



THE NAPPA REPORT

Volume 24, Number 2

May 2010

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The Status of Theft of Honest Services

By
Kelly Jenkins
NAPPA President

In dismissing the federal indictments against five City of San Diego employees, which included three city employees on the Board of the San Diego City Employees Retirement System and the administrator and the general counsel of the city pension fund, the district court summarized:

“Fortunately, due process forbids turning citizens into criminals through the application of novel, untested applications of a criminal statute. In this case, the defendants have been charged under a novel, untested application of the vague mail and wire fraud honest services statutes for carrying out pension fund business. A reasonable person of ordinary intelligence would not have known that what the defendants were doing violated the federal mail and wire fraud statutes. Under our Constitution, people are not to be punished for ‘violating an unknowable something.’”

U.S. v. Saathoff, Case No. 06cr43-BEN, p. 28 (U.S. Dist. Ct., Southern Dist. of California, April 6, 2010) (citations omitted).

Although sensible and practical, the *Saathoff* decision resolves too little. The immediately affected participants apparently will still suffer through the appeal process. Moreover, *Saathoff* is limited to a holding that the honest services fraud statutes were unconstitutionally vague as applied to the defendants in that case. The precedential value is necessarily limited.

A more complete analysis of the honest services fraud statutes will be provided in the three cases pending in the U. S. Supreme Court this term, referenced in the first footnote of the *Saathoff* decision.¹

The most directly applicable of these cases is *Weyhrauch*. *Certiorari* was granted in *Weyhrauch* not to consider constitutional vagueness, but to consider a more basic statutory construction question:

“Whether, to convict a state official for depriving the public of its right to the defendant's honest services through the non-disclosure of material information, in violation of the mail-fraud statute (18 U.S.C. §§1341 and 1346), the government must prove that the defendant violated a disclosure duty imposed by state law.”

The *Saathoff* opinion characterized the basis of the *Saathoff* case indictment as “the failure to disclose some alleged conflict of interest....” No disclosure requirement in California law was noted² and the opinion criticized the indictment for relying on an amorphous federal law disclosure requirement. See, *Saathoff*, text

at fn.2 and pp. 18-20. It is possible, then, that the *Weyhrauch* case will effectively dispose of the *Saathoff* appeal on non-constitutional grounds simply because there is no disclosure requirement under California law.

Some commentators have suggested that the Supreme Court granted *certiorari* in three theft of honest services cases to provide a set of parameters to the federal statute – such as requiring violation of a state duty – to avoid the constitutional vagueness issue. Others read the tea leaves to the contrary and predict that the constitutional issue will ultimately control all three cases (though constitutional vagueness was directly addressed only in the *Skilling* case grant of *certiorari*).

In any event, the Supreme Court opinions will provide a watershed in prosecution of theft of honest services cases. Hopefully some needed clarity will be provided in rulings before the end of this Court term, in June. The facts in *Saathoff* demonstrate just how important that can be for us as well as our clients.

The legal ethics session of NAPPA’s summer legal education conference will explore the lawyer’s professional responsibilities in light of the Supreme Court cases. Your attendance will be rewarded.

Endnotes

1. *Skilling v. U.S.*, 130 S.Ct.393 (2009); *Weyhrauch v. U.S.*, 129 S.Ct. 2863 (2009); *Black v. U.S.*, 129 S.Ct. 2379 (2009).
2. Indeed, as *Saathoff* noted, the California Supreme Court held in *Lexin v. Superior Court*, 47 Cal.4th 1050 (2010) that for all but one defendant trustee no inherent underlying criminal conflict of interest exists under California law to be disclosed. In *Lexin* the court determined that although retirement board trustees are fiduciaries that may be subject to civil liability, if they approved contracts in which their only financial interest is an interest in benefits shared generally with their constituency at large, the trustees didn’t violate California’s criminal conflict of interest statutes. Only defendant Saathoff was considered by the *Lexin* court to have received a unique benefit that may not meet this standard. Even as to that defendant, the *Saathoff* court found that any implied federal law disclosure requirement would be so vague as to preclude fair notice of what constitutes federal criminal conduct. *Saathoff*, pp. 18-20. Presumably the same argument could be made if the “non-disclosure of material information” were based on non-disclosure of a state civil law conflict of interest, such as that established by a fiduciary duty or employment relationship.

Benefitting the Board - Exploring the Educational Opportunities Available for Board Members

In an effort to provide their Board of Trustees with unique and relevant educational opportunities, a public pension fund recently used the NAPPA listserve to gather information about worthwhile programs other NAPPA members could recommend.

The public pension fund responsible for the survey was open to a wide variety of subject matter and simply had the goal of providing their board members with any experience that could strengthen their abilities or improve their knowledge of how to better function on the Board.

Though nothing was specified when soliciting recommendations, the public pension fund found themselves most interested in seminars providing information about conflicts of interest, best practices for investment policies and procedures, ethics, and fiduciary issues.

Responses from NAPPA members varied. Some included their education policies. Others listed either specific conferences or simply organizations they had been pleased with in the past. Listed below are some of the recommendations gathered from the listserv.

Organization	Conference Name (If Mentioned)
Callan Associates (www.callan.com)	Callan College
Ceres (www.ceres.org)	Annual Conference
Council of Institutional Investors (www.cii.org)	Spring Meeting Fall Meeting
Florida Public Pension Trustees Association (www.fppta.org)	
Government Finance Officers Association (www.gfoa.org)	
Information Management Network (www.imn.org)	
Institute for Fiduciary Education (www.ifecorp.com)	Real Estate Investing – Spring Market Makers
Institute for International Research (www.iir.org)	
International Foundation of Employee Benefit Plans (www.ifebp.org)	CAPPP Employee Pension – Part II U.S. Annual Employee Benefits Conference Trustees and Administrators Institutes
National Association of Public Pension Attorneys (www.nappa.org)	
National Association of Securities Professionals (www.nasphq.org)	
National Association of State Retirement Administrators (www.nasra.org)	Annual Conference
National Association of State Treasurers (www.nast.org)	
National Conference on Public Employee Retirement Systems (www.ncpers.org)	Trustee Education Seminar (TEDS) Annual Conference and Exhibition
National Council on Teacher Retirement (www.nctr.org)	
National Education Association (www.nea.org)	
Opal Financial Group, Inc. (www.opalgroup.net)	
Pension Real Estate Association (www.prea.org)	Annual Conference
World Pension Forum (www.worldpensionforum.com)	

Illinois Public Pension Fund Association (www.ippfa.org) – Certified Trustee Training
The Certified Trustee Training is composed of four eight-hour modules, totaling 32 hours of instruction. Training is given at locations throughout Illinois.

