

HEALTH CARE PRIORITY ALERT REFORM

Employee Benefits ■ January 7, 2013

New Year's Resolution for Employers: Become Familiar with Onslaught of New Health Care Reform Regulations

By Mary V. Bauman; baumanm@millerjohnson.com; 616.831.1704

Federal regulators were extremely busy during the past six weeks, releasing several new sets of regulations concerning Health Care Reform. Employers need to study the guidance and understand how it will impact them.

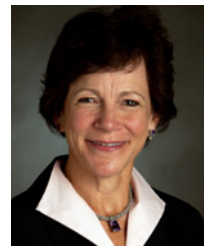
This *Priority Alert* summarizes the key developments, including:

- Significant proposed regulations just released concerning the employer pay or play penalty taking effect in 2014.
- Regulations describing how it will be determined whether an employer's health plan provides minimum value for purposes of the pay or play penalty.

- A round-up of the new taxes and fees which take effect in 2013 and 2014 including the increased Medicare payroll tax, the new Patient Centered Outcomes Research Institute fee, and temporary reinsurance program fee.

- An update on the new wellness programs rules taking effect in 2014.

Miller Johnson plans to offer webinars and workshops on Health Care Reform in 2013. We will send emails with information on dates and times. Also, please look for details on our website in the Events section.



Mary V. Bauman



IN THIS ISSUE

2

New Regs for
Pay or Play Penalty

4

In the News

5

Additional Medicare Tax

6

Patient Centered Outcomes
Research Fee

7

Minimum Value Test for
Pay or Play

8

Temporary Reinsurance
Program

9

Wellness Programs

10

Contact Us

UPCOMING SEMINAR

MARY BAUMAN, FRANK BERRODIN and JIM BRUINSMA will conduct "Health Care Reform Update: How to Prepare for 2014" seminars on January 15 in Grand Rapids, January 16 in Lansing and January 17 in Novi for the Michigan Chamber of Commerce. They'll provide a summary of

health and flex plan changes required for 2013 and 2014, an explanation of new taxes and fees and the employer response to 2014 pay or play penalty. In addition, they will summarize employer reporting requirements and health care reform provision designed to assist employers.

New Regulations Require Employer Action in Preparation for 2014 Pay or Play Penalty

By Mary V. Bauman; baumanm@millerjohnson.com; 616.831.1704



Mary V. Bauman

The IRS welcomed in 2013 with proposed regulations designed to help employers implement the 2014 pay or play penalty under Health Care Reform. The new regulations were published on January 2, 2013. They carry forward and expand upon prior guidance and offer some new transition relief.

PAY OR PLAY PENALTY

Beginning January 1, 2014, large employers with at least 50 full-time employees are subject to two different pay or play penalties (also known as employer shared responsibility payments):

- First, if an employer **doesn't offer health coverage** and at least one low income full-time employee enrolls in health coverage on an exchange and obtains a premium credit, the employer must pay an annual penalty of \$2,000 multiplied by all the employer's full-time employees, disregarding the first 30. The penalty is payable on a monthly, pro-rata basis.
- Second, if an employer **does offer health coverage** but it is not affordable (see below) or is not of minimum value (see related article in this *Priority Alert* on page 7) and a low income full-time employee enrolls in health coverage on the exchange and obtains a premium credit, the employer must pay an annual penalty of \$3,000 for each such full-time employee. (However, this penalty is capped at \$2,000 multiplied by all of the employer's full-time employees, disregarding the first 30.)

KEY QUESTIONS ANSWERED

The proposed regulations answer many questions concerning the penalty including the following:

What if an employer offers health coverage to some, but not all, of its employees; which penalty applies?

