

# PRIVATE HEALTH INSURANCE MARKET REFORMS



**Presented to AICP, Western Chapter**

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# OVERVIEW

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- On March 25, 2010 both chambers of Congress passed H.R. 4872, the Health Care Education and Reconciliation Act of 2010. The Senate adopted the measure by a vote of 56-43 earlier in the day while the House approved the legislation, together with technical revisions made by the Senate, late in the evening. H.R. 4872 was signed by President Obama on March 30, 2010.
- Health Care Reform legislation is the single largest piece of domestic policy legislation since the Depression.
- Will have implications for every person, health care provider, business, and level of government.
- Will impact 1/6<sup>th</sup> of the U.S. economy.
- Will result in billions of new spending, billions of deficit reduction, new taxes, penalties and new structures and entities.
- Extends coverage to 95% of the current population and 32 million currently uninsured.
- Cost -- \$938 billion over 10 years.
- Deficit Reduction -- \$143 billion over 10 years and \$1.2 trillion reduction over 20 years.

# TIMING OF INSURANCE MARKET REFORMS

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- Certain practices of health insurance companies, such as unreasonable annual or lifetime limits, rescissions and discrimination against individuals with pre-existing conditions are subject to immediate reform.
- The reforms effective shortly after enactment are intended to be either permanent (e.g., prohibition against rescissions) or are temporary programs before the principal insurance reforms take effect (e.g., high-risk pool for individuals with pre-existing conditions).
- Most health insurance reforms are implemented over a term of years and are fully implemented by 2014.

# BENEFITS NOT SUBJECT TO REQUIREMENTS

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- Coverage for accident, or disability income insurance
- Coverage as a supplement to liability insurance
- Workers compensation
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Limited scope dental or vision benefits
- Long term care, nursing home care, community-based care, or any combination
- Coverage for specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Medicare supplement

# INSURANCE MARKET REFORMS PRIOR TO FULL IMPLEMENTATION

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- No Lifetime or Annual Limits
- Prohibition on Rescissions
- Coverage of Preventative Health Services with no Cost-sharing
- Extension of Dependent Coverage
- No Pre-Existing Condition Exclusion for Children
- Development and Utilization of Uniform Explanation of Benefits
- Prohibition of Discrimination Based on Salary
- Ensuring Quality of Care
- MLR Caps
- Independent Appeal Process
- Annual Review of Premium Increases
- High-Risk Pool for Individuals with Pre-existing Conditions
- Reinsurance for Early Retirees
- Information about Affordable Coverage Options
- Administrative Simplification

# GRANDFATHERED PLANS

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- Individual and group plans in existence on the date of enactment can be maintained.
- Enrollment would be limited to those who were currently enrolled and their families, and for employer sponsored plans, to new employees and their families.
- Existing group plans subject to collective bargaining agreements would be grandfathered until the agreement terminates.
- Grandfathered plans would still be subject to certain market reforms such as:
  - Uniform explanation of benefits
  - Limits on MLR
  - Prior to 1/1/2014, extension of coverage to dependents less than 26, to the extent that the dependent is not eligible to enroll in an employer-sponsored health plan
  - No lifetime caps on benefits (and beginning in 2014, no annual benefit caps)
  - Prohibition on rescissions
  - Prohibition on excessive waiting periods
  - No pre-existing condition exclusion (effective 1/1/2014)

# NO LIFETIME OR ANNUAL BENEFIT LIMITS

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- Lifetime Limits: Effective for plan years beginning on and after a date that is 6 months after enactment, no group health plan or health insurance issuer offering group or individual insurance coverage may establish lifetime limits on the value of benefits for any participant or beneficiaries.
- Annual Limits: For plan years beginning prior to January 1, 2014, no group health plan or health insurance issuer may establish “restricted” annual limits on essential benefits for any participant or beneficiary.

# PROHIBITION ON RESCISSIONS

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Effective for plan years beginning 6 months after enactment, no group health plan no health insurance issuer offering group or individual health insurance coverage may rescind such a plan or coverage (including self-funded plans) with respect to an enrollee once the enrollee is covered under the plan or coverage, unless the covered individual committed fraud or material misrepresentation.