Stanford Law School (www.law.stanford.edu) – Fiduciary College (March of each year)
Geared toward fund trustees and seven fund management executives, Fiduciary College arms attendees with the knowledge necessary to face the challenges today's pension fiduciaries may face. Attendees will look at best practices from many different arenas to determine how to best handle oneself now and as new situations and challenges unfold.

Diligent Enough?

Investment Decisions Require Ongoing Due Diligence

by

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Los Angeles Water and Power Employees' Retirement Plan

U.S. public pension systems - under tremendous pressure to generate high returns to cover future obligations - must continue to press their financial advisors to provide ongoing due diligence. Failure by advisors to conduct sufficient due diligence at every stage of the investment process may not only lead to significant losses to the pension systems and their beneficiaries, but also result in litigation against the advisors for breach of their fiduciary duties.

Background

Over the last decade U.S. public pension systems have come under intense pressure to abandon traditionally conservative investment portfolios in exchange for taking on more risk in an attempt to compensate for the shortfalls between assets held and projected future benefit obligations. To confront the risk of becoming underfunded, public institutional investors have dramatically increased their asset allocation to private equity funds, real estate funds, hedge funds, and funds of funds in much the same way that private endowments and foundations have been lured to riskier investments as a means for diversification and higher returns.

Public institutional investors, whether managing small or sizable portfolios, typically do not make investment decisions on their own. Rather, they retain financial advisors and consultants to recommend appropriate levels of allocation to different financial products and investment vehicles. Public pension systems' staff and board members have come to rely on advisors to not only recommend appropriate levels of asset allocation and investment in specific funds, but to also conduct the necessary due diligence on their behalf. If advisors fail to conduct appropriate and sufficient due diligence at every phase of the investment process, investors could face major losses. Requiring advisors to sustain continued due diligence throughout the investment process can help public institutional investors avoid or, at least, minimize losses, even in challenging financial climates.

The Advisors' Role

Investment in alternative investment funds requires a high level of due diligence which public pension systems' staff normally cannot perform on their own. Instead, the staff and the board of directors depend significantly on advisors. Prior to recommending an investment in a fund to staff and board members of a public institutional investor, advisors typically will meet with fund managers, review the fund's marketing materials, and conduct independent research as to the fund's performance in order to determine if the

investment opportunity is appropriate for its client's portfolio. Advisors review specialized databases for information on fund performance, investment terms, fundraising related information, top quartile results, firm stability, turnover, and changes in strategy over time. Furthermore, advisors also monitor the type of investments made by large public pension systems. This is an interactive process which must invariably include reference checks, in-person interviews, and on-site meetings.

Public institutional investors' staff and board members have no other option but to rely heavily on their advisors to conduct due diligence for a number of different reasons. First, fund level information is not easily accessible to public institutional investors. Second, public institutional investors' staff members – particularly those at smaller pension systems – are largely unable to perform extensive due diligence on their own. Third, agency budgets, which have shrunk significantly in the last several years, may preclude a sufficient number of investment professionals. Furthermore, investment staff may not have the necessary training or expertise to review sophisticated models or data, or to conduct verification of regulatory and/or legal problems relating to performance. Lastly, the sheer volume of investments in a given period may be too much for staff to handle and monitor the various manager relationships. Because public pension systems have neither the budgets nor compensation in line with private industry, it seems certain that public institutional investors will continue to rely on advisors to conduct due diligence on their behalf.

The Potential Pitfalls

Despite the extensive due diligence process most advisors perform, they undoubtedly make recommendations based not just on objective and independent research but also based on referrals and pre-existing relationships. Public pension systems relying on advisors' recommendations may be unaware of the relationships between the advisors and the recommended funds. Since funds are restricted from generally soliciting and openly marketing to non-qualified investors, the funds rely heavily on referrals as a prime distribution channel. Funds have relationships with advisors, consultants, and third party placement agents. These parties make recommendations to their institutional investor clients in part based on these relationships with the funds.

Most fund investors, both public and private, are well aware that private equity and hedge funds generally lack basic levels of transparency and offer less information than other more regulated investment vehicles such as mutual funds. Public pension systems

have complained for years about limited access to performance statistics, information about fund's auditors, trading models, pricing policies, self-administration, and custody. Lack of transparency necessitates a reliance on advisors to conduct thorough and comprehensive due diligence. For this reason, it is critical that advisors conduct sufficient due diligence at every stage of the investment process – even when recommending an investment in a fund based on prior relationships and trust placed in the fund's principals. Failure to do so may result in significant losses to the pension systems and their beneficiaries.

According to an NYU Stern's School of Business study, 1 in 5 hedge fund managers misrepresented their fund or its performance to investors during formal due diligence investigations.¹ The study used data from 444 due diligence reports commissioned by investors between 2003 and 2008, covering some of the most prominent hedge funds in operation today – those funds with up to \$8 billion in assets under management and managers with average experience of 19 years in the industry. The study's authors noted managers most commonly misrepresent the amount of money under management, the fund's performance, and the funds' regulatory and legal histories. Managers also misrepresented years of experience and, in some cases, even their criminal records. Astonishingly, the study found misrepresentations or inconsistencies in approximately 42% of the due diligence reports reviewed. Furthermore, the study found 21% of managers verbally stated incorrect information.

Due diligence conducted by advisors only prior to the investment recommendation stage is insufficient without extensive follow-up thereafter, no matter how appropriate the investment recommendation may have been initially. Prior to approval and execution of investment documents, the investment process typically includes meeting with advisors, analyzing the advisors' reports and recommendations, conducting meetings and conference calls with the fund, presenting the recommendation to the board of directors, and reviewing the fund documentation by staff and/

or outside legal counsel. Advisors and consultants need to stay continually involved in the investment process. For many public pension systems, the investment process can take anywhere from three to nine months to complete – a considerable interval during which fund level information can easily change because of losses due to market conditions, regulatory investigations, law suits, etc. An advisors' failure to stay involved at every phase of the investment process can be disastrous to the public pension systems they represent. Fiduciary obligations to the public pension systems also require continued monitoring of the funds.