An employer that provides at least 95 percent of its full-time employees with health coverage, or if greater, coverage to all but five of its full-time employees, is considered to offer health coverage for purposes of the pay or play penalty. So, if an employer offers health coverage to 98 percent of its full-time employees, it is not subject to the \$2,000 penalty but is subject to the \$3,000 penalty with respect to each low income full-time employee who isn't eligible for the employer's health plan and who enrolls in health coverage on the exchange and obtains a premium credit. (This is in addition to the penalty with respect to each low income full-time employee who is eligible for the employer's health plan but where the plan isn't affordable or not of minimum value).

Is an employer only required to offer health coverage to its employees (and not dependents) in order to avoid the penalty?

For 2014, the penalty will not apply if the employer offers health coverage (which is affordable and of minimum value) to its full-time employees. Offering coverage to dependents is not required. However, beginning with the 2015 plan year, employers must also offer coverage to an employee's dependents in order to avoid the penalty. For this purpose, "dependent" means the employee's dependent children (including natural, adopted, step and foster children) until age 26 and does *not* include the employee's spouse.

Does the penalty apply on a combined basis in the case of commonly-owned employers?

Employers that are part of the same controlled group or affiliated service group as defined by Section 414 of the Internal Revenue Code must be aggregated for purposes of determining

Pay or Play PENALTY



whether the employer is a large employer (with at least 50 full-time employees) for purposes of being subject to the penalty. If the penalty applies, the commonly-owned employers are also only entitled to one 30 full-time employee reduction. The reduction is allocated ratably among the employers. However, the penalty is otherwise calculated and paid on an employer-by-employer basis. So, for example, each commonly-owned employer may separately elect whether to adopt a safe harbor measurement period/stability period and if it does so, the length and starting date.

TRANSITION RELIEF

The proposed regulations include several new transition rules to assist employers, including the following:

- **Delayed Effective Date for Non-Calendar Year Plans.** The pay or play penalty takes effect on January 1, 2014. The regulations introduce a delayed effective date for certain employers with non-calendar year plans that were in effect on December 27, 2012. First, with respect to employees eligible for or enrolled in the employer's health plan under its terms as in effect on December 27, 2012, the penalty will not apply until the first day of the employer's 2014 plan year. However, if the employer doesn't currently offer health coverage to all employees working at least 30 hours per week, this transition rule doesn't apply to those ineligible employees who will be considered full-time under the pay or play penalty. As a result, there is also a second transition rule providing a delayed effective date until the first day of the employer's 2014 plan year for all of the employer's employees provided at least 1/4 of the employer's employees are currently covered under its plan or at least 1/3 of its employees were offered coverage during the most recent open enrollment period.
- **Short Measurement Period for 2013.** Previous guidance allowed employers

to adopt an optional 3 to 12-month measurement period to determine if ongoing employees work, on average, at least 30 hours per week for purposes of the penalty. If an employee works the required hours during the measurement period, the employer must offer the employee the requisite health coverage during the subsequent stability period in order to avoid the penalty. The stability period must be the greater of six months or the length of the measurement period (see *Priority Alert* September 2012: *New Guidance Helps Employers Determine Who is a Full-Time Employee Under Pay or Play Penalty* for details). These measurement period and stability period rules create time constraints for employers who want to use a 12-month stability period for 2014, particularly for employer health plans operating on a calendar year basis (because the 12-month measurement period must begin by January 1, 2013). Consequently, solely for purposes of the stability period beginning in 2014, the employer may adopt a measurement period shorter than 12 months as long as certain requirements are satisfied. First, the measurement period must be at least 6 months long. Second, the measurement period must begin no later than July 1, 2013 and end no earlier than 90 days before the first day of the 2014 plan year.

- **Shorter Look Back for Large Employer Determination.** Employers with at least 50 full-time employees on business days during the preceding calendar year are subject to the pay or play penalty for the following year. The proposed regulations include a special transition rule for 2014 to assist employers who are close to the threshold in evaluating whether the penalty will apply. Specifically, employers may use any consecutive six-month period in 2013 for purposes of making the large employer determination for 2014 (rather than the entire year).

