

# HEALTH LAW FOCUS

*A Periodic Newsletter Published by The Health Care Department of  
Honigman Miller Schwartz and Cohn LLP*

## **IMMIGRATION ADVISORY ARE YOU FOLLOWING THE H-1B RULES?**

*By: Carol A. Friend*

Many physicians and other health care workers are employed in the United States in the H-1B non-immigrant status. After the recent terrorist attacks, the President, Attorney General and Congress have all focused a great deal of attention on increasing the enforcement activities of the Immigration and Naturalization Service ("INS") and tightening immigration laws and procedures. Consequently, it is more important than ever for health care providers to understand and follow the requirements associated with employing foreign national employees ("FNEs") in the H-1B status. This article will provide an overview of the H-1B requirements for a non-H-1B dependent employer (generally defined as an employer with less than 15% of its employees in the H-1B status).

**Labor Condition Application.** Prior to obtaining H-1B status for an FNE, an employer must make several attestations in a Labor Condition Application ("LCA") which is then filed with, and certified by, the U.S. Department of Labor ("DOL"). By signing the LCA, an employer affirms as follows:

**Wages.** The FNE will be paid the "required wage rate" for the occupation (the higher of the prevailing wage for the occupation in the area of intended employment or the actual wage paid to similar employees in the same occupation at the same work location); will be paid for non-productive time; and the employer will offer the FNE benefits on the same basis as U.S. workers.

**Working Conditions.** Employment of the FNE will not adversely affect the working conditions of other similarly employed workers.

**Strike.** There is no strike, lockout, or work stoppage in the course of a labor dispute affecting employees in the occupation at the work site.

**Notice.** Notice of the LCA filing (through posting) has been provided to other workers at the location and a copy of the LCA (including instructions) has been provided to the FNE on or before the date employment begins.

### **Public Inspection File and Record Keeping Requirements.**

Certain documentation regarding the H-1B position must be placed in a separate file and made available for inspection by any member of the public. The public inspection file must be maintained for at least one year following the conclusion of employment or, if a timely complaint is filed, until the complaint is resolved. The items which must be maintained for public inspection are summarized as follows: (1) copy of the signed LCA; (2) statement of the current rate of pay for the FNE; (3) copy of the prevailing wage determination or wage survey; (4) memo on how the actual wage was calculated, and summary of periodic increases; (5) summary of the benefits offered to U.S. workers in the same classification; (6) list of entities in the U.S. in the same control group of companies; and (7) evidence that the posting and notice requirements have been met. All LCA and public inspection materials should be kept separate from other employment records. Separation of these records will avoid a confidentiality breach and unnecessary disclosure of other data.

If the FNE previously worked for the employer under another status, such as an F-1 student in optional practical training status, it is necessary for the employer to update the FNE's Form I-9 once H-1B status is obtained. Also, when H-1B status is extended, it is necessary for an employer to complete the re-verification portion of the FNE's Form I-9.

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**Continuing Obligations.** An employer has several continuing obligations once the FNE commences employment in the H-1B status.

**Traveling Employees; Corporate Reorganizations.** If the FNE is assigned to a new place of employment not listed on the original LCA, the employer may be required to conduct a new posting at the additional work site or file a new LCA and an amended H-1B petition. The DOL has established a multi-tiered inquiry to determine an employer's obligations when an FNE is assigned to a new work location (even temporarily). Also, the DOL has set forth specific rules to determine if a corporate reorganization which results in a "new" employer will require the filing of a new LCA and an amended H-1B petition. Both of these issues generally require a fact-specific analysis by an immigration attorney.

**Whistleblower Protection.** An employer is prohibited from intimidating, threatening, blacklisting, discharging or otherwise discriminating against an employee (or former employee or applicant for employment) because such individual has disclosed information to the employer or anyone else regarding a potential violation, or for cooperating in an investigation or proceeding regarding an H-1B violation.

**No Benching.** An employer is required to pay an FNE the required wage for the full hours specified in the H-1B petition, even if the FNE is in a nonproductive status due to a decision by the employer, or based on the FNE's lack of a permit or license. This provision, however, does not apply to nonproductive time due to non-work related factors, such as voluntary absences at the request of the FNE.

