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WHAT'S INSIDE

TAFT-HARTLEY REPORT

Congress Addresses Problem of Surprise Medical Bills

On December 12, 2019, U.S. House of Representatives and U.S. Senate committee leaders announced a bipartisan agreement to draft legislation to ban surprise medical bills from out-of-network providers. Although details of the agreement have not been released, the lawmakers did release a general proposal of what to expect.

This proposal is, in part, a reaction to two common situations in which patients will receive "surprise" bills from (1) out-of-network emergency room doctors, anesthesiologists, and other specialists, and (2) air ambulance services. It is estimated that 18% of emergency room visits and 16% of inpatient admissions at in-network hospitals resulted in at least one out-of-network bill.[1] These out-of-network bills usually leave patients exposed to high costs through both the cost-sharing requirements of their own health plans as well as "balance billing" from their providers.[2] Balance billing is a practice in which out-of-network providers, who have not negotiated a discounted rate with an insurer, bill patients the difference between what the provider received from the insurer and their full charge for the service.[3]

Under the proposed legislation, payment disputes between providers and insurers would be set at the median in-network rate for the geographic area in which the services are incurred.[4] Additionally, the legislation would prohibit air ambulance services from billing patients more than the in-network amount, even if the service is not covered by the patient's insurance network.[5]

The proposed legislation also aims at tackling transparency issues between providers and health plans. Specifically, the legislation would remove "gag clauses" in agreements, which often prevent sponsors of group health plans from obtaining de-identified claims data which they could use to compare the prices they are getting at hospitals with other facilities. This type of information could help employers determine whether they are receiving a good deal from their insurance carrier.[6]

[1] Pollitz, Karen and Matthew Raw. *Surprise bills vary by diagnosis and type of admission*. Peterson-KFF Health System Tracker. December 9, 2019.
[2] *Id.*
[3] *Id.*
[4] Hansard, Sara. *Surprise Medical-Bill legislation Gets Boost in Bipartisan Deal*. Bloomberg Law News. December 9, 2019.
[5] *Id.*
[6] *Id.*

The proposed legislation would also include lowering the threshold for arbitration. With the new proposal, the threshold for taking disputed bills to arbitration will be lowered from $1,250.00 to $750.00.

Although health insurers and employer groups have supported the inclusion of a market-based benchmark to resolve billing disputes, some groups have expressed concerns about arbitration being abused and patient access to hospital care being jeopardized when insurers are incentivized to remove hospitals from their networks.[7] At this time, the text of the agreement has not yet been released; accordingly, lawmakers have not detailed exactly how payments to providers would be determined. Our office will continue to monitor the proposed legislation for its impact on the Taft-Hartley world.

Court Finds Withdrawal Liability Cannot Be Decelerated

On August 13, 2019, the U.S. Court of Appeals for the Seventh Circuit held in *Bauwens v. Revcon Technology Group, Inc.* that Trustees of the Electrical Contractors Association and Local Union 134 International Brotherhood of Electrical Workers Joint Pension Plan could not agree to an employer's installment payment plan regarding its withdrawal liability after the Trustees had already demanded full payment after the employer defaulted.

As background, when a contributing employer withdraws from a pension plan, ERISA requires that Trustees "as soon as practicable" provide the withdrawing employer with the total amount of withdrawal liability and dates for payments due the pension fund. If an employer fails to pay within 60 days of receiving notice of failure to make a payment, the Trustees can deem the employer to be in default, which means that the plan may accelerate the outstanding liability of the employer. In other words, once in default, the Trustees can require payment of the entire withdrawal liability amount at one time, instead of allowing the employer to pay down the liability through a payment schedule.[8] As a result, when an employer defaults and the Trustees accelerate the withdrawal liability, the employer owes the total outstanding withdrawal liability, plus accrued interest, which started accruing as of the due date of the first missed payment.[9]

In *Bauwens*, Revcon Technology Group withdrew from the pension plan in 2003. In 2006, the trustees notified the company that it owed approximately $400,000 in withdrawal liability and demanded payment.