Pay or Play PENALTY



NEW AFFORDABILITY SAFE HARBORS

If an employer offers health coverage to its full-time employees, it must be affordable and of minimum value in order to avoid the \$3,000 penalty. Previous guidance offered a safe harbor method, based on an employee's W-2 pay, of defining affordability for this purpose. The new proposed regulations continue the W-2 safe harbor and offer two additional, alternative safe harbors.

W-2 safe harbor. Under this safe harbor, the affordability test is satisfied if the employee's contribution for single coverage under the employer's lowest cost medical option does not exceed 9.5 percent of the employee's Box 1 W-2 pay for that year. The proposed regulations provide that if an individual is not a full-time employee for the entire year, the employee's W-2 wages should be adjusted to reflect the portion of the year when the employee was offered coverage. Then, the adjusted wages should be compared to the employee's share of premium during that period.

Rate of pay safe harbor. Under the rate of pay safe harbor, the employer would take an hourly employee's hourly pay rate in effect at the beginning of the year and multiply it by 130 (the benchmark for full-time status for a month under the pay or play penalty). If the employee's contribution for single coverage under the employer's lowest cost medical option does not exceed 9.5 percent of the employee's monthly wage amount, the affordability test is satisfied. A similar safe harbor is available for salaried employees based on the employee's monthly salary in effect at the beginning of the year.

Federal poverty line safe harbor. Under the federal poverty line safe harbor, coverage provided to an employee is affordable if the employee's cost for single coverage under the employer's plan does not exceed 9.5 percent of the federal poverty line for a single individual as in effect as of the beginning of the year.

Pay or Play PENALTY



IN THE NEWS

MARY BAUMAN joined James Haveman (Michigan Dept. of Community Health) and Chris Ward (PhRMA and Partnership to Fight Chronic Disease) in presenting at the 2012 Health Care Summit on November 16. Her presentation was recapped in the *Grand Rapids Business Journal* article "Employers face deadline for health mandates" on November 26. She explained what employers need to consider including definitions, employer costs, and effective dates. Bauman also covered state exchanges, "fairness issues" and some possible scaling back in Health Care Reform. The summit was sponsored by the Grand Rapids Chamber of Commerce.



IRS Issues Proposed Regulations on Additional Medicare Tax

By Tripp Vander Wal; vanderwalt@millerjohnson.com; 616.831.1796

New IRS proposed regulations provide individuals and employers with withholding and reporting guidance regarding the additional Medicare tax beginning in 2013. Health Care Reform imposes an additional Medicare tax on high income earners. Currently, the Medicare portion of payroll taxes is 1.45 percent and is imposed on *both* employers *and* employees (a total of 2.9 percent).

The additional Medicare tax is 0.9 percent of income over certain threshold amounts. And, it is imposed *only* on employees. The threshold amounts are: \$250,000 for married taxpayers filing jointly; \$125,000 for married taxpayers filing separately; and \$200,000 for all other taxpayers.

EMPLOYEE RESPONSIBILITY

The additional Medicare tax is reported on an individual's IRS Form 1040 (U.S. Individual Income Tax Return). As a result, it is subject to underpayment of *income* tax penalties.

Under the new regulations, the additional Medicare tax is only required to be withheld by employers for employees with wages that exceed \$200,000 in a *calendar* year (regardless of the employee's other income or tax filing status). Employees may *not* request that an employer withhold the additional Medicare tax on wages less than \$200,000. But, employees *may* request an employer withhold additional amounts for income tax using IRS Form W-4 (Employee's Withholding Allowance Certificate). Because the additional Medicare tax is reported on an individual's 1040, this will have the same result as withholding the additional Medicare tax.

Married taxpayers who expect to exceed the applicable additional Medicare tax threshold when their wages are combined, but with one (or both spouses) individually earning less than \$200,000, should use the W-4 to request the employer withhold additional income tax, to avoid underpayment penalties. Alternatively, the employee may make (or increase) his or her estimated income tax payments throughout the year.

