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TAFT-HARTLEY REPORT

Fifth Circuit Upholds Use of Single Document as SPD and Plan Document

In May 2017, the Fifth Circuit affirmed the U.S. District Court for the Eastern District of Texas's holding that an ERISA welfare plan beneficiary was obligated to reimburse the plan for medical expenses it paid on her behalf when she recovered monies from a third party in a medical malpractice action, even though the welfare plan did not have a plan document separate from its summary plan description ("SPD"). *Rhea v. Alan Ritchey, Inc.*, 858 F.3d 340 (5th Cir. 2017).

The beneficiary unsuccessfully argued that although the welfare plan's SPD did include a reimbursement provision, she was not obligated to reimburse the plan for medical claims paid on her behalf because the SPD referenced a nonexistent "official plan document" whose terms would ultimately govern in the event of a conflict with the SPD. The beneficiary interpreted the U.S. Supreme Court's holding in *Cigna v. Amara* to require ERISA plans to maintain separate plan documents and SPDs.[1]

The Fifth Circuit distinguished *Amara*, which held that SPD terms are not enforceable over conflicting plan document terms, from the instant matter, where the issue concerned whether an SPD could function as a plan document in the absence of a separate plan document. The Fifth Circuit ultimately concluded that the SPD in this case sufficiently complied with ERISA's written instrument requirements and further rejected the beneficiary's claim that the welfare plan "lied" about the existence of a plan document, noting that while the reference to it in the SPD was "sloppy," it "does not render the Plan's terms unenforceable" and did not constitute a breach of a fiduciary duty.[2] The Court accordingly found that the welfare plan was entitled to reimbursement, as well as attorney's fees and costs.

Both *Rhea* and *Amara* illustrate the importance of maintaining SPDs and plan documents that comply with ERISA's written instrument requirements in order to shield funds from unnecessary litigation. Johnson & Krol generally advises its welfare fund clients to maintain a combined plan document and SPD in order to avoid conflicting terms as contemplated in *Amara*. These documents should be explicitly identified as a combined document. The Fifth Circuit's holding lends support to this combined document approach so long as the document meets the criteria for both plan documents and SPDs.

If you have questions regarding your plan's SPD or plan document, please contact Johnson & Krol.

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[1] 131 S. Ct. 1866 (2011).

[2] *Rhea*, 858 F.3d at 9.

Fifth Circuit Court of Appeals Vacates Department of Labor Fiduciary Rule

In April 2016, the United States Department of Labor ("DOL") revamped the fiduciary rule completely altering the definition of an investment advice fiduciary. The new fiduciary rule greatly expanded the professionals that could be included in the definition of fiduciary for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). The new fiduciary rule was met with a great deal of opposition that has recently culminated with a new decision by the United States Court of Appeals for the Fifth Circuit. It now appears that, after years of implementation, the new fiduciary rule will be vacated and replaced by the old fiduciary rule.

In 1975, the DOL promulgated what is known as the five-part test to determine who could be considered a fiduciary under ERISA. Under the five-part test, a person is a fiduciary if: (i) they render advice to the plan as to the value or advisability of buying, selling or investing in securities or other property, (ii) on a regular basis, (iii) pursuant to a mutual agreement, arrangement, or understanding, written or otherwise, between the plan and the plan fiduciary, (iv) the services will serve as a primary basis for investment decisions, and (v) the advice given is individualized to the plan based on its particular needs, strategy, or policies. 29 C.F.R. §2510.3-21(c)(1) (2015). This rule was replaced by the DOL in 2016 with a new rule asserting an individual is a fiduciary whenever they render investment advice for a fee in connection with a recommendation as to the advisability of buying, selling or managing investment property. Among other things, the new rule removed the regular basis requirement, making a one-time recommendation enough to create fiduciary liability.

On March 15, 2018, the United States Court of Appeals for the Fifth Circuit in *U.S. Chamber of Commerce v. DOL*, Case No. 17-10238, held that the new fiduciary rule should be vacated. The Court's reasoning was two-fold. First, the Court reviewed the common law definition of "fiduciary" to determine if the rule itself was sound. The Court held that the new fiduciary rule was too broad, as it possibly could affect individuals like stockbrokers and insurance agents, and therefore held the new rule conflicted with the text of 29 U.S.C. §1002(21)(A)(ii) and the common law definition of fiduciary. Moreover, the Court held that even if the text did not conflict, the rule could not be upheld due to an administrative flaw in the way the DOL created the rule.

