JOHNSON & KROL, LLC

Taft-Hartley Report

JULY 2011 ISSUE

Health Care Reform – Review of Constitutional Arguments

Shortly after President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law, over twenty lawsuits brought the constitutionality of this law into question. Federal district courts and appellate courts are flooded with constitutional challenges.

To date, the PPACA scorecard is three district courts and one appellate court have upheld the law and two district courts have overturned the law. A district court in Florida struck down the entire law after it determined that the individual mandate exceeds Congress's authority.[1] This ruling has already been appealed to the US Court of Appeals for the 11th Circuit and arguments were held in early June. In Virginia, the 4th Circuit Court of Appeals heard arguments in May to resolve a split decision between the US District Court for the Eastern District of Virginia[2] which ruled against the individual mandate and the Western District of Virginia[3] which dismissed the challenge by holding that the individual mandate is constitutional under the Commerce Clause. Most recently, the US Court of Appeals for the 6th Circuit upheld the Western District of Michigan's decision that Congress had the authority to legislate the individual mandate provision pursuant to its legislative power under the Commerce Clause.[4]

The main issue that is being called into question is the individual mandate provision. Starting in 2014, the Affordable Care Act will require most Americans to buy health insurance or pay an income tax penalty. The administration argues that without the insurance mandate, it is not reasonable to require insurers to cover all applicants regardless of their health status.

Proponents of the health care reform bill argue that Congress has the power to pass legislation that falls within any of its relevant powers enumerated in the Constitution. There are two sources of congressional power. First, the General Welfare Clause provides Congress the power "to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States." The second power is provided in the Commerce Clause, which provides Congress the power "to regulate commerce . . . among the several states."

The General Welfare Clause allows Congress to impose taxes to provide for the general welfare of the country. Proponents of the law believe that by taxing individuals for failing to secure health insurance does promote the general welfare of the United States by insuring more people and preventing them from being denied insurance coverage because of preexisting conditions. By requiring all Americans to have health insurance, the national risk pool will include younger, healthier than average Americans who previously could not afford health insurance and as a result the cost of health insurance premiums will be reduced.

Under the Commerce Clause, the Court originally interpreted interstate commerce to mean only the movement of goods or services across state lines, or transactions between people in different states. However, the Court has expanded the Commerce Clause to also include local matters that substantially affect interstate commerce. Proponents argue that mandating health insurance directly affects interstate commerce because of the direct effects covering or not covering individuals has on the economy. Similar to the General Welfare Clause argument regarding the change to the national risk pool, proponents say that lowering the cost of premiums has a direct effect on interstate commerce.

Conversely, opponents of the PPACA argue that people who choose to not buy health insurance are not engaging in any action that Congress can regulate and that Congress is really attempting to regulate *inactivity*. Therefore, Congress does not have power to regulate inactivity.

An additional argument against the individual mandate is that it violates the Fifth Amendment by allowing the government to take property without just compensation. "Takings" occur when the government seizes property from particular individuals. Proponents of health care reform argue that the individual mandate is a tax, not a taking, similar to Constitutionally-allowed income taxes and excise taxes that are levied on a large population and that regulate people's behavior by taxing their income or consumption.

The health care reform battle will continue over the next few years. The individual mandate is effective in 2014 and will likely be ultimately decided by the United States Supreme Court. Until then, many of the other health care reform provisions remain in effect today and are not being challenged.

INSIDE THIS ISSUE:

Illinois Workers' Compensation Reform Bill Signed	2
Secretary of DOL Files Amicus Brief in Seventh Circuit Breach of Fiduciary Duty Case	2
ACA Update - Amendments to Claims and Appeals Regulations	3
Supreme Court Declines Review of Case Upholding Plan Language Regarding the "Make Whole" Doctrine	3
Court Rules that Insurer Can Freely Negotiate Rates with Different Plans	4
Proposed DOL Regulations Expand Definition of 'Fiduciary' Related to Investment Advice	4
Collection of Unpaid Apprenticeship Scholarship Loans	5
Proposed NLRB Rules Would Change Union Election Procedures	6

Illinois Workers' Compensation Reform Bill Signed

On June 28, 2011, Governor Pat Quinn signed into law a bill which makes various changes to the Illinois workers' compensation system. Many are calling this law a comprehensive overhaul of the system which is designed to reduce the burdens on business owners and continue to protect injured workers. Others believe that this law does little for injured workers. This article is meant to outline the major changes to this law.

Some of the provisions designed to save Illinois businesses between $500 and $750 million dollars include: (1) a 30 percent reduction in fees paid to doctors and hospitals for treating injured workers, which will provide the most cost-savings; (2) a requirement that physicians and arbitrators must use standards set by the American Medical Association when determining impairment and disability; (3) employers will be allowed to organize medical networks to handle workers' compensation cases, which will allow employers to choose which doctors the employees can see for treatment; and (4) new rules that cap awards for carpal tunnel syndrome.