Conclusion

Due to the nature of the business and restrictions on solicitation, funds understandably must rely on relationships with advisors to recommend their funds to public investors. However, it is imperative that advisors still conduct intensive due diligence regardless of the relationship, level of trust, the fund's reputation, or performance history. And public institutional investors need to hold their advisors more accountable. Public investors should insist that aggressive due diligence of the funds and their principals be conducted at every stage of the investment process, not just from the initial recommendation and document execution, but throughout the term of the investment. If advisors do not conduct extensive due diligence, as part of the financial advisory services offered to their clients, then they fail to provide the type of services needed to help their clients obtain the best possible returns and expose their clients to significant risk. Failure to perform adequate due diligence may result in not only monetary losses but also possible law suits against advisors as a means for investors to recoup some of these losses.

Endnotes

1. New York University's Stern School of Business study, published on June 16, 2009, by Stephen Brown, William Goetzmann, Bing Liang and Christopher Schwarz

Cornerstone Research's Report on Federal Securities Class Action Settlements in 2009 Highlights Public Pension Fund Achievements

by

Wayne Schneider¹

General Counsel, New York State Teachers' Retirement System

On March 24, 2010, Cornerstone Research issued its latest annual report reviewing the securities class action settlements of the previous year. You might have seen a news story in the financial press about the report, bearing a headline such as: "U.S. securities class action settlements up 38%!" Given the broad coverage of the report in the financial press, I wasn't sure whether I could add anything, but I'll give it a try.

The lead story is that a considerable amount of money still changes hands in federal securities class actions settlements. The 103 settlements in 2009 yielded \$3.83 billion in gross settlement dollars before fees and expenses. The global amount was higher than amounts achieved in many recent years, including 2008, though significantly less than in 2000 (\$5.1 billion), 2005 (\$10 billion), 2006 (\$18.3 billion) and 2007 (\$7.36 billion).

In 2009, "institutional investors" accounted for 65% of the settlements with higher settlements associated with the presence of "institutional investors". That said, "higher settlements are associated with cases involving public pension plans as lead plaintiffs" as opposed to cases in which other "institutional investors" serve as lead plaintiffs. The report continues:

Any relationship between higher settlement outcomes and participation of public pension plans as lead plaintiff may be explained by these relatively sophisticated investors choosing to participate in stronger cases. In addition, public pension plans tend to be involved in larger cases—cases in which the public pension plan may have the potential for a substantial claim against the defendants. However, a statistical analysis of settlement amounts and participation of public pension plans as lead plaintiff shows that even when controlling for estimated "plaintiff-style" damages (case size) and other factors that affect settlement amounts (such as the nature of the allegations), the presence of a public pension plan as lead plaintiff is still associated with a statistically significant increase in settlement size. (Emphasis added)

Arithmetically, settlements in 2009 averaged about \$37 million per settlement, although that particular figure has little meaning in view of the typical skewed distribution of settlement amounts with lots of small settlements and fewer really big settlements. The median class settlement remained at \$8 million, meaning that 50% of the settlements in 2009, as in 2008, were for \$8 million or less. Even assuming the settlements in the bottom half were

not significantly less than \$8 million, those settlements could not account for any more than \$425 million of the \$3.83 billion total.

The report indicates the distribution of settlements by dollar value in 2009 was comparable to historic trends. Although the report indicates no settlement of \$1 billion or more was included in the \$3.83 billion total for 2009, a healthy chunk (about 24%) was accounted for by the \$925 million settlement in UnitedHealth, a case in which a public fund served as lead plaintiff. The report indicates that historically \$100 million plus settlements have represented only about 7% of the total number of settlements, although they presumably account for a much larger share of the dollar value of settlements. Unfortunately, the report does not identify any other settlements in excess of \$100 million included in the \$3.83 billion, so it is difficult to assess how much of the 2009 global amount is accounted for by such settlements. The report does note that, for analytical reasons, it excluded \$586 million aggregate settlement in the IPO securities litigation.

The number of settlements (103) appears fairly typical. The number of settlements since 2000 has fluctuated in the 90-120 range with a low of 90 settlements in 2000 and a high of 119 settlements in 2005. This seems somewhat remarkable to me given the more dramatic cyclicity in the commencement of cases with more cases being filed during downturns in the financial markets. The report notes the average length of time between the filing of a case and settlement approval has recently increased from 3 1/2 to 4 years. In 2009, the number of settlements with non-cash components had declined to 1% of the settlements, the lowest percentage in the last 10 years.

The report spends a lot of time attempting to analyze how settlement amounts compare with estimates of class damages. The report's statistical analysis appears to indicate that generally the percentage of class damages recovered goes down as the amount of class damages increases. Cases involving auditors are associated with higher settlements on a percentage basis while, perhaps surprisingly, the presence of '33 Act claims are not. Case involving derivative claims and SEC actions are also associated with higher settlement amounts.

The report touches on the frequency with which particular firms showed up as lead or co-lead counsel to the class in 2009 settlements. A certain West Coast firm showed up in 26% of the cases. The next four firms were in the 7-11% range. No figures, however, are provided as to the amounts of the settlements in the

cases they were involved. The report also notes that, consistent with past trends, the 2nd and 9th Circuits had the most settlements. Along with the 3rd Circuit, they accounted for 67 settlements. The 5th and 11th Circuits appear to have broken trend with relatively few settlements, 6 in the 5th Circuit and only 3 in the 11th Circuit.

As mentioned above, the report focuses on the gross amount of settlements. The report contains no discussion of the attorneys' fees awarded in the settled cases, even though the awards have a substantial impact on the net amount ultimately distributed to class members. I can at least report the fee request in UnitedHealth was 12% of the \$925 million settlement, which the court reduced to 7% in its award.

Going back to the headline which began this article, it was a good year for settlements, though admittedly nowhere near the

“golden year” of 2006 when 90 settlements (led by 6 settlements in excess of \$1 billion) grossed over \$18 billion. It will be interesting to see whether the most recent downturn will result in settlement totals returning to that level in future years.