In 2008, after Revcon missed several payments, the trustees notified Revcon of its default and demanded payment immediately. After Revcon failed to pay, the Trustees accelerated the outstanding liability and filed a lawsuit in the U.S. District Court for the Northern District of Illinois in 2008. However, before appearing in court, Revcon offered to pay the scheduled payments it missed and resume making payments pursuant to a settlement agreement in exchange for dismissal of the lawsuit. The Trustees agreed to dismiss the suit, however, Revcon defaulted again in 2009, 2011, 2013, and 2015. As they did in 2008, the Trustees filed a lawsuit against Revcon each time and subsequently dismissed each lawsuit after Revcon agreed to pay installments pursuant to a settlement agreement.[10]

Eventually, the Trustees filed the 2018 case that ended up before the Seventh Circuit after Revcon defaulted again. Revcon argued that the applicable 6-year statute of limitations applied because the claim for withdrawal liability began to accrue in 2008 when the pension fund first accelerated the employer's withdrawal liability. The Trustees argued that they revoked the 2008 withdrawal liability acceleration when they dismissed the first 2008 lawsuit and with each of the dismissals thereafter. According to the Trustees, the parties agreed to decelerate the previously accelerated debt when they agreed to return to the installment plan. The U.S. District Court for the Northern District of Illinois agreed with Revcon and dismissed the case.

The Seventh Circuit upheld the District Court's decision to dismiss the case based on the statute of limitations. The Court held that ERISA, as amended by the Multiemployer Pension Plan Amendments Act ("MPPAA"), is silent on whether trustees can decelerate previously accelerated debt if the parties agree that they want to return to a settlement agreement with a payment plan. Revcon argued that this silence means accelerated withdrawal liability cannot be decelerated under the MPPAA, whereas, the Trustees construed the MPPAA's silence as a "gap" which the court should fill by creating a deceleration mechanism.[11] Rather than create precedent (otherwise known as "common law"), the Court found that deceleration of the withdrawal liability did not happen in this case because the MPPAA does not explicitly permit deceleration. As a

[7] *Id.*
[8] Fask, Sarah Bryan. *Seventh Circuit Holds that a Deceleration of Withdrawal Liability is Unavailable Under ERISA's Common Law*. Litter. September 5, 2019.
[9] 29 U.S.C. § 1399(c)(3).
[10] Fask, Sarah Bryan. *Seventh Circuit Holds that a Deceleration of Withdrawal Liability is Unavailable Under ERISA's Common Law*. Litter. September 5, 2019.
[11] *Bauwens v. Revcon Technology Group, Inc.* No. 18-3306 (7th Cir. 2019).

result, it found that because the withdrawal liability became due in 2008, the Trustees' claim was barred by the 6-year statute of limitations. According to the Court, the statute of limitations for the entire withdrawal liability began to run on the date of the acceleration in 2008 because at that time, the pension plan had the right to sue for the entire accelerated amount.

Although the Court found that the pension plan could not pursue its claim under the MPPAA, it did state that it could pursue its claim for breach of the settlement agreements in state court. The pension plan is free to explore remedies for the breach of the settlement agreement under state contract law.

What does this ruling mean for trustees of multiemployer pension plans? This ruling should not discourage trustees from pursuing claims of withdrawal liability. Instead, trustees should take care to not enter into settlement agreements that provide for scheduled payments after a default has occurred, or at the very least, do so with the understanding that the agreement will likely only be enforceable in state court as a breach of contract claim.

Fifth Circuit Upholds Post-Death QDRO

In a case concerning a dispute between a deceased plan participant's ex-wife and his widow, the U.S. Court of Appeals for the Fifth Circuit upheld a Qualified Domestic Relations Order ("QDRO") entered approximately fifteen (15) months after the participant's death.[12] In doing so, the Court of Appeals reasoned that the participant's ex-wife protected her rights and acted promptly in obtaining a QDRO, even though it was entered after the participant's death.

During the time the deceased participant and his ex-wife were married, the husband participated in an employer sponsored 401(k) plan ("Plan") and designated his then wife as the beneficiary under the Plan. The couple divorced in 2014 and agreed to a settlement that awarded $500,000 of the 401(k) funds to the ex-wife. The settlement terms were submitted to the divorce court but not ruled on until two days after the ex-husband/participant died in a plane crash in October 2015. At that time, the divorce court entered a judgment of partition incorporating the settlement terms into the divorce decree and awarded the ex-wife her interest in the 401(k) Plan. The participant immediately remarried after his divorce in 2014, and in November 2016, the deceased participant's new wife—now a widow—sued in federal court to enforce her rights as the surviving spouse under the Plan. The ex-wife did not obtain a QDRO until January 18, 2017, approximately fifteen (15) months after the domestic relations order ("DRO") was issued in October 2015. Notwithstanding, the Appellate Court upheld the District Court's finding that the ex-wife's QDRO was timely and proper.