Additional protections added for injured workers include: (1) enhanced enforcement against employers who fail to maintain proper workers' compensation coverage; and (2) the creation of a process for electronic billing from providers which will protect workers from disruption to their treatment.

Other reforms include changes to the Illinois Workers' Compensation Commission. Current arbitrators' terms will end on July 1, 2011, and strict performance evaluations will be considered in the arbitrators' re-appointment. Arbitrators will now serve a three-year term (previously a six-year term) and will be required to follow the same ethical rules that apply to judges (i.e., prohibited from accepting gifts). Also, new arbitrators will be required to be licensed attorneys.

Secretary of Labor Files Amicus Brief in Seventh Circuit Breach of Fiduciary Duty Case

In *Kenseth v. Dean Health Plans*[5], the Secretary of the Department of Labor filed an amicus brief encouraging the Seventh Circuit to award monetary damages to a health plan participant for the plan administrator's breach of its fiduciary duties. The participant argued that she relied on the plan's call center's advice that a procedure would be covered, but the plan denied her claim after the procedure was performed. The issue stems from Section 502(a)(3) of ERISA which provides for appropriate equitable relief for a claim of breach of fiduciary duty. The Secretary and the plan participant argue that in the absence of a monetary award, the plan participant would not have a meaningful remedy through available equitable relief.

In this case, the plan administrator notified participants that they should contact a call center for advice on whether medical procedures would be covered by the plan. At no time did the plan notification or the call center inform the participants that the advice given would not bind the plan to the advice. The participant was informed that a medical procedure would be covered and in reliance of such advice, she had the medical procedure performed. After the procedure, she was informed by the plan that it would not pay for the procedure. The participant followed the administrative claims and appeals procedures and eventually filed suit in federal court. The participant alleged that the plan breached its fiduciary duties by denying payment for her surgery and that the plan should be estopped from denying her benefits because she relied on the information provided by the call center.

The district court found in favor of the plan and the plan participant appealed to the Seventh Circuit. The Seventh Circuit reversed the district court's ruling and found that the plan fiduciaries were liable under ERISA when they failed to warn the participants that the information provided by the call center would not bind the plan to their advice. The Seventh Circuit held that while the plan fiduciaries did breach their fiduciary duties, it remanded the case to the district court to rule whether the participant had any monetary remedies. At this time, the district court case has not been resolved.

The Secretary of Labor argues in her amicus brief that the district court should award the participant monetary damages or order the plan to disgorge to the participant any ill-gotten gains it received through its fiduciary breach. The brief acknowledges that the Supreme Court has held in past decisions related to breaches of non-fiduciaries that Section 502(a)(3) does not provide for monetary damages. However, it has yet to rule on whether this Section allows for monetary damages when there is a breach of fiduciary duty. The Secretary argued that monetary remedies are the only just compensation for the plan's breach in this situation.

ACA Update — Amendments to Claims and Appeals Regulations

Recently, the DOL, HHS and IRS (the "Agencies") released amendments to the interim final rule released last year regarding claims and appeals procedures under the Patient Protection and Affordable Care Act ("ACA").

The original draft regulations required that plans send out all appeal denials to an independent review organization (IRO) for an "external review" after plan's final internal appeal decision and upon request by the participant. The recent amendments limit the type of benefit determinations subject to the external review requirements to medical necessity denials and coverage cancellations. Additionally, because of the difficulty finding and contracting with IROs, plans now have until January 1, 2012, to contract with two IROs and until July 1, 2012 before they are required to contract with a third IROs to provide these "external reviews".

Additionally, under the original draft regulations, all urgent care decisions (life threatening) had to be decided within 24 hours. In response to public comments about the 24-hour timeline, the amendments expand the urgent care decision timeline to 72 hours.

Finally, the original regulations required that plans provide the diagnosis code, treatment code and meaning of the codes in explanations of benefits (EOB). The amendments eliminate this requirement but mandate that plans provide this technical information upon request.

These changes should substantially ease the administrative burden expected last year when the original regulations were released. However, it is important to keep up to date on all ACA developments as the guidance is issued as it is updated and revised often. For copies of the recently issued claims and appeal model notices, further information on the recent changes or other ACA compliance and implementation issues, please contact our office.

Supreme Court Declines Review of Case Upholding Plan Language Regarding the "Make Whole" Doctrine

The U.S. Supreme Court declined a petition to review the decision of the Eleventh Circuit[6] that upheld plan language that refused to apply the make whole doctrine in a subrogation case. The Eleventh Circuit held that if it overrode the plan's language regarding the make whole doctrine, it would frustrate ERISA's purpose to protect contractually defined benefits.