**Strike or Lockout Notification.** An employer must notify the DOL within three days of the commencement of a strike or lockout at the place of employment involving workers in the H-1B occupation.

**Benefits.** An employer must offer FNEs benefits and eligibility for benefits (including participation in health, life, disability and other insurance plans, retirement and savings plans, bonuses and stock option plans) on the same basis, and in accordance with the same criteria as offered to U.S. workers.

**Transportation Costs.** An employer is obligated to pay the cost of return transportation for any FNE whose period of employment is terminated by the employer prior to the expiration date of H-1B status. The INS expects employers to meet this obligation, although it does not directly verify compliance.

**Termination of Employment.** An employer should send a letter

to the INS revoking the H-1B petition if the H-1B employee's employment is terminated for any reason prior to expiration of H-1B status. Failure to do so could cause an employer to be liable for back pay.

*Carol A. Friend is a member of Honigman Miller Schwartz & Cohn's Corporate Department. Ms. Friend devotes her full-time practice to providing employment-based immigration legal services to the Firm's clients. For further information regarding H-1B compliance or any other employment-based immigration matter, please contact Ms. Friend at 313-465-7374 or by e-mail at cfriend@honigman.com.*

## **IRS ISSUES FINAL EXCESS BENEFIT REGULATIONS**

**By: Gerald M. Griffith and Cynthia F. Reaves**

Recent action by the IRS has significantly increased the likelihood of enforcement of intermediate sanctions (or penalty excise taxes) for many non-fair market value health care transactions. On January 23, 2002, the IRS published final regulations under section 4958 of the Internal Revenue Code of 1986 (the "Code"). Congress enacted section 4958 as part of the Taxpayer Bill of Rights 2 ("TBOR2") legislation. The statute establishes a series of excise taxes, commonly referred to as "intermediate sanctions penalties," which may be imposed upon certain exempt organization insiders, referred to as "disqualified persons," who enter into excess benefit transactions with organizations which are exempt pursuant to section 501(c)(3) or 501(c)(4) of the Code. An excess benefit transaction arises where the value of the consideration which the exempt organization receives is less than the consideration or compensation it pays to the disqualified person. In addition to imposing a two-tier tax upon disqualified persons, the statute also authorizes a tax upon any organization manager who knowingly approved of the excess benefit transaction. The tax which can be imposed upon the disqualified person is assessed in two tiers, in an amount up to 225% of the amount of the excess benefit. Organization managers may face a 10% tax liability which is capped at \$10,000 for any one excess benefit transaction.

Under the intermediate sanction provisions, however, where an exempt organization establishes a rebuttable presumption with respect to a particular transaction, the burden of establishing that the transaction resulted in an excess benefit will be placed upon the IRS. The IRS will thereafter be required to demonstrate that the transaction did, in fact, result in an excess benefit. The rebuttable presumption may be established where the organization adheres to the following guidelines: (1) the arrangement is approved by the disinterested members of the

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exempt organization's board (or committee thereof); (2) the board relies on appropriate data as to the comparability of the compensation or fair market value of the consideration; and (3) the board or committee's determination is contemporaneously documented.

The final regulations supercede the temporary regulations which the Internal Revenue Service issued on January 10, 2001, both of which contain changes from the proposed regulations which were issued in 1998. The key changes and clarifications in the final regulations include:

- The safe harbor for organization managers relying on the rebuttable presumption procedure was revised to require only that the steps to establish the procedure were followed (while reiterating that simply failing to follow the procedures does not per se result in an excess benefit). If action on one of the steps was deficient, however, the safe harbor may not apply.
- The IRS clarified the scope of the exclusion of Section 115 governmental entities from the excess benefit rules. It appears likely that hospitals owned and operated by governmental entities will be exempt from the intermediate sanctions provisions; however, where the hospital is leased to a nonprofit operating entity that entity still may be subject to these rules.
- In a revised example, the final regulations clarify that a management company will be a per se disqualified person if it has the authority typically associated with a CEO or COO to supervise the management of a hospital. Previously, it appeared that only individuals could be per se or automatic disqualified persons.
- The preamble notes that there may be private benefit issues if other owners of a controlled entity (that is not wholly owned) do not pay proportionate amounts of compensation for services provided by a disqualified person to the controlled entity. This situation may arise in any number of joint ventures and hospitals need to address those cost allocations fairly and in advance.
- In these regulations, the IRS clarified that where transfers of property are subject to a substantial risk of forfeiture, it can still be a fixed payment arrangement thus allowing reasonableness to be determined at the time the parties enter into the contract. This clarification should be helpful in analyzing a variety of deferred compensation arrangements.
- The final regulations do not include specific revenue sharing rules and any future rules would be issued first in proposed form according to the preamble. The preamble, however,

reiterates that inurement may still be present where an insider receives no more than reasonable compensation from a revenue sharing arrangement. In addition, the preamble acknowledges that this may be a rare situation where it is not also an excessive compensation issue.

- A single individual may be the "authorized body" for purposes of establishing the rebuttable presumption of fair market value under the final regulations if state law allows that authority to be delegated to a single individual. Under the Michigan Nonprofit Corporation Act, for example, boards and committees of a nonprofit corporation may consist of a single director or trustee.
- The final regulations attempt to avoid abuses involving entities that lose their exempt status by requiring that correction payments be made to entities already in existence for at least 60 months before the transfer and restricting attempts by the disqualified person to control how the recipient of the correction payment distributes its funds.

The final regulations are helpful to tax-exempt health care organizations in planning their affairs. Although certain questions remain for another day, such as whether any additional restrictions should apply to revenue sharing arrangements and what additional factors will be considered in determining whether excess benefits jeopardize exemption, now that final regulations are in place the IRS may be more willing to issue rulings on intermediate sanctions questions. Even before that guidance is issued, however, it is likely that IRS enforcement activities will increase and we will see more examples of health care organizations and their executives and physicians being assessed penalty excise taxes for alleged excess benefit transactions. The best protection against those assessments is to make TBOR2 compliance a central and active part of your organization's compliance program.

### **FINAL STARK II PHASE I REGULATIONS: A ONE-YEAR REPRIEVE FOR PERCENTAGE COMPENSATION ARRANGEMENTS**

*By: Carey F. Kalmowitz*

The Centers for Medicare & Medicaid Services ("CMS") recently granted hospitals and other health care entities operating under percentage-based compensation arrangements with physicians a one-year reprieve from having to unwind those arrangements, and potentially having to renegotiate thousands of physician contracts that currently do not comply with the "set in advance" standard under the Stark II Phase I Rule published by CMS on January 4, 2001 (66 Fed. Reg. 856) (the "Phase I Final Regulations"). The Phase I Final Regulations

interpret certain provisions of the Stark Law, including certain definitional standards such as “set in advance,” a requirement under many of the statutory and new regulatory exceptions (*i.e.*, that compensation under the financial relationship be “set in advance”).

CMS announced the policy change on December 3, 2001, delaying for one year (*i.e.*, until January 6, 2003) the effective date of part of the definition of the “set in advance” compensation requirement. This delay, according to CMS, is intended to provide the agency with an opportunity to reconsider its position that “percentage compensation” arrangements could not meet the “set in advance” definitional requirement, as well as to allow time to publish further guidance on the issue.

CMS noted that it had received comments indicating that hospitals and other providers commonly pay physicians for their professional services using a compensation methodology that takes into account a percentage of a fluctuating or indeterminate measure (*e.g.*, revenues billed or collected for physician services). Several commenters pointed out that, by prohibiting percentage compensation formulas typically used when contracting with physicians (*e.g.*, arrangements structured to comply with the “personal service arrangements” or “academic medical center” exceptions), an incongruity arose between this aspect of the Phase I Final Regulations, and the compensation methods permitted under the statute for many physicians. For example, neither the definition of “group practice,” nor the “employment exception” contains the “set in advance” requirement. As a result, a group practice often could compensate a member of the group on a percentage of revenue basis. A hospital seeking to contract with a physician, however, could not pay him or her on a percentage basis as an independent contractor because compensation under a personal service arrangement must be “set in advance.”