The 2009 Cornerstone report can be accessed on line at http://securities.cornerstone.com/pdfs/Cornerstone_Research_Settlements_2009_Analysis.pdf

Endnotes

1. The views expressed are solely those of the author and do not necessarily represent the views of the System by which he is employed. The author is most grateful to Keith L. Johnson of Reinhart Boerner Van Deuren s.c. and to his colleague Joseph Indelicato for their helpful comments on drafts of this article.

Health Care Reform and Governmental Group Health Plans: The Initial Impact

by

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The Patient Protection and Affordable Care Act (“PPACA” or “Act”), as amended by the Health Care and Education Reconciliation Act (“Reconciliation Act”), imposes a number of new requirements on self-insured and fully-insured group health plans, including group health plans sponsored by governmental employers, group health plans that cover only retired employees, and defined contribution health plans such as health reimbursement arrangements. While the changes under the PPACA go into effect over the next several years, this article focuses solely on the most immediate actions required by governmental employers and governmental retirement systems that sponsor or administer group health plans, including group health plans that cover retirees only.

The PPACA delegates significant authority to regulatory agencies, which are tasked with filling in much of the detail as to how group health plans meet their new obligations to employees and retirees. As we await this much needed guidance, employers and retirement systems must nonetheless begin planning for the many imminent changes brought by the Act.

This article discusses the following:

- The impact of the PPACA on retiree-only group health plans;
- The meaning of a “grandfathered plan” under the Act;
- The coverage reforms and reporting mandates applicable to *all* group health plans, generally effective January 1, 2011;

- The additional coverage reforms applicable to group health plans that are *not* grandfathered, generally effective January 1, 2011;
- The new early retiree reinsurance program;
- The changes to the Medicare Part D doughnut hole; and
- The continued availability of the HIPAA opt out rules.

First Things First: The Impact on Retiree Health Plans

The PPACA amended the Public Health Service Act (“PHSA”) to eliminate the exception for group health plans that cover two or fewer employees.¹ The PHSA is the federal law that in the past has extended many COBRA provisions to governmental health plans. The PPACA uses the PHSA as a primary vehicle for effecting health care reform. Many employers and retirement systems have historically relied upon the PHSA exception for group health plans with two or fewer employees as the basis for exempting retiree-only health plans from several significant coverage mandates. The PHSA, as amended by the PPACA, does not appear to contain any language that would exempt retiree-only health plans from the full impact of the PPACA, nor from existing mandates that historically have not been applicable to these plans due to this exception, such as mental health parity. Unless the Secretary of Health and Human Services (“HHS”) issues

regulations exempting retiree-only health plans from some or all of the PPACA (which, given the affirmative statutory deletion of this exception from the PHSAs, she may not have the authority to do), these plans will likely need to comply with the reforms and mandates discussed in this article and to consider how the Act's requirements will impact them given many of the unique features of retiree plans.

The Threshold Issue: Does Your Plan Have Grandfathered Plan Status?

The applicability of many of the coverage and reporting requirements under the PPACA depends on whether the group health plan qualifies as a "grandfathered plan." Generally, a grandfathered plan is a group health plan that was in existence on March 23, 2010.² The Act provides that a group health plan will retain its grandfathered status even if the plan permits employees participating in the plan to enroll their family members and/or permits new employees and their families to join the plan. Under a special rule, a fully-insured group health plan maintained pursuant to a collective bargaining agreement will retain grandfathered status until the date on which the last collective bargaining agreement relating to the coverage terminates. Such a union plan can be amended to comply with some, but not all, of the Act without losing grandfathered status. It is unclear whether a union plan will become subject to the general grandfathering rule when the last agreement terminates.

The statutory language of the PPACA leaves many questions unanswered with respect to grandfathered plan status. For example, the Act is silent as to whether, and what types of, plan design changes could cause a plan to lose its grandfathered status. Because prior versions of the Act specified that changes could not be made to grandfathered plans, the Act's silence could be read to mean that Congress intended that at least some changes could be made to plan design, such as changes to providers, amendments to conform to the Act's coverage mandates or other laws, or even changes to non-essential health benefits, without sacrificing grandfathered status. The Act also does not address whether an existing employee who is not currently a participant in the plan may join the plan without causing the plan to lose grandfathered status, or whether a newly retired employee could join a retiree group health plan without causing the plan to lose grandfathered status. Because the applicability of so many of the new reforms turns on whether a plan is grandfathered, it is expected that regulations will be issued fairly soon to clarify the parameters of grandfathered status. How broadly or narrowly the regulators draw such parameters will depend on whether, as a policy decision, they want to force more plans under all provisions of the PPACA.

Round One of Changes Required for Group Health Plans

The PPACA amends the PHSAs and the Internal Revenue Code to provide two rounds of health coverage reforms and reporting obligations applicable to group health plans. The first round of

reforms takes effect with the first plan year that begins on or after September 23, 2010, or January 1, 2011 for calendar year plans.³ The second round of reforms becomes effective for plan years beginning on or after January 1, 2014, and includes restrictions on waiting periods, a complete prohibition on pre-existing condition exclusions, and mandated cost-sharing limits.⁴ The second round of reforms coincides with a host of the more sweeping changes under the Act, including an individual mandate to maintain health coverage and the establishment of state-run private insurance marketplaces, called "exchanges," through which individuals and small employers can purchase health insurance at guaranteed levels of coverage. This article will focus only on the first round of reforms because the implementation of the later reforms will likely be impacted by future regulations issued prior to 2014.

The following first round of reforms apply to *all* group health plans, including grandfathered plans.

*No lifetime or annual limits*⁵

- **Requirement.** Group health plans are generally prohibited from establishing any lifetime limits or annual limits on the dollar value of any "essential health benefits" for any participant or beneficiary. This general prohibition does not apply with respect to covered benefits that are not essential health benefits. "Essential health benefits" will be defined by the Secretary of HHS, but include services in ten broad categories and are intended to cover the scope of benefits provided under a typical employer plan. For plan years prior to 2014, the Secretary may permit a group health plan to place "restricted" annual (but not lifetime) limits on essential health benefits, as defined by the Secretary.
- **Considerations.** This mandate applies to lifetime limits and annual limits on the *dollar value* of benefits provided to a participant or beneficiary. It appears that a group health plan is still permitted to place other limitations on benefits, such as limits on days of treatment or number of visits. In addition, unless a dental or vision plan is a separate plan or policy of insurance, or, if self-insured, a separately electable benefit for which a participant must pay an additional premium, it appears that such plan would also be subject to this mandate. Finally, there is a question as to whether participants who have already met a lifetime or annual dollar limit would need to be reinstated under the plan.