# COVERAGE OF PREVENTATIVE HEALTH SERVICES

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- Effective for plan years beginning 6 months after enactment, group health plans and health insurance issuers in the individual market are required, at a minimum, to provide coverage for preventative services:
  - that have a rating of “A” or “B” from the United States Preventative Services Task Force
  - immunizations recommended by the Centers for Disease Control and Prevention, and
  - with respect to women, breast cancer screening, mammography and prevention.
- No deductible or other cost-sharing on preventative services will be permitted.

# EXTENSION OF DEPENDENT COVERAGE

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Effective for plan years beginning 6 months after enactment, coverage under group and individual health benefit plans will be required to extend coverage to adult children until they are 26 years of age.

# NO PRE-EXISTING CONDITION EXCLUSION FOR CHILDREN

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Effective for plan years beginning 6 months after enactment, no group health plan or health insurance issuer offering group or individual health insurance coverage may impose any pre-existing condition limitation on any enrollee under 19 years of age.

# UNIFORM EXPLANATION OF BENEFITS

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- Not later than 12 months after enactment, HHS in consultation with the National Association of Insurance Commissioners, is required to develop a summary of benefits and coverage explanation that accurately describes the benefits and coverage that all insurers will be required to use.
- Applies to group and individual coverage.
- The summary of benefits and coverage can not be longer than 4 pages in length and must be printed in print no smaller than 12-point font.
- The summary of benefits and coverage must include:
  - Uniform definitions of standard insurance and medical terms
  - Description of the coverage and cost sharing
  - Renewability and continuation of coverage provisions
  - A statement of whether the plan or coverage provides minimum essential benefits
  - A statement that the plan or coverage share of total allowed costs of benefits is not less than 60% of such costs
  - A statement that the outline is a summary of the policy or certificate and that the coverage document should be consulted to determine the governing contractual provisions and a contact number for the consumer to call with additional questions.
- Any inconsistent state requirements regarding descriptions of coverage that provides less information than that required by the act are pre-empted.

## PROHIBITION ON DISCRIMINATION BASED ON SALARY

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- For plan years beginning 6 months after enactment, a sponsor of a group health plan (other than a self-insured plan) will be prohibited from establishing rules relating to health insurance eligibility of any full-time employee based on total hourly or annual salary of the employee.
- May not discriminate in favor of higher wage employees.
- Employee contributions may vary by-salary.

# ENSURING QUALITY OF CARE

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- Not later than 2 years after enactment, HHS in consultation with certain experts in health care quality, is required to develop and implement annual reporting requirement with respect to plan or coverage benefits and health care reimbursement structures that:
  - Improve health outcomes through use of quality reporting, case management, care management, chronic disease management.
  - Implement activities to prevent hospital re-admissions
  - Implement activities to improve patient safety and reduce medical errors through use of clinical best practices
  - Implement wellness and health promotion activities
- Plans will be required to report annually to HHS and all enrollees whether the benefits under the plan or coverage satisfy the necessary elements
- HHS can develop and impose penalties for non-compliance with requirements.

# MINIMUM MEDICAL LOSS RATIOS

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- Health insurance issuers will be required to publicly report for each plan year, the percentage of total premium revenue expended on:
  - Reimbursement for clinical services provided to enrollees under such coverage
  - For activities that improve health care quality, and
  - All other non-claims costs (excluding state and federal taxes and licensing and regulatory fees)
- Beginning not later than 1/1/2011, non-claims costs cannot exceed:
  - 15% for large group coverage
  - 20% for small groups and individual coverage
- If non-claims costs exceed applicable percentage, the insurer will be required to provide an annual rebate on a pro-rata basis to each enrollee for such coverage in the amount that non-claims expenses exceed the limits.
- States would be permitted to increase the MLR percentages by regulation.
- $MLR = (\text{incurred claims} + \text{loss adjustment expenses} + \text{activities that improve health care}) \div \text{earned premiums}$ .

