 27, 2021, service providers of ERISA covered group health plans must disclose all direct and indirect compensation that the service provider (including its affiliates and subcontractors) expects to receive for providing brokerage or consulting services to the plan, if the total amount exceeds $1,000.00,adjusted for inflation. These are known as "Section 202 Disclosures."

Requiring service providers to make Section 202 Disclosures will help plan fiduciaries identify possible conflicts of interest. For example, a service provider previously may not have disclosed expected compensation from a third-party for referring the plan to the third-party for services. Section 408(b)(2) ensures that group health plan fiduciaries receive complete and timely information about such third-party compensation arrangements in writing prior to entering, renewing, or extending service provider arrangements.

Direct vs. Indirect Compensation:

Direct compensation is payment from the plan for services received directly by the covered plan. In contrast, indirect compensation describes payments a service

When a service provider can reasonably expect its total compensation for its services to the plan to exceed $1,000.00, it must provide the plan fiduciary with detailed written information about the services to be provided and the corresponding direct compensation (in aggregate or by service) and indirect compensation it expects to receive as a result thereof. In addition to disclosing expected indirect compensation, service providers must describe each indirect compensation arrangement to which it is a party in detail, as well identify the compensating party and list the services it provided for compensation. For transaction-based compensation, the service provider must identify the compensating party and recipients of the compensation. Finally, the service provider must account for the calculation and refund of pre-paid services in the event that the contract terminates and describe any compensation it expects to receive as a result of or in connection with the termination of the contract with the plan.

Compliance with ERISA

Plan fiduciaries must obtain Section 202 Disclosures prior to contracting with service providers, as transactions without such disclosures are considered prohibited under ERISA and the plan could be subject to penalties from the Department of Labor. Service providers are obligated to supply plans with Section 202 disclosures within 90 days of a written request. If service providers fail to supply disclosures, plan fiduciaries are obligated to report such failures to the Department of Labor within 30 days of the service provider's failure to respond.

Why it Matters

Pricing in the healthcare industry has been opaque at best for decades. The interplay between insurance networks and providers is largely hidden from the view health plan sponsors and the public. The hope is that this section of the CAA will help shed light on this shadowy world and thus bring more competition on price down the road. Original drafts of this legislation would have allowed provider receives from third parties, and includes commissions, finder's fees, and other incentive payments.

Who is a Broker or Consultant?

Under the CAA, "brokerage or consulting services" is broadly defined and includes parties that are not traditionally viewed as brokers or consultants. Third-party administrators, pharmacy benefit managers, and wellness vendors all qualify as brokers or consultants under the CAA, and therefore must also make Section 202 Disclosures to group health plans before entering into an agreement with the plan. Plan fiduciaries should review such disclosures for reasonableness.

the public to peer behind the curtain on Big Pharma too. But alas, their lobby was too powerful, and that portion of the legislation was dropped.

If you have any additional questions about the CAA, Section 202 Disclosures, or 408(b)(2) of ERISA or how any of this may affect your plan, please contact us.

COVID-19 CAN BE TREATED AS A DISABILITY ACCORDING TO EEOC GUIDANCE

On December 14, 2021, the Equal Employment Opportunity Commission ("EEOC") updated its COVID-19 Technical Assistance Guidance to address when COVID-19 is a "disability" within the meaning of the Americans with Disabilities Act ("ADA"). The

ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity. The ADA further requires an employer to provide reasonable accommodation to qualified individuals with disabilities who are employees or applicants for employment, except when such accommodation would cause an undue hardship.

The EEOC has made clear that, in certain circumstances, individuals with COVID-19 will be entitled to job protections under the ADA.

A reasonable accommodation is a modification or adjustment to a job, the work environment, or the way things are usually done during the hiring process. These modifications enable an individual with a disability to have an equal opportunity not only to get a job, but successfully perform their job tasks to the same extent as people without disabilities.

The EEOC has made clear that, in certain circumstances, individuals with COVID-19 will be entitled to job protections under the ADA. The EEOC has emphasized that the determination requires an individualized, case-by-case assessment of how COVID-19 has impacted the individual. According to the EEOC, COVID-19 will be deemed an ADA disability where it "substantially limits a major life activity," either physically or mentally. However, COVID-19 is not always a disability under the ADA.