ERISA provides an eighteen (18) month window for determining whether a DRO is a QDRO.[13] If the DRO is determined to be a QDRO during that period, the plan administrator must pay the segregated amounts to the person entitled to them under the QDRO. However, if during the eighteen (18) month period, the DRO is determined not to be a QDRO, or the issue as to whether such order is a QDRO is not resolved, then the plan administrator must pay the segregated amounts to the person "who would have otherwise received them."[14]

Here, the Appellate Court found that the participant's ex-wife acted promptly in obtaining a QDRO within the eighteen (18) month period. The Court further concluded that the QDRO provisions of ERISA do not suggest that the ex-wife had no interest in the Plan until she obtained a QDRO; instead, they merely prevented her from enforcing her interest until a QDRO was obtained.

This case serves as a reminder to plan administrators and plan sponsors to establish appropriate procedures regarding the eighteen (18) month determination period and to send notice to the alternate payee as soon as the plan learns of a possible or pending divorce proceeding. Had the ex-wife in this case failed to obtain a QDRO within the eighteen (18) month period, the Plan could have ended her withholding.

IRS Extends ACA Reporting Deadline

On December 2, 2019, the Internal Revenue Service ("IRS") issued Notice 2019-63 extending the deadline for furnishing to individuals the 2019 Forms 1095-B and 1095-C from January 31, 2020 to March 2, 2020. The extension provides more time to applicable large employers ("ALEs"), health insurance carriers, and self-insured group health plans to complete and distribute the forms.

As background, Sections 6055 and 6056 were added to the Code by the Affordable Care Act ("ACA"). Section 6055 requires health insurance carriers, self-insured group health plans, and other providers of minimum essential coverage ("MEC") to file an annual report with the IRS, and issue annual statements to covered individuals indicating the calendar months in a given year in which individuals were enrolled in MEC. Section 6056 requires ALEs that are subject to the ACA's employer shared responsibility rules to file

[12] The case is *Miletello v. RMR Mechanical, Incorporated,* 921 F.3d 493 (5th Cir. 2019).
[13] *See* 29 U.S.C. § 1056(d).
[14] *Id.*

information returns with the IRS and provide statements to their full-time employees about the health insurance coverage the employer offered.

The IRS stated the reason for the extension was that it determined a substantial number of employers, insurers, and other providers of MEC needed additional time beyond the January 31, 2020 deadline to gather the required information to prepare the 2019 Forms 1095-B and 1095-C.[15] As such, the Department of the Treasury ("Treasury Department") and IRS extended the original deadline for furnishing the forms to individuals by 30 additional days.[16] The IRS will not grant any additional extensions.

Similar to previous years, the Notice does not provide an extension for filing the 2019 Forms 1094-B, 1095-B, 1094-C and 1095-C with the IRS.[17] These forms must still be filed with the IRS by February 28, 2020, or March 31, 2020, if filing electronically.

Most notably, the Notice also provided new transition relief for entities that are required to furnish the Form 1095-B to covered individuals. Because the individual mandate penalty was reduced to zero for 2019, the Treasury Department and IRS have been studying whether and how the 6055 reporting requirements should change for future years.[18]

More specifically, the Treasury Department and IRS pointed out that an individual no longer needs the information on the Form 1095-B to compute his or her federal tax liability or file an income tax return with the IRS.[19] Nonetheless, entities that are required to furnish the Form 1095-B to individuals must still spend resources to do so. Accordingly, the IRS stated in the Notice that it would not assess a penalty against a reporting entity for failing to furnish a Form 1095-B to covered individuals provided two conditions are met.

First, the reporting entity must post a notice prominently on its website stating that responsible individuals may receive a copy of their 2019 Form 1095-B upon request. The notice must also provide an email address and a physical address to which a request may be sent, as well as a phone number that individuals may use to contact the reporting entity with any questions.[20] Second, the reporting entity must provide any requested Form 1095-B within 30 days of the request.