# INDEPENDENT APPEALS PROCESS

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- Effective for plan years beginning 6 months after enactment, group health plans and health insurance issuers offering group or individual health insurance coverage are required to implement a process for appeals of coverage determinations and claims under which the plan or issuer must, at a minimum:
  - Have an effective internal claims appeal process
  - Provide notice to enrollees in a culturally and linguistically appropriate manner of available internal and external appeals process
  - Allow an enrollee to review their file
  - Allow an enrollee to present evidence and testimony as part of the appeals process
  - Allow an enrollee to receive continued coverage pending the outcome of the appeal
  - Provide an external review process that includes the consumer protections set forth in the NAIC Uniform External Review Model Act

# ANNUAL REVIEW OF PREMIUM INCREASES

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- Beginning with the 2010 plan year, HHS, in conjunction with the states, is required to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage.
- The annual review process will require health insurance issuers to submit to HHS and the relevant state a justification for any unreasonable” premium increase prior to the implementation of the increase.

# INFORMATION ABOUT AFFORDABLE COVERAGE OPTIONS

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- Not later than July 1, 2010, HHS, in consultation with the states, is required to establish a mechanism, including an Internet web site through which a resident of any state is able to identify affordable health insurance coverage options in that state.
- Not later than 60 days after enactment, HHS is required to develop a standardized formant for the presentation of information regarding affordable coverage options, availability, premium rates, cost sharing and the percentages of total premium revenue spent on health care compared to administrative expenses.

# ADMINISTRATIVE SIMPLIFICATION

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- Not later than July 1, 2011, HHS is required to adopt a single set of operating rules for the electronic exchange of information that can be used to:
  - determine an individual's eligibility and financial responsibility for specific services prior to or at the point of care
  - that provide for timely acknowledgement, response and status reporting that supports a transparent claims and denial management process, and that describes all data elements in unambiguous terms.
- In adopting the operating rules, HHS is required to seek to reduce the number and complexity of forms (including electronic and paper forms) and the data entry required by patients and providers.

# HIGH-RISK POOL FOR INDIVIDUALS WITH PRE-EXISTING CONDITIONS

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- Not later than 90 days of enactment, HHS is required to establish a high-risk pool to provide temporary health care coverage for eligible individuals until 1/1/2014, when the exchanges and guarantee issue provisions become effective.
  - Eligible Individuals
    - US citizen or lawfully present in US
    - Not covered by creditable coverage for 6 months prior to application to the pool
- and
  - Has a pre-existing condition
- An issuer or employment based health plan must reimburse the high risk pool for health care expenses of individuals who were encouraged by the issuer to disenroll from coverage prior to enrolling in the high risk pool (“Anti-Dumping”).
- HHS may contract with existing state high risk pools that meet specified criteria.

# REINSURANCE FOR EARLY RETIREES

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- Not later than 90 days after enactment, HHS is required to create a temporary reinsurance program to assist participating employment based plans with the cost of providing health benefits to eligible retirees who are between 55 and 64 who are not active employees of an employer that maintains an employment based plan and their dependents. A trust would be created and funded with no more than \$10 billion. Program terminates 1/1/2014.
- HHS will reimburse an employer for 80% of the portion of a claim by an early retiree above \$15,000 and below \$90,000.
- Amounts paid to the employer plan must be used to lower costs directly to participants in the form of premiums, co-payments and out-of-pocket costs, but could not be used to enhance the general revenue of the employer maintaining the plan.
- Payments to employers will not be considered income for income tax purposes.
- Employers will need to file an application to participate in program and to obtain reimbursement of claims.

# Insurance Market Reforms at Full Implementation 1/1/2014

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- Prohibition Against Discriminatory Premiums
- Guaranteed Availability of Coverage
- Guaranteed Renewability of Coverage
- Prohibition Against Pre-existing Condition Exclusion
- Prohibition Against Eligibility Rules Based on Health Status
- Requirement for Comprehensive Health Insurance Coverage
- Prohibition on Excessive Waiting Periods
- Establishment of Exchanges
- Individual Mandate
- Employer Mandate

# FAIR HEALTH INSURANCE PREMIUMS

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- Effective 1/1/2014, premiums in the individual and small group markets must be established using adjusted community rating rules.
- Rates will not be permitted to vary based on health status, gender, class of business, or claims experience.
- Premiums would be permitted to vary based only on:
  - Self-only or family enrollment
  - Rating area
  - Age (by no more than a 3 to 1 ratio across age rating band), and
  - Tobacco use (by no more than a 1.5 to 1 ratio).
- States to establish 1 or more rating areas within the state.
- HHS to consult with NAIC regarding minimum size of community rating areas and permissible age bands.
- Issuers in the individual and small group markets will be required to consider all enrollees in all plans offered by the issuer in the applicable market as a single risk pool, including enrollees not enrolled in such plans offered through the exchange.
- State insurance commissioners would be required to report information to HHS regarding premium trends and recommendations to the exchanges regarding whether an issuer should be excluded from participation because of excessive rates.