Here is an example of the additional Medicare tax:

Taxpayer A, who is married and files a joint return, receives \$190,000 in wages from his employer for the calendar year. B, A's spouse, receives \$150,000 in wages from her employer for the same calendar year. Neither A's nor B's

wages are in excess of \$200,000, so neither A's nor B's employers are required to withhold the additional Medicare tax. A and B are liable to pay the additional Medicare tax on \$90,000 (\$340,000 minus the \$250,000 threshold for a joint return).

The additional Medicare tax is \$810 (\$90,000 x .9% or .009). A or B should submit a W-4 to his or her employer to request an additional \$810 in withholding to avoid underpayment of income tax penalties (or make estimated tax payments).



Tripp Vander Wal

EMPLOYER RESPONSIBILITY

As indicated above, employers are required to withhold the additional Medicare tax on any employees with wages in excess of \$200,000.

Calculating wages for purposes of withholding the additional Medicare tax is the same as calculating wages for current payroll taxes (except for the \$200,000 threshold). And, if an employer over-remits or under-remits the additional Medicare tax, the employer may make interest-free adjustments or claims for refunds similar to those allowed for under-remitted or over-remitted income tax withholding.

Employees are ultimately liable for the additional Medicare tax. But, if an employer fails to withhold the additional Medicare tax (or fails to withhold the correct amount) the employer is liable for the correct amount *until* the employee pays the additional Medicare tax with his or her 1040. This does not relieve an employer from "penalties or additions to tax" that may apply for its failure to properly withhold the additional Medicare tax.

SELF-EMPLOYED INDIVIDUALS

The additional Medicare tax also applies to individuals that earn self-employment income. The additional Medicare tax does not apply to self-employment income below the thresholds described above. But, for individuals with both self-employment income and wages from an employer, the threshold amounts are coordinated. In other words, an individual's threshold amount for self-employment income is reduced (but not below zero) for any amounts the individual receives in wages. Here is an example:

Additional Medicare Tax, continued on page 6

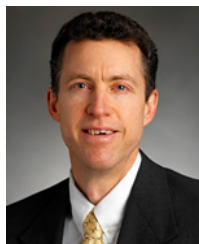
Additional Medicare Tax, *continued from page 5*

C, a single filer, has \$145,000 of self-employment income and \$130,000 in wages (C's employer is *not* required to withhold the additional Medicare tax). The \$130,000 of wages reduces the self-employment additional Medicare tax

threshold from \$200,000 to \$70,000. C is liable for \$675 of additional Medicare tax on \$75,000 of self-employment income (\$145,000 – \$70,000 (the reduced threshold) x .9%).

Final Regulations on Calculating Patient Centered Outcomes Research Fee Issued

By Frank E. Berrodin; berrodinf@millerjohnson.com; 616.831.1769



Frank E. Berrodin

One of the goals of Health Care Reform is to reduce health care costs in the United States. One way the government hopes to do so is by creating a Patient Centered Outcomes Research Institute, a private, nonprofit corporation to research the clinical effectiveness of medical procedures, treatments and drugs. Of course, someone has to pay for this research, and you probably have an idea of who that will be.

HOW MUCH?

The fee starts at \$1 per individual life for the first year, \$2 per individual for the second year and an amount to be determined for the following five years. The total fee for a plan for a plan year equals the applicable dollar amount multiplied by the average number of lives (employees and dependents) covered under the plan, calculated in one of three ways:

1. The actual count method;
2. The snapshot method; or
3. The Form 5500 method.

Different methods may be used for different plan years.

WHO MUST PAY?

The fee must be paid by the insurer of fully insured plans (including retiree only plans) and the employer/plan sponsor of self-insured plans. HRAs are generally exempt from the fee if they are integrated with a self-insured plan. HRAs integrated with a fully insured plan are subject to a separate fee (but it is only based on employees; dependents are disregarded). Limited scope dental and vision plans and most medical FSAs are also not subject to the fee. The fee may not be paid out of plan assets.

WHEN?