This new transition relief only applies to Section 6055 reporting (i.e., the Form 1095-B). The transition relief does not apply to Section 6056 reporting (i.e., the Form 1095-C). This means that applicable large employers that offer self-insured health plans must still complete Part III of the Form 1095-C for any full-time employee.

Finally, and perhaps most importantly, the new transition relief only applies to the requirement to provide the Form 1095-B to covered individuals. These forms must still be completed and filed with the IRS by the applicable deadline.

National Labor Relations Board Takes Aim at Scabby the Rat

For those who are even tangentially connected to the labor market, the image of Scabby the Rat is likely one of the first that comes to mind when visualizing a labor dispute. Birthed by the Bricklayers in Chicago, the symbol has grown into a mainstay at picket lines across the country. In previous years, Scabby has enjoyed protection under the National Labor Relations Act ("NLRA"). Historically, the National Labor Relations Board ("NLRB") and United States District Courts have held that Scabby the Rat, by itself, is not coercive, and can be used to target "secondary employers" such as general contractors that hire non-union subcontractors, and who are typically a union's primary targets.

There are signals from the NLRB that the protection that Scabby has historically been afforded could be changing. Recently, a hotel in Philadelphia filed a charge with the NLRB after a union positioned two (2) 8- to 12-foot rats between the entrances to the hotel and restaurant, which allegedly scared away customers. The union was protesting a non-union contractor that was performing work for the hotel, termed "secondary employer." The next day, the union's protesters also brought a bullhorn. After the hearing on the NLRB's complaint, the administrative law judge ("ALJ") declared that the union had a free-speech right to put inflatable rats outside a hotel to protest — but the union did not have the right to scream into a bullhorn and disturb guests and customers. Nonetheless, the hotel appealed the ALJ's decision to the full NLRB. The five member board has not yet issued a ruling. However, many analysts believe the NLRB may reverse its previous decision allowing Scabby the Rat to target "secondary employers."

In a recent brief filed in a case involving a different union, the NLRB's general counsel, Mr. Peter Robb, stated that a "huge, menacing inflatable rat placed near a business entrance thus

[15] Notice 2019-63.
[16] The IRS takes into account that 2020 is a leap year and that March 1, 2020 falls on a Sunday.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*

inherently conveys a threatening and coercive message that will restrain a person." Notwithstanding Mr. Robb's fear of balloons, precedent lies with Scabby the Rat. Specifically, in 2011, the NLRB ruled that displaying Scabby the Rat at a secondary employer's premises to protest the labor practices of a different contractor is not coercive and therefore does not violate U.S. labor laws.

Notably, the NLRA prohibits conduct found to "threaten, coerce, or restrain" a secondary employer not directly involved in a primary labor dispute, if the object of that conduct is to cause the secondary employer to cease doing business with the primary. In its 2011 ruling, the Board found that Scabby the Rat does not involve any confrontational conduct, which is the essence of picketing, nor is Scabby coercive in other ways. Rather, the Board held Scabby itself is symbolic speech that draws "attention to the Union's grievance and cast[s] asperations on [the contractor], but we perceive nothing in the location, size or features of the balloon that [are] likely to frighten those entering the [place of business], disturb [customers], or otherwise interfere with the business."

Needless to say, although there are pending cases before the NLRB, Scabby the Rat will likely remain the timeless harbinger of union trouble for the foreseeable future. Though the Board may utilize these cases to limit the circumstances in which Scabby can make an appearance (e.g., when the union is protesting a secondary employer while their primary target is not present), it seems highly unlikely that the NLRB can go as far as to completely prohibit the use of Scabby in labor disputes.

Precertification and Exposure to Litigation for Health and Welfare Plans

In order to provide quality, timely, and cost-effective treatment plan to its members, a health and welfare plan may require that certain medical services and/or procedures receive "precertification" (also known as "preauthorization") from the plan prior to a member receiving those medical services and/or procedures. Essentially precertification of a service or procedure means that the health and welfare plan has determined that the requested services are medically necessary and an appropriate course of treatment for the patient. However, precertification should not promise that the services and/or procedures will be covered at any particular level by the health and welfare plan; these claims will still be subject to the terms and limitations of the plan.

In a number of recent lawsuits against health and welfare plans, out-of-network providers are alleging that a plan's precertification of a claim creates a separate and binding contract outside the scope of the plan document and pursuant to the terms of the provider. The rulings of these lawsuits may place health and welfare plans at a financial risk.