In that regard, the EEOC has offered the following to help employers understand the difference:

Examples of Individuals with an Impairment that Substantially Limits a Major Life Activity:

- An individual diagnosed with COVID-19 who experiences ongoing but intermittent multiple-day headaches, dizziness, brain fog, and difficulty remembering or concentrating, which the employee's doctor attributes to the virus, is substantially limited in neurological and brain function, concentrating, and/or thinking, among other major life activities.
- An individual diagnosed with COVID-19 who initially receives supplemental oxygen for breathing difficulties and has shortness of breath, associated fatigue, and other virus-related effects that last, or are expected to last, for several months, is substantially limited in respiratory function, and possibly major life activities involving exertion, such as walking.

Examples of Individuals with an Impairment that Does Not Substantially Limit a Major Life Activity:

- An individual who is diagnosed with COVID-19 who experiences congestion, sore throat, fever, headaches, and/or gastrointestinal discomfort, which resolve within several weeks, but experiences no further symptoms or effects, is not substantially limited in a major bodily function or other major life activity, and therefore does not have an actual disability under the ADA. This is so even though this person is subject to CDC guidance for isolation during the period of infectiousness.

These examples illustrate the principle that the ADA recognizes long-term disabilities as opposed to temporary illnesses or short-term injuries. Permanence is the determining factor in whether a condition qualifies as a disability under the ADA. For instance, two individuals could experience the exact same COVID-19 symptoms, and the one whose symptoms fail to dissipate will have a "disability" with the meaning of the ADA. The other employee, who only experiences the exact same symptoms for a brief period of time, will not be classified as disabled.

Evaluating whether an employee has an ADA disability should be done on a case-by-case basis using a process which pays attention to the particulars of an employee's and employer's situation. At the core of this inquiry is what is called the "ADA interactive process," which is a conversation between an employer and an employee to determine if the employee requires a reasonable accommodation to perform the essential functions of their job and if so, what the accommodation(s) may be. This process is initiated either by the employee's written or verbal request for assistance, or the employer's inquiry into workplace behaviors that may potentially be the result of a medical condition covered by the ADA. In evaluating the reasonableness of an accommodation request, a company may consider its nature and cost, its effect on expenses and resources, the overall financial resources, size, number of employees, and type and location of facilities of the employer (if the facility involved in the reasonable accommodation is part of a larger entity), the structure and function of the workforce, and the impact on the operation of the facility. In this conversation, the employee may request an accommodation or offer suggestions for accommodations that will allow them to perform essential job functions. However, the obligation to participate in the process goes both ways: an employee must also make a good faith effort to comply with any of the employer's reasonable efforts to provide an accommodation as well.

Overall, the COVID-19 pandemic has presented many new challenges for employers, which left them at times straining to apply existing rules to situations that may have not been within their initial contemplation. The EEOC's December 14, 2021 guidance concerning COVID-19's status as an ADA disability is an example of the latter. This firm will continue to monitor this situation as it evolves.

CHANGING THE RULES IS NOT A FIDUCIARY VIOLATION, BUT IT DOES VIOLATE THE TRUST AGREEMENT

In a recent Decision from the Second Circuit Court of Appeals, *Massaro v. Palladino,* 19 F. 4th 197 (2nd Cir. 2021), the Court decided that an improper amendment to a trust agreement was not a fiduciary violation, but was still a violation of the parties' Trust Agreement. This case involves a dispute between the Union Trustees and the Employer Trustees that manage two employee benefit plans on behalf of the Laborer's International Union of North America, Local Union No. 91. The essence of

The Employer Trustees filed suit in the Western District of New York[1] and alleged that the Union Trustees breached their fiduciary duties under ERISA when they passed by simple majority two amendments to the trust agreements. The district court granted summary judgment for the Employer Trustees holding that the Union Trustees had, in fact, breached their fiduciary duties under §404(a)(1)(D) of ERISA because the amendments were required to be passed by unanimous vote.

the dispute was that the Union Trustees improperly modified the trust agreements to make it more difficult for the Employer Trustees to select a replacement trustee.