The fee applies for plan years ending on or after October 1, 2012 and before October 1, 2019. For self-insured plans, the fee must be paid when the employer/plan sponsor files its Form 720-Quarterly Federal Excise Tax Return, which is due July 31 of the year following the last day of the plan year. Therefore, for calendar year plans, the first filing and payment will be due July 31, 2013.

Proposed Rule Helps Employers Determine Minimum Value for Purposes of the Pay or Play Penalty

By Mary V. Bauman; baumanm@millerjohnson.com; 616.831.1704

Beginning in 2014, a large employer offering employee group health coverage may still be subject to the pay or play penalty under Health Care Reform if the coverage isn't affordable or does not provide minimum value. A new HHS proposed rule helps determine if an employer's group health plan satisfies the minimum value test.

AFFORDABILITY TEST

In 2012, the IRS announced a safe harbor method of determining whether a health plan is affordable for purposes of the pay or play penalty. At least through 2014, the affordability test is met if the employee-required contribution for single coverage under the employer's lowest cost medical option for a year doesn't exceed 9.5 percent of the employee's wages for that year as reported on Box 1 of IRS Form W-2. On January 2, 2013, the IRS published proposed regulations recognizing two additional safe harbor methods (see the related article in this *Priority Alert* regarding the pay or play penalty on page 2).

MINIMUM VALUE TEST

Under Health Care Reform, a plan will satisfy the minimum value test if the plan's share of the total allowed cost of benefits provided under the plan is at least 60 percent. The new HHS proposed regulations offer three methods of determining minimum value:

1. **Calculator Method** HHS and the IRS will, in the future, offer a calculator. The plan will enter information about the plan's cost-sharing to determine whether the minimum value test is satisfied.
2. **Safe Harbor Checklists Method** Alternatively, a plan may use various design-based safe harbors which will be published by HHS and the IRS in the future. The safe harbors will be in the form of checklists to determine whether a plan provides minimum value. Each checklist will describe cost-sharing attributes of a plan in four categories of benefits:
 - Physician and mid-level practitioner care;
 - Hospital and emergency room services;
 - Pharmacy benefits; and
 - Laboratory and imaging services.

3. **Actuarial Certification Method** If an employer's plan contains non-standard features that aren't suitable for the calculator or do not fit the safe harbor checklists, the plan's minimum value can be determined by an actuarial certification.

HSA contributions and HRA contributions for the current year may be included in the minimum value determination.

A couple of other issues are also addressed in the proposed rule. First, another term in Health Care Reform is "essential health benefits" which is a list of ten categories of health care services and supplies including hospitalization, prescription drugs, and preventive and wellness services. Health plans on the exchange must provide essential health benefits. This requirement also applies to non-grandfathered fully insured plans in the small group market (generally, employers with no more than 100 employees). So, while other employer group health plans, such as fully insured large group plans and self-funded plans are not required to offer all categories of essential health benefits, coverage of essential health benefits for these latter plans will be a factor in determining whether the plan satisfies the minimum value test.

Second, Health Care Reform imposes caps on annual deductibles and maximum out-of-pocket amounts under health plans beginning in 2014. The proposed rule clarifies that these restrictions only apply to fully insured, small group plans and do not apply to fully insured large group plans or self-funded plans.

Temporary Reinsurance Program: Sticker Shock for Employers

By James C. Bruinsma; bruinsmaj@millerjohnson.com; 616.831.1708



James C. Bruinsma

Health Care Reform imposes a new fee on **group health plans** during 2014, 2015 and 2016. The purpose of this temporary fee is to establish a reinsurance pool for insurers in the **individual health insurance** market. By providing a reinsurance pool for these insurers, the goal is to lessen the risk for the insurers so that premiums for individual coverage will not increase

because of the guaranteed availability of insurance in this market beginning in 2014.

IRS proposed regulations issued during December 2012 estimate that the fee for 2014 will be **\$63 for each person** covered by a group health plan. The exact amount for 2014 will be determined later in 2014 when HHS can better determine the number of covered lives in group health plans for that year.