When a member goes to an out-of-network provider, a health and welfare plan may still pay the claim, but at a lower rate than the billed amount. An in-network provider has to accept the payment at the discounted network rate, while an out-of-network provider can balance bill the remainder of the claim to the member. As balance billing a member can be futile, out-of-network providers are now bringing these lawsuits against health and welfare plans demanding additional payment.

These recent lawsuits have all been brought in state court with a focus on the precertification of a claim, with most having one similar conclusion as to the notice of such precertification given by a plan. A number of state courts have permitted these claims to continue on the basis of breach of contract based on unclear precertification notices that do not specifically provide that these precertifications are subject to the terms and limitations of the plan.[21]

However, in another similar lawsuit, the precertification notice at issue specifically provided, in part, that the precertification was "NOT a guarantee of payment" and "is issued subject to the terms and the limitation of your agreement and the member's benefit plan."[22] The court in this case determined that the terms of the plan controlled and that ERISA preempted the out-of-network provider's claim for breach of contract. The court reasoned that the notice did not create a promise of payment, as the notice specifically provided that the claim could not be determined without referring to the terms of the plan.

Accordingly, there is one key takeaway in these recent lawsuits that should be noted by health and welfare plans. It is crucial that precertification notices specifically provide that any claim reviewed is still subject to the terms and limitations of the plan and they do not contain any language (or lack thereof) that creates a promise of payment. Plans should also review their plan documents regarding

[21] *See Comprehensive Spine Care P.A. v. Oxford Health Insurance Inc.*, 2018 U.S. Dist. LEXIS 207782 (D.N.J. Dec. 10, 2018); *Glastein v. Carefirst Blue Cross Blue Shield*, 2019 U.S. Dist. LEXIS 52746 (D.N.J. Mar. 218, 2019).

[22] *Atlantic Shore Surgical Associates v. Horizon Bluecross Blueshield*, 2018 U.S. DIST. LEXIS 90734 (D.N.J. May 31, 2018).

balance billing by out-of-network providers and ensure their staff is appropriately trained to provide accurate information to members regarding out-of-network providers.

International Officer's Pension Correctly Suspended

In August 2019, the United States Court of Appeals for the Ninth Circuit held that a "plan administrator," the Board of Trustees of the Northern California Electrical Workers Pension Plan ("Pension Plan") did not abuse its discretion in denying an application for an early pension applied for by a former Trustee and Business Manager.[23] John O'Rourke was a participant in the Pension Plan and Business Manager of his union, IBEW Local 6. Eventually, O'Rourke also became a Trustee on the Pension Plan. In or around 2010, O'Rourke left his Local 6 and Board positions to join the IBEW as an International Field Representative, followed by working as the Vice President for the IBEW Ninth District. In these positions, O'Rourke only performed administrative work and it was undisputed that he did not perform any traditional electrician work. The Pension Plan document defined "Prohibited Employment" as the performance of services in any capacity in the "Electrical Industry." Electrical Industry was defined as "all branches of the Electrical Trade in the United States." However, the term "Electrical Trade" was not defined.

In June 2014, O'Rourke applied for an early pension. The Board considered the application numerous times between June 2014 and March 2015 when they eventually denied it, deciding that O'Rourke, by working as an International Field Representative and Vice President for the IBEW, fell within the definition of Prohibited Employment. O'Rourke appealed and the Board subsequently denied his appeal. As a result, he filed a lawsuit against the Pension Plan and the Board. The Parties agreed that the Pension Plan document conferred discretion to the Board; therefore, an abuse of discretion review applied. O'Rourke argued that there were procedural irregularities in the review. Specifically, O'Rourke alleged that there was political hostility and personal animus towards him, shifting rationales provided for the denial, and the Board's rejection of Plan Counsel's opinion. The Court held that none of these arguments proved that the Board abused its discretion in denying his claim for benefits. For example, in 2010, when O'Rourke was on the Board, he had proposed a change in the rules to exempt work for unions from the definition of prohibited employment. However, the resolution was never adopted at that time. In addition, while Plan Counsel had initially given the opinion that Prohibited Employment would not cover the work O'Rourke was performing, after several meetings and memorandums, Plan Counsel acknowledged it had not reviewed previous determinations made by the Board that showed the Board had previously interpreted more broadly to include any work in the electrical trade, even administrative work. Therefore, while the Board did not follow Plan Counsel's initial advice, the Board did work with Plan Counsel and carefully made its decision, taking into account the way in which the Board had previously interpreted the definition of Prohibited Employment with regard to other claims for benefits. As a result, the Court decided that despite the ambiguous definition of Prohibited Employment in the Pension Plan document, the Board did not abuse its discretion in denying O'Rourke benefits. The Court also looked at the Board's interpretation of the Plan itself after reviewing the alleged procedural irregularities and determined that the Board's interpretation was valid.