The Trust Agreements set out the requirements for the appointment and removal of trustees as follows:

Section 3. Appointment and Removal of Trustees. One Employer Trustee will be appointed by each employer group signatory to Local 91 in the following manner: the Building Industry Employers Association of Niagara County, New York will appoint one Trustee, the Council of Utility Contractors Inc. will appoint one Trustee, and the Associated General Contractors of America New York State Chapter, Inc. will appoint one Trustee. The Union shall appoint three [] Union Trustees. The Trustees selected from their respective Employer groups and Union must have first-hand knowledge of investment strategies for the Fund, coupled with the capability to represent their employer group to advance the investment and prosperity needed for this Fund. . . . Trustees representing their respective Employer groups will be appointed by each employer group's own procedures. Any Employer Trustee may be removed from office at any time for any reason by the Employer Group that appointed him or her in the same fashion. Trustees representing the Union will be appointed by the Union, according to its own procedures. A Union Trustee may be removed from office at any time, for any reason, by the Union. . . .

There were no additional requirements placed on either the employers or the union regarding the selection of their respective trustee.

The Trust Agreements were subject to amendment by the Board of Trustees subject to the following provision:

Section 1. Amendment by Trustees. The provisions of this Trust Agreement may be amended to any extent and at any time by a document in writing adopted by a majority of

The Union Trustees appealed to the Second Circuit Court of Appeals. The Appellate Court held that the Union Trustees did violate the provisions of the trust agreements when they passed, by simple majority, the two amendments. However, the Appellate Court held that the Union Trustees did not breach their fiduciary duties because trustees generally do not act as fiduciaries when they pass amendments to a multi-employer benefit plan.

The Appellate Court focused on whether the Union Trustees' decision to pass the amendments "changed the manner in which Trustees are appointed"? The Court had little difficulty deciding that question in the affirmative and concluded that the amendments clearly changed the manner in appointing new trustees, pointing out that one of the amendments provided for a process by which a trustee could be seated by unanimous consent, whereas previously it was up to the Union's and Employer's "own procedures".

Having found that the Union Trustees violated the terms of the Trust Agreement, the Court turned to whether such a violation amounted to a breach of their fiduciary duties. The Court noted that the threshold question was not whether the person employed to provide services under a plan adversely impacted a plan beneficiary's interest, but whether that person was acting as a fiduciary when taking the action. The Court went on to describe how the trustees under ERISA wear two different hats: that of fiduciary and that of settlor.

A person acts as a fiduciary when they exercise discretionary authority or control respecting the management of a plan or exercises any authority or control respecting management or disposition of its assets. Alternatively, a person acts as settlor when they "make a decision regarding the form or structure of the plan such as who is entitled to receive plan benefits and in what amounts, or how such benefits are calculated". In *Lockheed Corp. v. Spink*, the United States' Supreme Court decided that plan sponsors (trustees) act in a settlor, rather than all of the Trustees. However, a decision of the Board of Trustees that would change (i) the total number of Trustees, or (ii) the manner in which Trustees are appointed as required in Article III, Section 3, above, will require a unanimous vote. . . .

This set up two different thresholds for votes – unanimity to change either the total number or manner of appointment of trustees - and a simple majority for everything else.

In January of 2019, a Union Trustee introduced two identical amendments to the trust agreements which added additional qualifications for Employer and Union Trustees and created a procedure by which candidates who did not meet these new criteria could petition the Board and be seated upon unanimous consent. The amendment required the Employer Trustee to "be the owner, officer or employee of a contractor that is [a] signatory to Laborers' Local No. 91 with headquarters located within the geographical jurisdiction of Local 91 and have contributed to the Pension Fund for the previous consecutive five [] years". The Amendments were passed on January 9, 2019,by a 4-2 vote, with all three Union Trustees being joined by one Employer Trustee.

Following passage of the amendments, the Council of Utility Contractors removed Anthony Majka (coincidentally, the sole Employer Trustee to vote with the Union Trustees) as its trustee and replaced him with James Panepinto. Panepinto did not meet the newly formed requirements for Trustee, and the Union Trustees objected to his seating.

fiduciary capacity, when they "alter the terms of the plan". 517 U.S. 882, 890 (1996). Although *Lockheed* was in the context of a single employer plan, its reasoning had been applied to a contributory, non-contributory or any other type of plan.

This reasoning had been applied to amendments to multi-employer benefit plans in *Janese v. Fay*, 692 F.3d 221 (2nd Cir., 2012). *Janese* held that the plaintiffs' claims in that case were subject to dismissal because the "defendants were not acting as fiduciaries when they amended the plans". *Id.* at 227. Once the Court decided that the Union Trustees did not violate their fiduciary duties because they were acting as settlors and amending the terms of the plan, and finding the Employers had not provided a good reason to depart from the holding in *Janese*, the Court vacated the District Court's holding and remanded for further proceedings. This case was most recently before the District Court in early February 2022 and the Court is deciding how to proceed given the Appellate Court's order narrowing the issues.