The total fee under the temporary reinsurance program is \$25 billion over the three-year period. The payment of the total fee is front-end loaded, with \$12 billion to be collected for 2014, \$8 billion to be collected for 2015, and \$5 billion to be collected for 2016. So the fee will decline over the three-year period.

CONTRIBUTING ENTITIES

If a group health plan is fully insured, the fee is paid by the insurer. If the group health plan is self insured, the fee is owed by the plan. It is anticipated that the TPA of a self-insured health plan will remit the fee on the plan's behalf. But, regardless of who actually sends the payment to HHS, the additional cost will be borne by plan sponsors and plan participants.

APPLIES TO MAJOR MEDICAL COVERAGE

The fee applies to a plan that provides major medical coverage. As a result, there are several types of health coverage which are *not* subject to the fee:

- Stand alone vision and dental plans
- Stand alone prescription drug plans
- HSAs
- HRAs that are integrated with a group health plan

- Medical flexible spending accounts (even if not an excepted benefit)
- Most employee assistance plans, disease management programs and wellness programs (if they do not provide major medical coverage)
- Hospital indemnity coverage
- Stop loss insurance

There is no exception to the fee for retiree only major medical plans. However, the IRS regulations clarify how the rules apply to a person who participates in an employer sponsored plan, but is also covered by Medicare. If the employer plan provides primary coverage, a fee must be paid for the person. But, if Medicare provides the primary coverage, no fee is required. (This latter rule exempts retiree plans provided as a supplement to Medicare.)

NUMBER OF COVERED LIVES

The fee is based upon the number of covered lives during the year, so it applies to both employees and dependents who participate in a plan. IRS regulations provide several alternative methods for counting the number of covered lives. These methods are generally based upon the average number of covered lives during the first nine months of the calendar year.

COLLECTING THE FEE

HHS will collect on a calendar year basis, regardless of the plan year for the group health plan. The contributing entity must provide information to HHS by November 15 regarding the number of covered lives during that year. HHS will then send an invoice to the contributing entity within 15 days of the submission of the annual enrollment count or by December 15, whichever date is later. The fee per person is the same for all group health plans.

The fee is payable within 30 days after receipt of the invoice. As a result, the first fee is likely to be paid in January 2015. The only good news is that the fee is tax deductible.

POSSIBILITY OF SUPPLEMENTAL STATE PROGRAM

A state is permitted to establish a supplemental reinsurance

Temporary Reinsurance Program, continued on page 9

program in addition to the federal program. If a state does establish a supplemental program, it may charge additional fees to fully insured plans. But Health Care Reform does not provide authority for a state to assess fees from self-insured plans.

ACTION BY EMPLOYERS

Because the fee begins to apply during 2014, there is no immediate action required by employers. However, as employers plan for implementing Health Care Reform in 2014, this is an important cost that needs to be considered.

New Regulations Will Allow Employers to Put More Teeth into Wellness Programs

By Mary V. Bauman; baumanm@millerjohnson.com; 616.831.1704

The U.S. Departments of Treasury, Labor and Health and Human Services have issued proposed regulations regarding the Health Care Reform change in the maximum permitted incentive amount for an employer wellness program offered in connection with a health plan. The new rules will allow employers to offer more significant incentives in connection with wellness programs beginning in 2014.

Under existing rules, a wellness program offered in connection with an employer group health plan must satisfy certain requirements. One is a cap on the amount of the incentive. It may not exceed 20 percent of the cost of coverage under the employer's health plan. Health Care Reform increases the cap to 30 percent starting with plan years beginning on or after January 1, 2014. In addition, under the proposed regulations, if the incentive is designed to reduce or prevent tobacco use, the cap is higher, at 50 percent of the cost of coverage under the employer's health plan.