## GUARANTEE ISSUE/GUARANTEE RENEWABILITY

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- For plan years commencing on and after 1/1/2014, individual and group health insurance must be offered on a guaranteed issue basis, and
- The issuer of Individual and group insurance must renew or continue such coverage in-force at the option of the policyholder regardless of health status.

# NON-DISCRIMINATION IN COVERAGE BASED ON HEALTH FACTORS

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- For plan years beginning on and after 1/1/2014, issuers in the group and individual markets would be prohibited from basing eligibility for coverage on health status related factors.
- Prohibited factors include:
  - health status
  - claims experience
  - receipt of health care
  - medical history
  - genetic information
  - evidence of insurability
  - disability and any other factor determined to be appropriate by HHS
- The offering of premium discounts or rewards based on enrollee participation in wellness programs would be permitted.

# PROHIBITION AGAINST PRE-EXISTING CONDITION EXCLUSION

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Effective for plan years beginning on and after January 1, 2014, no issuer of group or individual coverage may impose any preexisting condition exclusion with respect to any group or individual coverage.

# HEALTH INSURANCE EXCHANGES

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- Exchanges must be established in each state no later than 1/1/2014.
- States would have principal responsibility to establish the exchange. If the state so chooses or fails to establish an exchange, HHS will establish the exchange on behalf of state.
- Exchanges must be a governmental agency or non-profit entity established by the state.
- A state may establish and operate one or more exchanges if each exchange serves a distinct and sufficiently large geographic area.
- An exchange may operate in more than one state if each state in which the exchange operates permits such operation and HHS approves such regional or interstate exchange.
- Exchanges need to be self-sustaining by 1/1/2015 and may charge assessments or user fees to participating health insurance issuers.
- There is no requirement that a qualified individual use an exchange to enroll in a qualified health plan.

# FUNCTION OF HEALTH INSURANCE EXCHANGES

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- Certify, recertify, decertify health plans as qualified health plans
- Accept bids and negotiate and enter into contracts with insurers to participate in the exchange
- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance
- Maintain an Internet web site where enrollees may obtain standardized comparative information about the plans
- Utilize a standard format to present health benefit options in the exchange
- Assign a rating to each qualified health plan
- Inform individuals of eligibility requirements for Medicaid, CHIP and any applicable state program and automatically enroll individuals in any program for which the individual qualifies
- Establish and make available an online calculator for individuals to estimate their premium and any available cost sharing subsidies
- Issue certifications attesting that an individual has satisfied individual mandate or is exempt from mandate
- In coordination with insurance commissioners, establish oversight and enforcement of requirements

# REQUIREMENTS TO OFFER COVERAGE THROUGH HEALTH INSURANCE EXCHANGES

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- Be licensed and in good standing in the state
- Provide affordable premiums and provide justification for current rates
- Provide coverage for at least the “essential health care benefits”
- Use an uniform enrollment form
- Generally accept all enrollment and not market or design plans to discourage enrollment
- Each issuer would be required to consider all enrollees in qualified health plans in the individual and small group markets to be a single risk pool.
- Offer adequate provider network and include “essential community providers” that predominately serve low-income medically underserved individuals.
- Implement program integrity standards
- Insurers must offer at least one silver plan (provides coverage for no less than 70% the allowed cost of the essential benefits) and at least one gold plan (providing coverage for no less than 80% of allowed cost of providing essential benefits). Insurers could then offer bronze plans (provides coverage for approximately 60% of essential benefits) and platinum plans (covering 90% of allowed cost of providing essential benefits)

# QUALIFIED HEALTH PLAN

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- Only Qualified Health Plans may be sold on the exchanges.
- Effective 2014, a Qualified Health Benefit Plan is a health plan:
  - Certified by each exchange as meeting a specified list of requirements related to marketing, choice of providers, plan networks and other features and provides essential benefits.
  - Offered by an issuer licensed and in good standing in each state where it offers coverage
  - Offers at least one qualified health plan in the Silver level and at least one plan in the Gold level
  - Charge the same premium for a plan regardless if is offered in or outside the exchange.
  - Limits annual deductible for small group to \$2000 (individual) and \$4000 (families)
  - No cost sharing for preventative services and immunizations.