*Extension of dependent coverage*⁶

- **Requirement.** Group health plans that provide dependent coverage of children must continue to make such coverage available for an adult child until the child turns age 26. Coverage must be provided without regard to marital or student status, but does not have to be provided to the adult child's spouse or dependents. On May 10, 2010, the Secretary of HHS issued an interim final rule defining the term "dependent" for this purpose. Prior to 2014, a grandfathered group health

plan may limit eligibility to those adult children who are not eligible to enroll in any other eligible employer sponsored health plan *other than* a group health plan of a parent. To the extent that state law mandates coverage for dependents more broadly than the federal law, the state law will continue to apply.

Importantly, the Reconciliation Act amended the Internal Revenue Code to eliminate the imputed income concerns related to offering dependent coverage to adult children who do not qualify as federal tax dependents.⁷ For this purpose, a “child” is defined to include the employee’s son, daughter, stepchild, adopted child or child placed for adoption, or eligible foster child. On April 27, 2010, the Internal Revenue Service issued Notice 2010-38, which clarifies that employers can stop imputing income, *effective March 30, 2010*, with respect to any health plan coverage – including coverage under health flexible spending arrangements (“FSAs”), health reimbursement arrangements (“HRAs”), voluntary employees’ beneficiary associations (“VEBAs”), and 401(h) accounts in retirement plans – that is extended to an employee’s adult child who has not attained age 27 as of the end of the taxable year. Notice 2010-38 also provides that employers can immediately permit employees to make salary reduction contributions for health benefits under a cafeteria plan, including a health FSA, for children under age 27 as of the end of the taxable year, so long as the employer retroactively amends the cafeteria plan prior to December 31, 2010.

- **Considerations.** The interim final rule states that a group health plan may only define “dependent” for purposes of eligibility for coverage of dependent children in terms of the relationship between the child and the participant. In other words, a plan will no longer be permitted to place any sort of financial support or residency requirement on children under age 26. This will require group health plans that base dependent eligibility on the definition of dependent under Internal Revenue Code Section 152 to amend those provisions to remove such limitations. Note that if a group health plan does not cover dependent children, then this new requirement does not apply. Some retiree health plans cover retirees and their spouses, but not dependent children and, therefore, would not be affected by this mandate. In addition, the interim final rule makes clear that a group health plan is prohibited from charging higher or additional premiums for coverage of adult children under age 26 on the basis of age, although a plan is still permitted to increase premiums for coverage of additional dependents regardless of age (*e.g.*, self-only, self-plus-one, self-plus-two, self-plus-three-or-more). Therefore, group health plans that structure their premiums, for example, as employee-only, employee-plus-spouse, and family coverage would not be permitted to charge an additional or higher premium for the addition of a dependent child under age 26 if the employee has elected family coverage.

The interim final rule further makes clear that coverage must be extended during open enrollment to adult children regardless of whether they were covered under the plan when they were considered tax dependents. The interim final rule also provides a transition rule for 2010, under which group health plans offering dependent coverage are required to provide a special enrollment opportunity (and notice of such opportunity) for employees to enroll their adult children who are currently ineligible for coverage either because they aged-out of the plan or because they were never eligible for coverage due to their age, but who will become eligible when the PPACA provision takes effect. This opportunity to enroll must be available for at least 30 days, regardless of whether a plan holds an open enrollment period (although providing the opportunity during open enrollment for the next plan year will satisfy this requirement as long as the enrollment period for adult children is open for at least 30 days), and regardless of whether the child’s parent is currently enrolled in the plan.

The Secretary of HHS has urged insurance companies to continue coverage for dependents who graduate from college or age out of their parents’ health plans during 2010, prior to the Act’s effective date, noting both the general good health of adult children and also the money saved by avoiding the administrative costs of disenrolling adult children who will then be reenrolled the next plan year. Several major insurers have announced that they will agree to extend coverage to at least some adult children in 2010.⁸ This change may impact self-insured plans as well since insurers who also act as administrators may make changes to their processes to enable all employers to make extended coverage available early. The interim final rule states that guidance relating to grandfathered group health plans is forthcoming and that such guidance is expected to make clear that a group health plan will *not* lose its grandfathered status because it is amended to comply with this provision of the PPACA, including voluntary early compliance.

Employers and retirement systems that have already covered adult children as a matter of plan design or due to state law can immediately stop imputing income to employees for such coverage. Note that employers will still need to continue to impute income with respect to other individuals (other than adult children) who are not tax dependents of the employee, such as same-gender spouses, domestic partners, or the children of either.

Ban on pre-existing condition exclusions for children⁹

- **Requirement.** Group health plans are prohibited from imposing any pre-existing condition exclusions on enrollees under age 19. This requirement will be expanded to all enrollees effective for plan years beginning on or after January 1, 2014.
- **Considerations.** Because this requirement does not become effective until January 1, 2014 for enrollees age 19 or older,

it is unclear how pre-existing condition exclusions will be applied to adult children who enroll under the Act's provision requiring the extension of adult child coverage effective for plan years beginning on or after September 23, 2010. Presumably, a plan that enrolls an adult child over age 19 who was not previously enrolled could still impose a pre-existing condition exclusion (consistent with existing limitations under the Health Insurance Portability and Accountability Act of 1996 ["HIPAA"]) until plans are required to eliminate those exclusions for all individuals in 2014. Following the elimination of all pre-existing condition exclusions in 2014, Congress could repeal the creditable coverage and portability provisions under HIPAA, and/or the Departments of Treasury, Labor, and HHS could suspend the need to provide creditable coverage notices when a participant loses coverage under an employer health plan.