The case involved a plan participant who was involved in an accident and the case settled for $1.3 million. The plan paid approximately $263,000 in medical expenses related to the accident. The plan language stated that the plan was entitled to reimbursement from third-party settlements regardless of whether the plan participant was fully compensated or made whole by the settlement. The make whole doctrine provides that an insured who settled with a negligent third-party party is liable to the insurer only for the excess received over the total amount of his or her loss.

The participant argued that by forcing him to reimburse the plan, he would not be "whole" for the injuries he sustained in the auto accident. He further argued that as a matter of equity and in order to effectuate ERISA's policy of protecting plan participants and beneficiaries, the court should adopt and apply the make whole doctrine. The Eleventh Circuit previously applied the make whole doctrine in cases in which the plan was ambiguous and did not specifically preclude the make whole doctrine. However, here the court held that it would not apply the make whole doctrine when the plan language clearly states that it does not apply. Further, the court held that participants must reimburse the plan for benefits paid on his or her behalf in situations like this because if the plan were to relieve participants from this duty, the costs of the benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments.

The participant petitioned the Supreme Court to review and rule on this issue. However, the Supreme Court refused to review this case which likely shows that the Court does not believe there is a question of law to be decided by the Court.

Court Rules that Insurer Can Freely Negotiate Rates with Different Plans

The Sixth Circuit ruled in *DeLuca v. Blue Cross Blue Shield of Michigan*[7], that an insurer does not act as a fiduciary when it negotiates rates with different plans. In *DeLuca*, a plan participant in a self-insured plan sued BCBSM alleging that it breached its fiduciary duty when it negotiated better rates for a health management organization.

The Sixth Circuit agreed with the lower court in its holding that BCBSM was not acting as a fiduciary when it negotiated better rates with another plan. The court held that BCBSM was not acting as a fiduciary because the negotiations are business dealings not directly related to any specific ERISA plan and pertained to a broad range of consumers. The court did reiterate that BCBSM does serve as a fiduciary when it acted as an administrator and a claims-processing agent, but to extend the fiduciary status to BCBSM in this case would ultimately harm the company's ability to do business and would destroy its economic advantage in the health insurance market.

The court also held that in order to determine whether an entity is acting as an ERISA fiduciary, courts must examine the conduct at issue. When reviewing the conduct, the court must determine if the conduct rises to the level of management or administration of the plan or whether it is merely making a business decision. If the conduct is related to the management or administration of the plan it will be considered the act of an ERISA fiduciary. As in the *DeLuca* case, the court found that the conduct was related to a business decision and therefore, BCBSM was not an ERISA fiduciary.

Proposed DOL Regulations Expand Definition of 'Fiduciary' Related to Investment Advice

The Employee Benefits Security Administration (EBSA) released a proposed regulation that would expand the categories of persons considered to be a "fiduciary" under the Employee Retirement Income Security Act of 1974, as amended (ERISA).[8] EBSA stated that the retirement plan industry has changed significantly since the current fiduciary regulation was written and this proposed regulation would help close gaps in the law.

Under the current rule, the Department of Labor established a 5-part regulatory test for "investment advice" that gave a very narrow meaning to this term. The current regulation provides that before a person can be held to ERISA's fiduciary standards with respect to their advice, they must (1) make recommendations on investing in, purchasing or selling securities or other property, or give advice as to their value (2) on a regular basis (3) pursuant to a mutual understanding that the advice (4) will serve as a primary basis for investment decisions, and (5) will be individualized to the particular needs of the plan. An investment adviser is not treated as a fiduciary unless each of the five elements of this test is satisfied for each instance of advice.

The proposal would define a fiduciary as a person who provides investment advice to plans for a fee or other compensation and would expand the scope of what constitutes investment advice. To define investment advice, the proposed regulation establishes a two-part test.

Part 1 of the test describes the services one would perform for a fee or other compensation. The new proposal expands the parameters of "fee or other compensation" to include compensation that is direct or indirect, incidental or purposeful and can be for current or future advice. Further, the types of services that investment advice would include is expanded to include (a) appraisals, (b) fairness opinions about the value of securities or other property, (c) the routine valuation of investments, (d) advice and recommendations regarding the management of investments, (e) advice, whether provided on only a one-time basis or on a regular basis, and (f) advice, whether or not it serves as a primary basis for investment decisions.

Part 2 provides alternative conditions and the regulation states that people must meet at least one condition to fall under the investment advice parameters. The conditions include (1) acknowledged ERISA fiduciaries – those who explicitly state they are fiduciaries; (2) nonadvice ERISA fiduciaries – those who exercise control or discretionary authority over plan investment decisions or over plan administration; (3) security law investment advisers; and (4) a multifactor test – those who provide advice with an understanding that the advice might be considered during decision-making related to investment or management decisions.