# ESSENTIAL BENEFITS

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- Essential benefits include coverage for at least :
  - Hospitalization
  - Ambulatory patient services
  - Emergency services
  - Prescription drugs
  - Rehabilitative services and devices
  - Mental health and substance use disorder services
  - Preventative and wellness and chronic disease management
  - Maternity and newborn care
  - Pediatric services, including vision and dental care
  - Laboratory services

# EXCHANGE ELIGIBLE INDIVIDUALS & EMPLOYERS

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- Exchange-eligible Individuals
- State residents
- Seeking to enroll in a qualified health plan in the individual market
- Not incarcerated
- Lawful resident
  
- Exchange-eligible Employers
- A small employer that elects to make all full-time employees eligible for 1 or more qualified health plans in the small group market through an exchange.
- Beginning in 2017, each state may (but is not required to) allow large group plans to be offered through the exchanges.

# INDIVIDUAL MANDATE

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- Effective for tax years ending after 12/31/2013, most individuals would be required to maintain minimum essential benefits for themselves and their dependents
- Can satisfy requirements if covered by Medicaid, Medicare, CHIP, TRICARE, veterans health program, FEHBP, Indian health services plan, grandfathered plans, or any plan offered in the individual, small group or large group market that provides essential benefits.
- Penalty for Non-compliance
- Individuals who do not meet mandate would be required to pay a penalty for each month they are in non-compliance.
- The per-person annual dollar penalty would be phased in over time -- \$95 in 2014, \$325 in 2015, reaching \$695 in 2016 and then adjusted for inflation thereafter.
- Penalty reduced by ½ for any dependent under age 18.
- Taxpayers who do not pay the required penalty would not be subject to criminal prosecution or penalty.
- No lien or levy on any property is permitted with respect to the penalty.
- Penalty paid with tax return.
- Exemptions:
- Individuals whose required contribution for a calendar year exceeds 8% of household income would be exempt from the penalty.
- Those qualifying for religious exemptions
- Individuals not lawfully present in the United States
- Incarcerated individuals
- Individuals whose household income did not exceed 100% of federal poverty level
- Any person the HHS determines to have suffered a hardship with respect to the capacity to obtain coverage under a qualified health benefit plan.

# EMPLOYER MANDATE

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- All employers with more than 200 full-time employees (i.e., work at least 30 hours a week) that offers employees enrollment in one or more health benefit plans will be required to automatically enroll new full time employees in one of the plans offered. Employees will have the right to opt-out of any enrollment.
- Employers with more than 50 full-time employees must offer qualified coverage to their employees or pay a penalty.
- Penalty for Non-compliance
- Commencing in 2014, the total annual penalty would be limited to total number of full-time employees times 1/12 of \$2000 for any month without qualifying coverage. After 2014, the penalty would be indexed.
- The first 30 employees are not counted for the penalty calculation.
- An employer that offers coverage could be subject to penalties if one or more of its full-time employees were enrolled in a qualified plan for which a premium credit was paid for such employee. The penalty would be equal to the number of full time employees times 1/12 of \$3,000 each month for each employee receiving a tax credit.