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[1] *May v. Palladino*, 2020 U.S. Dist. LEXIS 85536, 2020 WL 24868192 (W.D.N.Y. May 13, 2020).

PRESCRIPTION DRUG AND HEALTHCARE

On November 23, 2021, the Departments of Labor, Health and Human Services (HHS) and Treasury ("Departments") published an interim final rule[1] on the implementation of certain provisions of the Consolidated Appropriations Act, 2021 (CAA). The rule focuses on the health transparency provision of the CAA requiring plans to report detailed information about prescription drugs and health care spending. The regulations were generally applicable to group health plans beginning December 27, 2021.

As background, the CAA requires group health plans to annually submit to the Departments certain information about prescription drug and health care spending. The interim final rule clarifies the data submission requirements for plans and issuers required under the CAA.

First, the Departments are allowing plans to satisfy their reporting obligations under the rule by having third parties, such as TPAs, or PBMs, submit some or all of the required information on their behalf. However, the plan must enter into a written agreement with the third party that is providing the information on its behalf in accordance with the rules.

The data submission required under the rule includes the following:

- General information on the plan, such as the beginning and end dates of the plan year, the number of participants, beneficiaries, or enrollees, as applicable, and each state in which the plan or coverage is offered;
- Certain top 50 prescription drug listings;
- Total spending on health care services by the plan, broken down by the type of costs;
- Specific prescription drug spending and utilization information;
- Premium amount information (including total premium amount broken down into plan sponsor and participant costs); and,
- Prescription drug rebate, fee, and other remuneration information, including how rebates impact premium and cost sharing amounts.

Plans are required to provide the first data submissions to the Departments no later than one year after the date of enactment of the CAA, which would have been December 27, 2021, and by June 1 of each year thereafter. Accordingly, calendar year 2020 information should have been submitted by December 27 2021, calendar year 2021 information by June 1, 2022, calendar year 2022 information by June 1, 2023, and so forth. The Departments are, however, deferring enforcement during the first year of applicability. Specifically, the Departments will not initiate enforcement action against a plan that did not report by the first deadline on December 27, 2021 or by the second deadline on June 1, 2022. If necessary, plans can submit the required data submissions for the 2020 and 2021 reference years by **December 27, 2022.**

Group health plans should be preparing to meet the deadline for the 2020 and 2021 reference years. Specifically, plans should discuss reporting requirements with their TPAs and PBMs. Plans may also need to revise their services agreements to address liability for and the accuracy of the information that is reported and the ways in which the plan can review such reporting to confirm its accuracy. If you have any questions regarding how this rule will affect your plan, please contact our office.

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[1] 86 FR 66662

CHANGES TO STATE LAWS

While many of our employer/employee, contractor/union relationships and employee benefits are governed by federal law, it is always important to remember to look at state laws that may apply. Below is a short survey of employment, benefit and related state laws that became effective in 2021/2022 that may be of interest to J+K clients. This is not an exhaustive list, and some state laws may be preempted by federal law or not apply for other reasons. Please reach out to ask about any specific situation you may be facing.

ILLINOIS

Certified Payroll -
Effective January 1, 2022
IDOL will maintain a database of certified payroll that is available for search by the public. Contractors must file certified payrolls by the 15th of each month and by the 16th day of each month, the relevant documents will be made available for search by the public.

Mental Health –
Effective January 1, 2022
Requires insurers with group accident and health policies to guarantee that covered individuals have access to treatment for emotional, mental, nervous or substance use disorders or conditions.

Non-Compete –
Effective January 1, 2022
Non-compete clauses will not be allowed in

KENTUCKY

Worker Safety –
Effective July 1, 2021
Kentucky passed a law that prohibits the Kentucky Occupational Safety and Health Standards Board from enacting or continuing to enforce any regulations that are more stringent than any corresponding federal OSHA regulations.

Open Records Law –
Effective June 29, 2021
Kentucky modified its open records law to limit the ability of individuals to request open records who do not live, work or conduct business in Kentucky. The law was also revised to allow requests by email and gives governmental agencies five days to respond.