This decision will likely have a major effect on the future of the new fiduciary rule. The DOL had forty-five (45) days to challenge the decision. However, as many expected, the DOL did not challenge the Court's decision, as President Trump has expressed that he would like to see the new fiduciary rule vacated. The Fifth Circuit was expected to enter an order vacating the fiduciary rule on May 7, 2018; however, it has not yet done so. The Fifth Circuit's decision will apply across the country and essentially kill the new fiduciary rule. What happens next is still uncertain; however, it appears that the DOL will simply revert to the old five-part fiduciary test.

Foruria v. Centerline Drivers, LLC - COBRA Notice to Last Address on File Sufficient

In November 2017, the U.S. District Court for the District of Idaho held that the Defendant complied with the COBRA Notice requirements under Section 1166 of the Employee Retirement Income Security Act of 1974 ("ERISA") by sending its COBRA Notice to the Plaintiffs at their last address that was on file.[3] David Foruria was employed by Centerline Drivers, LLC ("Centerline") as a commercial truck driver. During one of Mr. Foruria's deliveries, Mr. Foruria suffered an injury for which he subsequently required surgery. As a result, Mr. Foruria took time off from work under the Family and Medical Leave Act ("FMLA").

On December 10, 2015, during Mr. Foruria's time off, Centerline terminated his employment. Thereafter, on December 31, 2015, Mr. Foruria and his dependent, Carol Foruria, lost their medical coverage under Centerline's health plan. Accordingly, on January 13, 2016, Centerline sent its COBRA Notice to Mr. Foruria and Mrs. Foruria at the last address that Centerline had on file. However, Mr. Foruria and Mrs. Foruria allege that they did not receive the COBRA Notice until September 2016, as the COBRA Notice was sent to their physical address instead of their P.O. Box address.

Mr. Foruria and Mrs. Foruria ("Plaintiffs") then brought a lawsuit against Centerline ("Defendant") alleging, amongst other claims, that Centerline failed to notify them of their COBRA benefits under the health plan as required under Section 1166 of ERISA. Plaintiffs argued that the Defendant should have sent the COBRA Notice to their P.O. Box address instead of their physical address since Mr. Foruria sent an address change form to Centerline on February 6, 2016 with their P.O. Box address. However, it is important to note that Centerline had already sent its COBRA Notice

[3] *Foruria v. Centerline Drivers, LLC*, 2017 U.S. Dist. LEXIS 193940 (D. Idaho Nov. 6 2017).

on January 13, 2016 to their physical address as that was the address it had on file.

The Court disagreed with the Plaintiffs and held that the Defendant complied with the requirements of 29 U.S.C. § 1166 when it sent the COBRA Notice to the Plaintiffs via mail to their physical address on file at the time the COBRA Notice was sent.[4] Moreover, the Court held that "whether Plaintiffs received the notice or not is not material to a determination of Centerline's compliance with COBRA requirements; the law only requires that an employer make a 'good faith' effort to provide notification."[5]

If you have any questions regarding complying with COBRA requirements under ERISA, please do not hesitate to contact our office.

Supreme Court Dismisses Sixth Circuit's Decision Providing Lifetime Retiree Medical Benefits

On February 20, 2018, the United States Supreme Court unanimously reversed a decision by the Sixth Circuit Court of Appeals in yet another lifetime retiree medical benefits case in *CNH Industrial N.V. v Reese*.[6]

In 1998, CNH Industrial N.V. and CNH Industrial America (collectively, "CNH") agreed to a collective bargaining agreement which provided healthcare benefits under a group benefit plan to certain "employees who retire under the Pension Plan."[7] The group benefit plan was "made part of" the collective bargaining agreement and "ran concurrently" with it.[8] The collective bargaining agreement also contained a general durational clause stating that it would terminate in May 2004.[9]

After the collective bargaining agreement expired, a class of retirees and surviving spouses filed a lawsuit against CNH, seeking a declaration that their health care benefits vested for life. The District Court initially awarded summary judgment to CNH, but after reconsideration, it awarded summary judgment to the retirees.[10]