*Form W-2 reporting*¹⁰

- **Requirement.** Beginning for the tax year of 2011, employers must report the aggregate cost of employer provided health care coverage (both employee and employer) on each employee's Form W-2. Aggregate cost is to be determined in accordance with rules similar to those that apply for purposes of determining COBRA premiums for self-insured plans. The aggregate cost total includes employer contributions to health reimbursement arrangements, but does not include contributions to a health savings account ("HSA") or salary reduction contributions to health FSAs.
- **Considerations.** This requirement is informational in nature. Because retired employees do not receive Forms W-2, it is unclear how this requirement will be met with respect to retiree health care. Presumably, at least one function of this informational report is to determine whether the value of employer-provided coverage will exceed certain limits and be subject to penalty taxes for excess coverage that go into effect in 2018. Because the value of retiree coverage would also appear to be subject to the excess coverage penalty tax in 2018, it seems likely that a similar reporting requirement will be imposed on retiree plans in the future, whether through a Form 1099 or through a more direct reporting mechanism to the Internal Revenue Service.

*Changes to FSAs, HRAs, and HSAs*¹¹

- **Requirement.** Effective January 1, 2011, over-the-counter medications will no longer be reimbursable expenses from health FSAs, HRAs, and HSAs, unless the medication is either prescribed or constitutes insulin. Additionally, penalty taxes on distributions from HSAs for non-medical expenses will increase from 10% to 20% (and from 15% to 20% for Archer MSAs) as of January 1, 2011. Finally, a \$2,500 contribution limit will be imposed on health FSAs as of January 1, 2013.

- **Considerations.** These changes to the FSA, HRA, and HSA requirements are straightforward revenue raisers for the federal government to help pay for the cost of the Act. The effect of all of these changes will be to increase individuals' taxable income with respect to reimbursements that previously would have been excludable from income. The "hard" effective date of January 1, 2011 relating to the elimination of reimbursement for over-the-counter medications under a health FSA would appear to mean that these medications could not be reimbursed during the 2 ½ month grace period, if any, under the FSA. Note that the restrictions on reimbursable *medications* do not impact other medical expense items available for reimbursement from a health FSA, such as contact solution, band-aids, and other first aid supplies that are not medications.

Additional Round One Changes For Plans Without Grandfathered Status

The Act contains a number of additional requirements that apply to those group health plans that do not have grandfathered status, effective the first plan year that begins on or after September 23, 2010, as follows.

*Mandated coverage for preventive health services*¹²

- **Requirement.** Group health plans must provide first dollar coverage without any cost-sharing requirements (*e.g.*, deductibles, co-pays, co-insurance, etc.) for preventive care services recommended by the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices, and preventive care and screenings for children and women recommended by the Health Resources and Services Administration. Some recommendations from the U.S. Preventive Services Task Force include:
 - Screening adults for depression;
 - Intensive behavioral dietary counseling for adult patients with known risk factors for cardiovascular and diet-related chronic diseases; and
 - Screening and behavioral counseling interventions to reduce alcohol misuse by adults in primary care settings.

There will be at least a one year period between the time any such new recommendation is made and the plan year in which the service or immunization must be provided without cost-sharing requirements.

- **Considerations.** While many group health plans have moved to provide some level of preventive care services on a first-dollar basis, plans frequently limit the benefits by either limiting the services that are considered "preventive" or by imposing a dollar limit on preventive or wellness benefits. This provision will require plans to cover, without dollar limits and without any cost-sharing, a defined set of preven-

tive care services. Note that current recommendations by the U.S. Preventive Services Task Force relating to breast cancer screening, mammography and prevention do not include the controversial standards that were issued in November 2009 which generally delayed the recommendation for women to begin receiving routine preventive mammograms from age 40 to age 50.

It is unclear how these requirements will coordinate with the requirements relating to preventive care that currently apply to high deductible health plans and HSAs. High deductible health plans generally cannot provide any reimbursements until the plan's deductible has been satisfied. There is an exception, however, for preventive care services as defined under Section 1871 of the Social Security Act. The definition of preventive care for purposes of the new mandate and for high deductible health plans will need to be consistent in order for high deductible health plans to be able to satisfy the new mandate.

*Mandated patient protections*¹³

- **Requirement.** Group health plans must contain patient protections that permit participants to designate a primary care provider of their choice and a pediatric primary care provider of their choice for their children. Furthermore, group health plans that cover emergency services must do so without requiring prior authorization, regardless of whether the service provider is in-network and without imposing costs that are different than those imposed on in-network providers. Lastly, group health plans that cover obstetrical and gynecological care must permit women participants to have direct access to such care without a referral or authorization.
- **Considerations.** These provisions relating to choosing a primary care provider and pediatrician will only apply to group health plans that require enrollees to formally designate a primary care provider, and are limited to providers who are in the plan's network. Plans that do not require an affirmative designation of a primary care provider are not affected by these provisions. However, all plans will be affected by the provisions prohibiting prior authorization and requiring in-network cost-sharing for emergency services provided in an emergency services department of a hospital. Note that whether an individual has an "emergency medical condition" for purposes of seeking emergency services is determined by whether a "prudent layperson" would have reasonably expected the absence of immediate medical attention to place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, to cause serious impairment to bodily functions, or to cause serious dysfunction of any bodily organ or part.

*Extension of nondiscrimination rules*¹⁴

- **Requirement.** Internal Revenue Code Section 105(h) prevents self-insured group health plans from discriminating in favor of highly-compensated individuals in terms of eligibility and benefits in the self-insured plan. The result of violating these prohibitions is the taxation of the highly-compensated individuals on the discriminatory reimbursements they receive under the discriminatory plan. The Act now imposes similar nondiscrimination rules on *fully-insured* group health plans.
- **Considerations.** Fully-insured plans have sometimes been used to provide enhanced benefits to highly-compensated individuals such as executives and highly-placed public officials to avoid the nondiscrimination rules applicable to self-insured group health plans. Those practices will come to an end with the extension of the nondiscrimination rules to insured plans. In addition, the expansion of these requirements to fully-insured plans, as well as the extension of regulatory authority to the Secretary of HHS, will likely result in more scrutiny being placed on self-insured plans already subject to nondiscrimination rules.