The proposed regulations make other modifications to the existing 2006 wellness program rules. For example, one of the requirements for a wellness program is that the incentive be made available to all similarly-situated individuals. This requirement includes making available a reasonable alternative to qualify for the incentive if it is unreasonably difficult for an individual to satisfy the standard because of a medical condition or if it is medically inadvisable for an individual to attempt to satisfy the standard. The proposed regulations clarify that if the reasonable alternative is the completion of an educational program, the plan must make the educational program available instead of requiring an individual to find such a program on his or her own and may not require the individual to pay for the cost

of the program. Similarly, if the reasonable alternative is a diet program, the plan must pay any membership or participation fee for the program, but is not required to pay for the cost of food. Further, if the reasonable alternative is complying with the recommendations of a health care professional supplied by the plan and the individual's personal physician determines that the recommendations are not medically appropriate, the plan must provide a reasonable alternative that accommodates the personal physician's recommendations.

Currently many wellness programs identify individuals, through health risk assessments and biometric screenings, as having a chronic condition. These individuals are then asked to participate in a disease management program in order to qualify for an incentive. It was unclear under prior guidance whether such a requirement was subject to the HIPAA wellness program rules as health status based (or rather, whether it should be considered to be participation based because the individuals are only being asked to "participate" in the follow-up program). The proposed regulations clarify that such a two-step program is considered to be health status based for purposes of the rules.

Finally, the existing rules require disclosure of the availability of a reasonable alternative to individuals. The new regulations provide model language to use for this purpose.

CONTACT US

If you have any questions about an article in this issue or how any proposed health care reform changes will impact your organization, please contact the author of the article or another member of Miller Johnson's Health Care Reform Team.

If you would like to reprint articles, schedule a speaker, or receive our newsletter and alerts, please send an e-mail to healthcarereformteam@millerjohnson.com.



Miller Johnson is a member of Meritas, an association of independent law firms worldwide.

GRAND RAPIDS

p 616.831.1700

f 616.831.1701

KALAMAZOO

p 269.226.2950

f 269.226.2951

www.millerjohnson.com



These are some of the Miller Johnson attorneys available to answer your questions and provide assistance on issues related to health care reform (Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act):

MARY V. BAUMAN, CHAIR

616.831.1704
baumanm@millerjohnson.com

FRANK E. BERRODIN

616.831.1769
berrodinf@millerjohnson.com

JAMES C. BRUINSMA

616.831.1708
bruinsmaj@millerjohnson.com

DAVID M. BUDAY

269.226.2952
budayd@millerjohnson.com

TONY COMDEN

616.831.1757
comdent@millerjohnson.com

WILLIAM H. FALLON

616.831.1715
fallonw@millerjohnson.com

JEFFREY J. FRASER

616.831.1756
fraserj@millerjohnson.com

RICHARD E. HILLARY

616.831.1774
hillaryr@millerjohnson.com

KENNETH G. HOFMAN

616.831.1721
hofmank@millerjohnson.com

LAURETTA K. MURPHY

616.831.1733
murphyl@millerjohnson.com

NATHAN D. PLANTINGA

616.831.1773
plantingan@millerjohnson.com

MARK E. RIZIK

616.831.1744
rizikm@millerjohnson.com

STEPHEN R. RYAN

616.831.1746
ryans@millerjohnson.com

CHRISTOPHER "C.J." SCHNEIDER

616.831.1738
schneiderc@millerjohnson.com

TRIPP VANDER WAL

616.831.1796
vanderwalt@millerjohnson.com

MATTHEW L. VICARI

616.831.1762
vicarim@millerjohnson.com

SARAH K. WILLEY

269.226.2957
willeys@millerjohnson.com

If you received this from someone else and wish to receive your own copy, please send your name, company name and e-mail address to healthcarereformteam@millerjohnson.com.

This newsletter is a periodic publication of MILLER JOHNSON and should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and you are urged to consult your lawyer concerning your own situation and any specific legal questions you may have. For further information about these contents, please contact us.

© 2013 MILLER JOHNSON. All rights reserved.