The proposed regulation contains two significant changes from the current rule. First, the advice need not be provided on a regular basis. The Department does not believe that the significance of the advice diminishes if it is only provided once, as opposed to on a more consistent basis. Secondly, the proposed regulation would not require that the parties have a mutual understanding that the advice will serve as a primary basis for plan investment decisions. The DOL believes that a plan should be able to rely on advice for all decisions whether primary or not.

Accordingly, the proposed regulations could make investment consultants, appraisers and valuation experts, and broker-dealer firms fiduciaries. The effective date was extended until January 1, 2012.

Collection of Unpaid Apprenticeship Scholarship Loans

Apprenticeship training programs are key to maintaining highly trained employees in the construction trades. During periods of economic uncertainty when work is limited, many apprenticeship programs experience an increase in the number of apprentices and/or journeyman that accept employment with employers that do not contribute to the training fund. This raises the question of whether the scholarship loan agreement has been breached and if so, how does the training fund go about collecting the unpaid loan amount(s).

Whether or not the scholarship loan agreement has been breached depends on the specific terms of the agreement itself. Some loan agreements are structured such that a breach only occurs if the individual accepts employment in the same industry for an employer that does not have an obligation to contribute to a training fund (i.e., accepts employment in the same industry for a non-union employer). Other loan agreements provide for full repayment even if the individual accepts employment outside of the industry altogether. In the event of a breach, most scholarship loan agreements provide for the loan(s) to be repaid with interest. However, the process for collecting unpaid scholarship loans is different than the process for collecting delinquent employer contributions.

Many court decisions throughout the past decade have significantly limited training fund's ability to collect unpaid scholarship loans in federal court pursuant to ERISA. As a result, the training fund must typically file an action for breach of contract in state court. Once judgment is entered against the individual, wage garnishment can be an effective tool in recouping unpaid loans. Since educational loans cannot be discharged in bankruptcy, the debt follows the individual until it is repaid.

In order to best position the training fund to collect unpaid scholarship loans, it is important that the apprenticeship program properly structure the terms of the loan agreement, consistently monitor for breaches and seek to collect any unpaid amounts.

We encourage you to contact

JOHNSON & KROL, LLC

if you have any questions regarding the content within this newsletter.

(312) 372-8587

www.johnsonkrol.com

JOHNSON & KROL, LLC

Johnson & Krol, LLC
300 South Wacker Dr.
Suite 1313
Chicago, IL 60606

Phone: 312.372.8587
Fax: 312.255.0449
www.johnsonkrol.com

U.S. Postage Here

Proposed NLRB Rules Would Change Union Election Procedures

On June 22, 2011, the National Labor Relations Board (NLRB or Board) published a proposed rule that would amend the rules and regulations governing the filing and processing of petitions relating to the representation of employees for purposes of collective bargaining with their employer.[9]

The Board notes that the proposed rules are designed to expedite the representation election process. Some of the changes include: (1) allowing election petitions, notices and voter lists to be submitted electronically; (2) requiring a pre-election hearing to begin seven days after a hearing notice is served; (3) requiring the parties to state their positions no later than the start of the hearing, or otherwise forfeit their legal right to do so later; (4) postponing litigation of voter eligibility issues until after the election; (5) elimination of the ability to request a pre-election review by the NLRB; (6) requiring the employer to produce a preliminary voter list prior to the opening of the pre-election hearing; (7) consolidation of all election-related appeals to the Board into one post-election appeal; and (8) making NLRB review of post-election decisions as discretionary rather than mandatory.

In the proposed rule, the Board states that their goal is to remove unnecessary litigation, provide uniform pre- and post-election procedures, and facilitate the use of electronic communications and filing.

[1] *Florida v. U.S. Department of Health and Human Services,* 10-CV-00091, U.S. District Court, Northern District of Florida

[2] *Virginia v. Sebelius,* 10-CV-00188, U.S. District Court, Eastern District of Virginia

[3] *Liberty University v. Geithner,* 10-CV-00015, U.S. District Court, Western District of Virginia

[4] *Thomas More Law Center v. Obama,* 6th Cir., No. 10-2388 (June 29, 2011)

[5] *Kenseth v. Dean Health Plans, Inc.,* W.D. Wis., No. 3:08 CV-00001-BBC

[6] *O'Hara v. Zurich American Insurance Co.,* 604 F. 3d 1232 (11th Cir. 2010)

[7] *DeLuca v. Blue Cross Blue Shield of Michigan,* 6th Cir. No. 08-1085 (December 8, 2010)

[8] 29 CFR Part 2510 [75 Fed. Reg. 65263]

[9] 76 Fed. Reg. 36812