# PREMIUM CREDITS

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- Commencing 2014, HHS will pay a premium credit to the exchange on behalf of eligible individuals and small employers and the exchange will pay such credit to the plan providing coverage to the eligible individual or employer.
- Individual Credit: Premium credits would be calculated to ensure that qualifying individuals pay no more than a certain percentage of their income towards the second lowest cost Silver exchange plans available in area.
- Any individual with an income of less than 133% of the poverty line will not be required to pay more than 2% of his or her income for insurance. An individual with an income at 400% of federal poverty level will not be required to pay more than 9.8% of income for insurance. States are permitted to provide additional credits.
- To qualify for credit, individuals must not be eligible for any other coverage such as Medicare, Medicaid, employer sponsored plan or grandfathered plan.
- Small Business Tax Credit
- Effective 1/1/2010, a qualified small employer is one that purchases insurance for its employees in the small group market and pays at least 50% of the cost of the premiums towards a qualified plan.
- Small businesses with 10 full time employees or less and with average taxable wages of \$25,000 or less could claim full credit.
- Credit phased out as average employee compensation increases from \$25,000 to \$50,000 and as number of employees increases from 10 to 25.
- 50% credit of the lesser of (1) the employer premium contribution towards plans offered by the employer through the exchange, or (2) the contribution the employer would have made if each of those same employees had enrolled in a qualified plan with a premium equal to the average premium for small group coverage in the rating area.

# SELECT REVENUE PROVISIONS

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- Surcharge on high income individuals: Effective 12/31/2012, imposes an additional tax of 0.9% on high-income workers with wages over \$200,000 for single filers and \$250,000 for joint filers.
- Medicare Tax: 3.8% Medicare tax on investment income from interest, dividends, royalties, rents, gross income from trade or business, and net gain from disposition of property for individuals earning over \$200,000 and joint filers earning \$250,000 or more.
- Medical Expense Deduction: Increases the threshold for claiming the itemized deduction for medical expenses from 7.5% to 10%.
- Health Savings Accounts: Effective 1/1/2011, tax on distributions for withdrawals from HSA that are not used to pay medical expenses raised to 20%.
- Excise tax on high-cost plans: Effective 1/1/2013, imposes an excise tax of 40% on health insurers for coverage that costs in excess of \$10,200 for single coverage and \$27,500 for family coverage. Applies to insured and self-insured plans. For self insured plans, the administrator of the plan is liable for the tax. Higher limits for employees engaged in high risk professions.
- Excise tax on elective cosmetic medical procedures: Effective for procedures on and after 1/1/10, imposes a 5% tax on cosmetic surgery to be paid by the individual who receives the procedure.
- Annual fee on health insurers: Effective 1/1/2014, an annual fee would be imposed on all health insurers based on their market share. Fee would be applied to net premiums written and TPA fees. Fee would not apply to self-insured or federal and state entities. Annual fee would be \$8 billion in 2014, \$11.3 billion in 2015-2016, \$13.9 billion in 2017, \$14.3 billion in 2018 and \$14.3 billion + rate of premium grow thereafter.
- Annual fees on branded pharmaceutical manufacturers and importers: Effective 2011, imposes \$2.5 billion annual fee on prescription drug manufacturers and importers, increasing to \$4.1 billion by 2018 then back to \$2.8 billion in 2019 and thereafter. Paid pro-rata based on market share.
- Annual fee on medical device manufacturers: Effective 2013, Imposes annual fee on manufacturers and importers of medical devices based on annual sales in U.S. equal to 2.3% of the sales price.

# STRATEGIC CONSIDERATIONS

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- Greater Medicaid Expenses-- Of the 31 million uninsured individuals who will gain coverage, about ½ would do so through the expansion of Medicaid. Federal Government will pay 100% of the Medicaid expansion in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. States will still face enormous new financial burdens.
- New Regulatory Burdens: Health insurance industry will face intense regulatory scrutiny at both the state and federal levels. State legislatures would likely need to give state insurance regulators new powers to enforce the new rules in a hostile political environment. State departments of insurance will likely need to staff up in an environment of increasing state budget deficits. Unclear who at state level will be responsible for implementation of many of the requirements.
- Plan Designs: New benefit requirements, guarantee issue, no pre-existing conditions will affect plan designs. Limited credible data regarding effects of reform available to modify rates.
- Insurance Exchanges: States will be required to establish and operate insurance exchanges. States will need to determine which plans are eligible to participate, who is eligible for federal subsidies, build websites, technology and administrative capacity to operate the exchanges. Exchanges should reduce distribution costs for insurers and will potentially temper rate increases in small and individual markets.
- Legislation: Each state will need to conform laws to new federal requirements. Will require extraordinary cooperation among the parties which may be difficult to achieve in this environment.
- Preemption: Many state law provisions currently inconsistent with federal mandates. Preemption of state law will occur.

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# Questions & Answers

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