The Sixth Circuit affirmed the District Court's decision awarding summary judgment to the retirees, noting that the collective bargaining agreement was silent as to whether the retirees' health care benefits vested for life.[11] Even though the collective bargaining agreement contained a general durational clause, the Sixth Circuit determined that clause was inconclusive because the collective bargaining agreement "carved out certain benefits" for life insurance and stated that those coverages ceased at a time different than other provisions.[12] The Sixth Circuit also noted that the collective bargaining agreement "tied" health care benefits to pension eligibility. According to the Sixth Circuit, these provisions of the collective bargaining agreement rendered it ambiguous. As a result, the Sixth Circuit consulted extrinsic evidence. That extrinsic evidence, according to the Sixth Circuit, supported a lifetime of health care benefits.

The Supreme Court unanimously reversed the decision, while also scolding the Sixth Circuit for its interpretation of prior decisions from the Supreme Court. Several years ago, the Supreme Court held in *M&G Polymers USA, LLC v. Tackett* that the Sixth Circuit was required to interpret collective bargaining agreements according to the "ordinary principles of contract law."[13] Before the Supreme Court's decision in *Tackett*, the Sixth Circuit continuously presumed that collective bargaining agreements vested retiree benefits for life. The Supreme Court, however, rejected these presumptions as "inconsistent with ordinary principles of contract law."[14]

Here, the Supreme Court determined that the Sixth Circuit's decision did not comply with *Tackett's* direction to apply ordinary contract principles. The Supreme Court pointed out that the Sixth Circuit failed to apply the general durational clause contained in the collective bargaining agreement to the health care benefits. The Supreme Court also noted that the "Sixth Circuit read [the collective bargaining agreement] that way only by employing the inferences that this Court rejected in *Tackett*."[15] The Sixth Circuit "did not point to any explicit terms, implied terms, or industry practice suggesting that the [collective bargaining agreement] vested health care benefits for life."[16]

The Supreme Court continued to criticize the Sixth Circuit by stating that "no other Court of Appeals would find ambiguity in these circumstances," noting that "when a collective bargaining agreement is merely silent on the question of vesting, other courts would

[4] *Id*. at 24.
[5] *Id*.
[6] *CNH Industrial N.V. v. Reese*, 138 S. Ct. 761 (2018).
[7] *Id*. at 764.
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926 (2015).
[14] *Id*. at 937.
[15] *Reese*, 138 S. Ct. at 765.
[16] *Id*.

conclude that it does *not* vest benefits for life."[17] Ultimately, the Supreme Court held that the collective bargaining agreement was not ambiguous because it contained a general durational clause that applied to all benefits. The Supreme Court noted that the only reasonable interpretation of the collective bargaining agreement is that the health care benefits expired when the collective bargaining agreement expired in May 2004.

Union Goes on Offensive in "Right to Work" Debate

The International Union of Operating Engineers Local 150 ("Local 150") recently filed a federal lawsuit against the Village of Lincolnshire, Illinois, claiming that its members' tax dollars were being diverted to organizations which lobby against their beliefs and best interests. At issue is Lincolnshire's membership in the Illinois Municipal League ("IML"), which is a private, not-for-profit organization that accepts tax dollars as membership fees. Illinois law specifically authorizes municipalities to join the IML, which holds itself out as the "formal voice for Illinois Municipalities." The IML currently claims over 1,000 municipalities among its membership.

The IML lobbies its members on issues affecting collective bargaining rights, pension benefits, and wage rates on publicly funded construction projects. Specifically, Local 150 alleges that the IML advocated that municipalities adopt Illinois Governor Rauner's "Turnaround Agenda." A central part of Governor Rauner's "Turnaround Agenda" is urging municipalities to pass ordinances creating "Right to Work Zones," which would create right-to-work areas on a local basis. The Village of Lincolnshire was the only unit of local government to adopt a local "Right to Work Zone," which was struck down by the United States District Court for the Northern District of Illinois in a previous lawsuit filed by Local 150. Local 150 alleges that the IML's lobbying efforts conflict with its members' free speech rights guaranteed under the First Amendment.

The genesis of this lawsuit lies in a case that was recently decided by the United States Supreme Court: *Janus v. AFSCME*. At issue in that case was whether a public employer's collection of mandatory union dues is a form of forced speech under the First Amendment of the United States Constitution. The United States Supreme Court reversed previous precedent and held that it is a violation of an individual's First Amendment rights. The net effect is that all public employment became right to work on a nationwide basis.