Investigation Leads to Felony Conviction for Trustee in Ohio

In June 2019, Terry Doan was sentenced to a year in prison, followed by three years of probation, and ordered to pay nearly $200,000.00 in restitution to the Joint Apprenticeship Training Committee ("JATC") of the Heat and Frost Insulators and Allied Workers, Local 84 in Kent, Ohio. He pleaded guilty to one felony count of embezzlement from an employee benefit plan in February 2019. Doan was one of six trustees of the JATC. He also served as the financial secretary/treasurer for the JATC.

Doan's embezzlement scheme came to light after another trustee received a call about a bounced check in January 2017. The call came from a bank, but not the bank where the JATC account Doan oversaw was held. Based on this information, the trustee went to the JATC's actual bank, where it was discovered that in 2012 Doan had removed a requirement that all checks over a certain amount be signed by two trustees. When confronted with the information, Doan admitted to the theft.

Investigators learned that from 2013 to 2017 Doan had been cashing checks from the Fund's actual account into the second, unauthorized bank account, which was held at the bank where Doan also did his personal banking. The two-signature policy that Doan

[23] *O'Rourke v. N. Cal. Elec. Workers Pension Plan*, 934 F.3d 993 (9th Cir. 2019).

removed from the JATC account was likely put in place to prevent just this sort of situation from occurring. In all, prosecutors said Doan stole $195,147.00.

The investigation was handled by the U.S. Department of Labor's Employee Benefits Security Administration ("ESBA") and Office of Inspector General. The criminal case was prosecuted by the U.S. Attorney's Office for the Northern District of Ohio.

U.S. Attorney Justin Herdman said that Doan "betrayed the trust of the men and women in the union and is being held accountable for his actions." Joe Rivers, the ESBA's Regional Director in Cincinnati stated, "criminal acts like this directly impact participants in employee benefit plans by compromising their hard-earned benefits and eroding confidence in those chosen to manage their trust."

The 61-year-old Doan is currently serving his sentence at the Elkton Federal Correctional Institution in Lisbon, Ohio.

Kenneth A. Krol Retiring February 2020

In February 2020, we will say goodbye to Ken Krol, who is retiring after working at J&K since 2002. As many of our clients have encountered over the past 17 years, Ken is a master of pension plans and his expertise will be missed.

Ken graduated from Beloit College with a Bachelor of Arts Degree in 1977. Thereafter, he obtained a Master's Degree in Labor and Industrial Relations from the University of Illinois in 1978. After obtaining his Master's Degree, Ken worked for several large companies in employee relations. In 1985, Ken graduated from the Chicago-Kent College of Law with his Juris Doctorate.

Following law school, Ken worked for several large consulting firms prior to J&K. In 2002, Dennis Johnson hired Ken to join the firm. Ken became a partner in 2005 and the name was changed to Johnson & Krol, LLC in 2007. Since joining J&K, Ken has advised all of J&K's pension clients on compliance, plan interpretations, and plan changes.

Ken's experience with pension funds includes the early days of ERISA, when interest rates were so high that pension plans easily met their assumed rate of return, the subsequent reality check with interest rates, the adoption of the PPA, and the Great Recession.

Ken looks forward to spending his summers on Witches Lake in Northern Wisconsin, winters in Florida, and the rest of the time in the Chicagoland area. He also looks forward to spending time with his family, including his four grandchildren.

It will be difficult to replace Ken's expertise; however, he has worked closely with other attorneys in the firm for years to pass on his knowledge and expertise regarding multiemployer pension plans. J&K will still be able to provide the high level of service and expertise our clients have come to expect.

We wish Ken the best in his retirement!!

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