*Mandated claims appeal processes*¹⁵

- **Requirement.** Group health plans are required to have both an internal and external appeals process for appeals of coverage determinations and claims. The internal appeals process must initially be in accordance with the existing claims regulations under ERISA; however, the Secretary of HHS has discretion under the Act to modify those standards. The external appeals process for fully-insured group health plans must meet minimum state external review standards that satisfy the National Association of Insurance Commissioners Uniform External Review Model Act. The external appeals process for self-insured group health plans must meet similar minimum standards that will be established by the Secretary of HHS. A participant will have the right during the external review process to review his or her file, present evidence and testimony, and to receive coverage pending the outcome of the appeals process.
- **Considerations.** Some governmental group health plans already follow a claims and appeals process that is similar to ERISA, and some states already mandate an external review process similar to that in the Act. For those that already have internal and external procedures in place, the procedures may need to be expanded. For example, some internal and external appeals processes do not allow enrollees to present testimony or additional supporting materials, as will be required under the Act. For those governmental plans that are not already subject to a state-mandated external appeals process, the effects of this new requirement may be significant. The result of the external appeals process, which is conducted by an

independent third-party entity, will be *binding* on the plan, thus taking final decision-making authority outside of the plan's appeals committee or other decision-making body. Many employers and retiree group health plans will need to amend plan documents and change procedures to conform to these new requirements. Another potentially dramatic effect is the Act's requirement that enrollees receive continued coverage pending the outcome of the appeals process. It is as yet unclear whether this requires the plan simply to maintain the plan's coverage to the enrollee during the appeal, or whether it will require the plan to continue coverage of the particular condition subject to the appeal (and seek repayment of the reimbursed amounts later if the plan prevails in the appeals process).

Temporary Reinsurance Program for Early Retiree Coverage

The PPACA establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees.¹⁶ Plans maintained by any State or local government or political subdivisions thereof, or any agency or instrumentality of any of the foregoing, are eligible for the program. The Secretary of HHS is required to establish the program by June 21, 2010, although the Secretary anticipates that the program will be in place by June 1, 2010. The program terminates the earlier of January 1, 2014 or when the appropriated funding is exhausted. Given that the appropriated funding is only \$5,000,000,000, the timeframe in which the Secretary accepts applications under the program could be significantly shorter than January 1, 2014.

The purpose of the program is to encourage sponsors of retiree health programs to continue maintaining those programs – particularly for early retirees who are not eligible for Medicare – until the state-based health insurance exchanges established by the PPACA become operational in 2014. At that time, it is anticipated that pre-Medicare eligible early retirees (who have traditionally faced difficulties finding available and affordable coverage in the individual insurance market) will have a marketplace where they will be able to obtain affordable insurance without fear of being denied on the basis of pre-existing conditions. Consequently, the program represents a stop-gap measure to bridge the time between the passage of the PPACA and the time that the exchanges come online.

The program provides reimbursement to the retiree health plan of up to 80 percent of the claims cost for health benefits between \$15,000 and \$90,000 for any retiree who is at least age 55 and who is not eligible for Medicare coverage. Reimbursement is also available for the claims incurred by an early retiree's spouse, surviving spouse, and dependents, regardless of age. The term "dependent" includes eligible dependents under the plan, even if they do not qualify as a tax dependent. For purposes of reim-

bursement, "health benefits" means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary of HHS, but do not include HIPAA's so-called "excepted benefits" which include limited scope dental and vision benefits, as well as long-term care benefits. The program is available to both self-insured and fully-insured early retiree programs.

The reimbursable claims window will be adjusted for plan years beginning on or after October 1, 2011 based on the percentage increase in the medical care component of the consumer price index. The reimbursable amount includes *both* the costs paid by the plan sponsor and the costs paid by the early retiree (in the form of deductibles, copayments, or coinsurance), provided those costs can be substantiated by the sponsor and are not otherwise reimbursed by insurance or some other third-party arrangement. All reimbursements received must be used to lower the costs of the retiree health plan, such as to reduce premium costs for the employer or participants, or to reduce contributions, co-payments, deductibles, or other out-of-pocket costs for plan participants (not just early retirees). However, reimbursements cannot become part of the general revenues of the employer.

On May 3, 2010, the Secretary of HHS issued an interim final rule regarding the program's claims submissions, participation criteria, and application requirements. Regarding the submission of claims under the program, the interim final rule states that no claims may be submitted until the \$15,000 cost threshold is met. However, when claims *are* first submitted, the submission will have to include claims below the \$15,000 cost threshold for the plan year in order for the plan sponsor to demonstrate that the cost threshold has been met. Of course, those first \$15,000 in claims are not reimbursable. Costs may not be submitted until the claim has been incurred during the plan year, and has been paid. This appears to suggest as long as claims are *incurred* during a plan year, they may be paid *after* the end of the plan year and they will still be reimbursable. In addition, the interim final rule notes repeatedly that any reimbursement under the program is conditioned on the availability of the \$5 billion in program funds.

The interim final rule also provides a transition provision for 2010 plan years that begin before June 1, 2010 (*e.g.*, a 2010 calendar year plan). For claims that are incurred before June 1, 2010, up to \$15,000 per early retiree (or spouse, surviving spouse, or dependent) may be counted toward the \$15,000 cost threshold; however claims above \$15,000 incurred before June 1, 2010 will *not* be eligible for reimbursement. All claims incurred *on or after* June 1, 2010 will also be counted toward the cost threshold (if it was not already satisfied before June 1, 2010), and the claims that fall between \$15,000 and \$90,000 will be reimbursed for that plan year at 80 percent. For a calendar year plan, this means that claims incurred between January 1 and June 1, 2010 can count toward reaching the \$15,000 cost threshold, but claims that exceed \$15,000 that are incurred before June 1 will *not* be reimbursed. If a sponsor has already incurred at least \$15,000 in claims for

an early retiree by June 1, 2010, then each claim dollar incurred between June 1 and December 31, 2010 up to \$90,000 will be reimbursable at the 80 percent rate.

The program requires that participating retiree plans implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions and provide documentation of the actual cost of medical claims involved. The interim final rule states that chronic and high-cost conditions are those for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one plan participant. The commentary to the interim final rule suggests that the requirement to maintain these programs and procedures should be flexible on a plan-by-plan basis. For example, the commentary indicates that a plan sponsor might meet this requirement if it determines that diabetes, if not properly managed, is likely to lead to claims in excess of \$15,000 for a plan year for a plan participant. The sponsor may implement a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization. The standard is apparently meant to be scalable, but the sponsor must be able to demonstrate on audit that its programs and procedures have generated, or had the potential to generate, cost savings.