Local 150 is essentially using the same logic that *Janus* and his supporters employed before the Court, just in a different context. The Liberty Justice Center, which represents the Village of Lincolnshire, asserted in its *Janus v. AFSCME* brief that union "agency fees thus inflict the same grievous First Amendment injury as would the government forcing individuals to support a mandatory lobbyist or political advocacy group." Local 150 argues that if mandatory union agency fees are a form of forced speech, then certainly using tax revenue for an organization that advocates for a position its members disagree with is forced speech as well. As relief, Local 150 requests an injunction preventing the Village of Lincolnshire from using tax revenue on political or lobbying activities and a judgment that Lincolnshire's taxpayer-funded support of the IML is unconstitutional. An individual member who is also a party to the suit is also seeking a refund of any portion of his tax dollars that have been spent on political or lobbying activities through the IML or any other organization. The case is currently pending in the United States District Court for the Northern District of Illinois, Case No. 18-1310.

Security in the Event of an Employer Default

Many collective bargaining agreements and/or trust agreements, especially in the construction industry, require employers to post some sort of security - a surety bond, letter of credit, or cash escrow - in the event of a default. The goal of the security is to cover an employer's obligations to its employees, the fund(s), and/or the union if the employer is unable to pay for one reason or another. Each of these security options are fairly similar, but there are some distinctions that should be understood.

Surety Bonds

A surety bond is essentially an insurance policy that provides for "coverage" in the event of a pre-determined event. For surety bonds, the pre-determined event is an employer's failure to comply with its contractual payment obligations. Which of those contractual obligations (i.e., contributions, liquidated damages, etc.) are covered depends upon the written terms of the bonds. Similar to an insurance policy, a surety bond also provides for a maximum of what the "coverage" might be. For surety bonds, that is the amount of the bond. The surety company will normally require the employer to put up

[17] *Id*. at 766.

some collateral to secure the bond, which could be a personal guaranty, mortgage, and/or letter of credit.

Because surety bonds are issued by surety/insurance companies, they are governed by state insurance law. As such, a surety company likely has rights under state law to dispute a claim and deny payment. Thus, in order to enforce the obligation, the funds or union may have to file suit against the surety company to compel payment. Under state law, there would not be a mandated award of attorney's fees against the surety company like a claim for contributions under ERISA.

As a positive, a surety company will generally cover a claim that occurred while the bond is in effect even if the bond is cancelled or terminated by its terms when the claim is submitted. In addition, for companies that have good credit histories, the premium may be as low as 1% of the required bond amount.

As a negative, surety companies will communicate with the employer after the funds and/or union make a claim, which may substantially delay payment on the bond. For instance, a surety company may receive a simple response from the employer that it disputes the amount being sought and deny payment on the claim without reviewing any substantive documentation. And, as stated above, there is generally no fee shifting if the funds or union are forced to file suit.

Letters of Credit

A letter of credit is issued by a bank to guarantee payment up to the amount of the letter of credit. To obtain a letter of credit, the bank will likely require some sort of collateral from the employer, up to and including cash on deposit equal to the amount of the letter of credit. The type of collateral will depend on the creditworthiness of the employer.

Letters of credit are governed by the Uniform Commercial Code ("UCC"), which has been adopted by all fifty (50) states. Under the UCC, in order to demand payment on a letter of credit, a sight draft must be presented to the bank along with the original copy of the letter of credit, prior to its stated expiration date. A sight draft is basically a notarized statement which must include specific language identified in the letter of credit. Upon receipt of the properly executed sight draft, the bank is required by the UCC to make payment.

Compared to a surety company that issued a surety bond, the bank cannot question the validity of the amount claimed and is required to make payment immediately so long as there are no flaws in the sight draft. In terms of negatives, the letter of credit will not be honored if a sight draft and the original letter of credit are not presented on or before the stated expiration, and the cost is generally higher than the cost of a surety bond.

Cash Escrow

Recognizing that some employers do not have an established credit history and are thus unable to obtain one of the other forms of security, funds and unions have agreed to accept cash on deposit as security. This is a great option for the funds and/or union because they will have immediate access to money in the event of a default. However, a cash escrow, as the name indicates, will require the employer to deposit cash which means that the employer will not have access to the money. Depositing a large sum of cash will likely be very challenging for any employer.