MISSOURI

Mental Health Parity –
Effective July 7, 2021
Prohibits insurance companies from imposing more stringent limitations on mental health coverage than they have in place for medical or surgical coverage.

Workers' Compensation –
Effective July 7, 2021
Made changes to the Workers' Compensation statute, specifically to allow electronic payments and filing documentation.

Minimum Wage –

employment contexts for individuals making less than $75,000 a year.

Minimum Wage –
Effective January 1, 2022
Minimum wage will increase to $12 an hour.

INDIANA

Unemployment Fraud –
Effective July 1, 2021
Hoosiers may be penalized for intentionally putting wrong information on their unemployment documents, even if they never receive any unemployment compensation from the state.

Teachers' First Amendment Rights –
Effective July 1, 2021
Teachers must be able to resign from their union at any time and must re-authorize union payroll deductions on an annual basis.

"No Surprises Act" –
Effective January 1, 2022
Indiana hospitals will be required to provide patients with an estimated cost at least five days before any procedure.

Effective January 1, 2022
Minimum wage is $11.15 / hour for non-tipped employees who work for private employers.

OHIO

Minimum Wage -
Effective January 1, 2022
Ohio increased minimum wage for non-tipped employees to $9.30/hour. This only applies to employees of companies that earn more than $342,000 a year in gross income.

WISCONSIN

Regulating Pharmacy Benefit Managers –
Effective January 1, 2022
Pharmacy Benefit Managers or "PBM"s must but licensed with the state's Office of the Commissioner of Insurance. The bill also bans so-called pharmacist "gag-orders," which prohibit pharmacists from sharing information on alternative generic options which may cost less.

JOINING THE FIGHT

As the number of clients continues to grow, so does our team of dedicated lawyers. Johnson + Krol (J+K) is delighted to announce that William Kinney and Karsyn Kratochvil have joined our team. We welcome them and look forward to seeing their professional development and contribution to client matters.

WILLIAM M. KINNEY
SENIOR ATTORNEY

LLM (Master of Laws) (2008)
John Marshal Law School (UIC)

Juris Doctor (2005)
Northern Illinois University
College of Law

Bachelor of Social Science,
Law and Democracy (1993)
Michigan State University –
James Madison College

William Kinney (Bill) joined J+K in March of 2022 as a Senior Attorney. Mr. Kinney is a part of the firm's Employee Benefit Practice. He works to protect the employee benefit programs supported by Union members and Union Employers. He focuses on complex matters involving plan compliance, tax bankruptcy and litigation issues of ERISA and other benefit plans, including retirement, welfare, qualified and non-qualified benefit.

Prior to joining J+K, Bill worked for Cohen, Weiss & Simon, LLP in New York City where he worked as Of Counsel in the employee benefits practice group. Bill brings 17 years of experience and a unique perspective to the firm, as he has an intimate understanding of legal matters relating to

KARSYN M. KRATOCHVIL
ASSOCIATE ATTORNEY

Juris Doctor (2021)
University of Illinois Chicago
School of Law

Bachelor of Arts, Communications;
Minor in Political Science and
International Business (2018)
Coastal Carolina University

Karsyn Kratochvil joined Johnson + Krol in March of 2022 as an associate attorney and is part of J+K's litigation team. She focuses on Trial Advocacy, drafting settlement agreements, regulatory research, and handling claims for unpaid contributions on behalf of Taft-Hartley plan clients.

Prior to joining the firm, Karsyn clerked at the Cook County State's Attorney's Office in the felony trial division where she developed substantial research and writing skills. During law school, she was accepted onto the arbitration team and a mock trial team where she traveled and competed against other law schools. Through this, Karsyn was able to hone her skills in public speaking, critical thinking, and the art of forming persuasive, cohesive arguments. In her spare time, Karsyn enjoys reading books and traveling.

representation of employee benefit plans and litigation.

In addition to his substantial legal work, Bill is a contributing author of the ABA Employee Benefits Committee/Bloomberg Law (Blaw) treatise on Employee Benefits Law where he serves on the subcommittee tasked with the chapter on Collective Bargaining and Employee Benefits. He is Union Co-Chair of the ABA Labor and Employment Law Section Treatise Committee. During his free time, Bill enjoys music, hiking and gardening.

JOHNSON + KROL

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