The actual application process has not yet been announced; however the interim final rule provides detail about some of the information that must be provided with the application, and states that the application process will be similar to the application process for the retiree drug subsidy program. All participating plans must be certified by the Secretary of HHS. Plans will not be required to submit renewal applications once certified, but they will be subject to audits to assure fiscal integrity.

In order to take advantage of this opportunity, employers and retirement systems offering early retiree health coverage should take action now to consider whether applying for the program makes sense for their plan, and, if so, be prepared to submit their applications as soon as a process for doing so becomes available. Applications are reviewed in the order received, and will be returned if they are incomplete. The Secretary has discretion to stop taking applications based on the projected or actual availability of program funding. Therefore, it is critical for interested employers and retirement systems to submit a fully completed application as soon as possible after the application process opens.

Changes to the Medicare Part D Doughnut Hole

Currently, individuals who enroll in Medicare Part D are responsible for 25 percent of their prescription drug costs until they incur \$2,700 in costs, at which point they become responsible for 100 percent of their prescription drug costs until they incur \$4,350 in costs. After incurring \$4,350 in costs, Medicare Part D coverage becomes “catastrophic,” and enrolled individuals are only responsible for five percent of their prescription drug costs.

The gap of coverage between \$2,700 and \$4,350 is referred to as the Medicare “doughnut hole.”

The PPACA phases out the Medicare doughnut hole, with a complete elimination of the doughnut hole by 2020.¹⁷ Medicare Part D enrollees who reach the doughnut hole in 2010 will receive a \$250 rebate. Beginning in 2011, preventive care is free of co-payments and deductibles. Also in 2011, Medicare Part D enrollees who reach the doughnut hole will receive a 50 percent discount on brand-name drugs in the coverage gap. From 2011 through 2020, subsidies will be phased into the doughnut hole for generic drugs (beginning in 2011) and for brand name drugs (beginning in 2013). By 2020, coinsurance in the doughnut hole will be 25 percent, the same as for all prescription drug costs until catastrophic coverage begins.

One of the reasons that many employers and retirement systems currently provide retiree prescription drug benefits is the existence of the Medicare doughnut hole. However, with the eventual elimination of the doughnut hole in 2020, and the availability of private insurance exchanges in 2014 through which retirees may purchase individual insurance, employers and retirement systems may decide to reconsider providing retiree prescription drug coverage altogether.

HIPAA Opt Out

State and local government self-insured group health plans have historically been able to elect to “opt out” of certain HIPAA coverage mandates outlined in the PHSAs, so long as they provided annual written notice to enrollees and to the Secretary of HHS of this election. These mandates have included standards relating to benefits for mothers and newborns, mental health parity, required coverage for reconstructive surgery following mastectomies, and coverage for dependent students on medically necessary leaves of absence. Several different provisions of the Act amend these HIPAA opt out provisions in the PHSAs in a confusing and inconsistent manner.¹⁸ Although by no means clear, it appears that the HIPAA opt out provisions may no longer be available to state and local government health plans effective for plan years beginning on or after March 23, 2010. Governmental plans that have relied on these opt out provisions in the past should monitor forthcoming guidance from the Secretary carefully for more information on this potential change.

Conclusion

While additional guidance is required for governmental employers and retirement systems to implement the Act’s provisions, it is critical to begin thinking about how the “first round” of changes will affect governmental group health plans – both for active employees and for retirees. Retiree plans should be on the lookout for guidance on the early retiree reimbursement program in order to get in line for those reimbursements. Plans that cover

dependents should consider whether to implement the adult child coverage rule early to avoid potentially unnecessary disenrollment and reenrollment processes as some of these adult children drop off of the plan when they graduate from college this May, only to be reenrolled in the plan within the next few months when the Act's coverage requirements become effective. Finally, as plan sponsors begin thinking about making the mandatory changes for the next plan year, they should keep in mind the possibility that making discretionary changes to their plans could compromise any grandfathered status that the plans might now enjoy. This is another area in which plan sponsors should be on the lookout for upcoming guidance.

For the moment, the political debate is over and health care reform is upon us. Plan sponsors should carefully consult guidance and seek counsel in implementing this "first round" of changes. The "second round" is not far around the corner.

Endnotes

1. PPACA § 1562(a)(1) and/or PPACA § 1562(c)(12)(A), as amended by PPACA § 10107(a). Note, Section 1562 is re-designated Section 1563 by PPACA § 10107(b).
2. PPACA § 1251(a), as amended by PPACA § 10103(d), and further amended by Section 2301 of the Reconciliation Act.
3. *See generally* PPACA § 1001, as amended by PPACA § 10101.
4. *See generally* PPACA § 1201, as amended by PPACA § 10103.
5. PPACA § 1001, as amended by PPACA § 10101(a); new PHSA § 2711.
6. PPACA § 1001, as amended by Reconciliation Act § 2301(b); new PHSA § 2714.
7. Reconciliation Act § 1004(d).
8. *See* White House Fact Sheet, "Young Adults and the Affordable Care Act: Preventing Coverage Gaps, Lowering Administrative Costs and Eliminating Burdens on Businesses and Families," (Apr. 27, 2010), available at <http://www.whitehouse.gov/the-press-office/fact-sheet-young-adults-and-affordable-care-act>.
9. PPACA § 1201, as amended by PPACA § 2709(e); new PHSA § 2704.
10. PPACA § 9002; amends Internal Revenue Code § 6051(a).
11. PPACA §§ 9003–9005, as amended by PPACA § 10902 and Reconciliation Act § 1403; amends Internal Revenue Code §§ 106, 125, 220, and 223.
12. PPACA § 1001; new PHSA § 2713.
13. PPACA § 1001, as amended by PPACA § 10101(h); new PHSA § 2719A.
14. PPACA § 1001, as amended by PPACA § 10101(d); new PHSA § 2716.
15. PPACA § 1001, as amended by PPACA § 10101(g); new PHSA § 2719.
16. PPACA § 1102.
17. PPACA § 3315, as amended by Reconciliation Act 1101.
18. PPACA § 1562(a) and/or PPACA § 1562(c)(12), as amended by PPACA § 10107(a). Note, Section 1562 is re-designated Section 1563 by PPACA § 10107(b).