Generally, the terms of how and when a claim can be made will be detailed in an escrow agreement, or potentially in a collective bargaining agreement, trust agreement or bond policy. An escrow agreement would be governed by state contract law.

As a positive, obtaining payment will be controlled by the funds and/or union holding the money as the escrow agent, so it should be a simple process. As a negative, it will be very difficult for most employers to give up whatever cash, if any, they have available to sit in a cash escrow.

Federal Court Approves Additional Withdrawal Liability for Withdrawing Employers

The United States Court of Appeals for the Eleventh Circuit recently rejected an employer's claim that it cannot be assessed anything more than the withdrawal liability upon its exit from the plan. The case involves two separate measures of deficient funding for multiemployer plans: the accumulated funding deficiency and unfunded vested benefits. Under ERISA's minimum funding standards for defined benefit pension plans, a "funding standard account" is a required bookkeeping account where certain charges and credits are valued against each other. Where the charges exceed the credits, there is an "accumulated funding deficiency," essentially meaning that required minimum contributions have not been made to the plan. This differs from withdrawal liability which measures the assets of the plan compared to the value of non-forfeitable benefits under the plan. Where plan assets fail to meet the value of these benefits, there is withdrawal liability. The key distinction between these measures is that the Funding Standard Account is a means of tracking a plan employer's contributions relative to minimum funding

requirements under the law; it is not strictly a function of the plan's funded status.

In *WestRock RKT Co. v. Pace Indus. Union-Mgmt. Pension Fund*, No. 16-16443 (11th Cir. 2017), the Pace Industry union pension plan was less than 65 percent funded and was in critical status as defined by the Pension Protection Act of 2006 ("PPA"). The PPA requires such plans to have rehabilitation plans, which outline the steps it will take to improve its funding status. In 2010, the plan amended its rehabilitation plan to allow for the assessment of a portion of the accumulated funding deficiency against any employer who withdrew from the plan. A contributing employer, WestRock, sought a court order declaring that amendment invalid on two grounds. First, WestRock argued that the PPA allowed employers to bring procedural and substantive challenges when a board adopts or updates a rehabilitation plan. Second, it argued that ERISA's provisions which govern withdrawal liability, 29 U.S.C. Section 1451(a), outline the only liability that a plan may impose on a withdrawing employer.

The 11th Circuit rejected both of these arguments while affirming the lower court decision against WestRock. As to WestRock's first argument, the Court ultimately determined that the ERISA sections setting forth the requirements for rehabilitation plans do not prohibit a critical status multiemployer plan from charging withdrawing employers their share of the plan's accumulated funding deficiency. Because no ERISA violation was alleged, the Court did not resolve the question of whether employers have the ability to bring procedural and substantive challenges when a board adopts or updates a rehabilitation plan. As to WestRock's second argument, the Court found there was no indication from the text of the statute that Congress intended withdrawal liability be the only payments a withdrawing employer would ever face. The Court concluded that if Congress would have intended such a result, it would have stated so. As a result, the Court upheld the plan's assessment of a portion of the accumulated funding deficiency against employers who withdrew from the plan.

Trump Administration Drug Cost Initiative

On May 11, 2018, President Trump announced his American Patients First initiative, a series of potential policy options aimed at reducing the cost of prescription drugs. The plan includes more than 50 initiatives.

The Fact Sheet issued by the White House indicates drug prices are being driven up unfairly and are a burden on the American people. Besides high drug prices, the statement addressed flaws with government rules regarding: Medicare Part B and Part D, the 340B program, the regulatory process and patent system preventing low-cost drugs from coming to the market, a lack of transparency in drug prices, and the financial burden placed on American taxpayers (related to drug development) by foreign countries' ability to obtain low prices from U.S. drug makers.

In an effort to drive down drug prices, the President's blueprint calls for encouraging innovation while promoting better price competition and addressing "foreign freeloading." The White House statement also indicates the Department of Health and Human Services ("HHS") will take steps, including the ten listed here, to increase competition and reduce prices: (1) end the gaming of regulatory and patent processes by drug makers to unfairly protect monopolies; (2) advance biosimilars and generics; (3) evaluate whether price competition would be enhanced by requiring pharmaceutical companies to include prices in their advertisements; (4) streamline and hasten the approval process for over-the-counter drugs; (5) clarifying policies for sharing information between insurers and drug makers in an effort to facilitate access to new drugs; (6) relying more on value-based pricing by expanding outcome-based payments in Medicare and Medicaid; (7) work to give Medicare Part D plan sponsors more bargaining power with pharmaceutical companies; (8) update Medicare's drug-pricing dashboard to increase transparency; (9) require that Medicare Part D plan members be provided with an annual statement of plan payments, which includes out-of-pocket spending and drug price increases; and (10) prohibit Medicare Part D contracts that prevent pharmacists from informing patients when they could pay less out-of-pocket by not using insurance.

The administration is also considering proposals to remove the limit on Medicaid total manufacturer rebate amounts; pass through Medicare Part D rebates to consumers at the point of sale; trimming the 340B program; pressuring other countries to pay more for their drugs; allowing up to five states to opt out of the Medicaid drug rebate program in exchange for more formulary management tools than afforded by current law; and facilitating long term state financing of utilization for important new drugs. Ideas such as these may limit or reduce the number of rebates and price concessions in the market; however, the plan is short on specifics, and has been criticized for

being underwhelming in its scope and doing little to support states' actions to rein in costs.

On May 14, 2018, HHS Secretary Alex Azar spoke to stakeholders about the drug-pricing blueprint, stating there are four strategies for reform: improved competition, lowering out-of-pocket costs, enhanced negotiation, and incentives for lower list prices. He also provided a bit more detail. He described how much more appealing it is for a new drug to go into Medicare Part B, where the government simply pays the bills as submitted, versus Medicare Part D, where there is some negotiation. Secretary Azar stated the administration intends to bring negotiation to Medicare Part B through a Competitive Acquisition Program for drugs and increase the effectiveness of negotiation in Medicare Part D by giving them the same negotiating power that private sector plans already have. He also indicated that President Trump has called for HHS to merge Medicare Part B into Part D.

One thing missing from the President's speech and his blueprint was his campaign proposal to have the federal government negotiate directly with drug makers to lower prices for Medicare. Another campaign proposal not in the initiative is the idea of allowing American consumers to import low-cost drugs from outside the United States.

Many of the ideas contained in the blueprint can be enacted without legislation through rulemaking and guidance documents; others will require the assistance of lawmakers and their realization may be further down the road. In the end, it will take time for these ideas to play out and to determine what, if any, savings result from the American Patients First initiative.

MEET JOHNSON & KROL'S NEWEST ASSOCIATE

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Education
Juris Doctor (2003)
DePaul University College of Law

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William joined Johnson & Krol in 2018 as an Associate Attorney. William's practice concentrates in ERISA and labor litigation.

Prior to joining the firm, William served as Deputy Director of Investigations and Chief Regulatory Prosecutor at the Illinois Department of Insurance. While there, he oversaw criminal and regulatory investigations; worked with federal, state, and local prosecutors; and oversaw the prosecution of administrative hearings.

William also served as an Assitant State's Attorney for Cook County, Illinois from 2003-2008, where he worked in a number of different divisions, prosecuted hundreds of criminal cases, including numerous jury trials, and argued before the Illinois Appellate Court.

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Kelley C. Robinson Named Johnson & Krol's Newest Member

Johnson & Krol is proud to announce Kelley C. Robinson has been named its newest Member. Since joining Johnson & Krol in 2012, Kelley has worked tirelessly on behalf of our clients and made a great many of Johnson & Krol's successes possible.

Kelley is part of Johnson & Krol's robust employee benefits practice in which she assists clients with a variety of employee benefit plan issues, including compliance and administration. Kelley's practice areas include plan design, plan document drafting, fiduciary compliance, service provider arrangements, prohibited transactions, reporting and disclosure requirements, participant communications, and benefit claims and disputes. Kelley also advises plan sponsors and plan fiduciaries on all aspects of compliance with the laws regulating employee benefit plans, including ERISA, the Internal Revenue Code, Affordable Care Act (ACA), HIPAA, COBRA and the Mental Health Parity and Addiction Equity Act (MHPAEA).

Johnson & Krol is honored to welcome Kelley as a Member and looks forward to her continued contributions to the firm's success. Congratulations, Kelley!