Until at least January 6, 2003, providers are relieved of the burden of renegotiating arrangements with physicians that would otherwise not qualify for a Stark Law exception as a result of the “set in advance” definition. CMS emphasizes, however, that all other criteria required to meet a particular exception remain in effect and must be met in order to comply with the Stark Law. For example, compensation arrangements must continue to be consistent with “fair market value,” and cannot take into account the “volume or value of referrals,” where these standards are required for a particular exception. All other provisions of the Phase I Final Regulations, with the exception of the “set in advance” definition, became effective as of January 4, 2002. Accordingly, even though percentage of revenue compensation arrangements with independent contractor physicians will not necessarily violate the Stark Law during the one year delay, the parties nonetheless need to ensure that all other aspects of the arrangement satisfy the standards of an applicable exception.

## **OIG WARNS HEALTH CARE INDUSTRY OF ABUSIVE PRACTICES OF BUSINESS CONSULTANTS**

*By: Ann T. Hollenbeck*

The Office of Inspector General (“OIG”) of the Department of Health and Human Services recently issued a Special Advisory Bulletin (the “Bulletin”) to the health care industry to alert providers to certain marketing and other practices used by some independent consultants that may increase the risk of abuse of the Medicare and Medicaid programs. While the OIG acknowledged that a “vast majority” of relationships between providers and consultants are legitimate business activities, the OIG reported that a small minority of unscrupulous consultants engage in improper practices and may encourage their clients to abuse the Medicare and Medicaid programs. The OIG warned that these practices may expose not only the consultant to potential legal liability, but the provider as well. The OIG reminded the industry that hiring a consultant does not relieve a provider from its responsibility to ensure the integrity of its dealings with federal health care programs. In the Bulletin, the OIG identified the following four categories of questionable practices and provided several examples of each.

***Illegal or Misleading Representations.*** The first category is characterized by consultants who misrepresent that they have “inside” or “special” access to the OIG or to OIG materials. The OIG reported that in some cases consultants may misrepresent that their services or products are approved, certified or recommended by Medicare, the Centers for Medicare and Medicaid Services or the Department of Health and Human Services. Examples of these misrepresentations include a consultant’s statement that: (i) its reimbursement seminars are mandatory for obtaining a provider number, (ii) it is recommended by the OIG, and (iii) it offers recognized accreditation or certification for compliance programs and compliance officers.

***Promises and Guarantees.*** The second category describes circumstances where consultants may explicitly or implicitly promise or guarantee specific results that are unreasonable. The OIG stated that in some cases consultants may resort to improper means to effectuate such promises, including submitting false claims or preparing false cost reports on behalf of a provider. Examples of such promises include: (i) a valuation consultant who promises that its appraisal will yield a fair market value that satisfies the provider’s needs, and (ii) a billing consultant who promises its advice will produce a specific dollar or percentage increase in reimbursements.

***Encouraging Abusive Practices.*** The third category is

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characterized by cases of abuse where consultants knowingly encourage providers to abuse the Medicare and Medicaid programs through aggressive billing schemes and fraudulent practices. The OIG warned that this conduct potentially subjects both the consultant and the provider to liability under the False Claims Act. Examples include a consultant who suggests that a provider use inappropriate billing codes to elevate reimbursement or bill for an expensive item or service with a high reimbursement rate when a less expensive item or service with a lower reimbursement rate was actually provided to a patient.

**Discouraging Compliance Efforts.** The last category of abuse describes consultants who make absolute or blanket statements that a provider should not undertake certain compliance efforts (such as retrospective billing reviews) or cooperate with pay audits. The OIG stated firmly in the Bulletin that voluntary compliance efforts, such as internal auditing and self-review, are important tools for doing business with the federal health care programs.

The OIG concluded the Bulletin by stating: "In general, if a consultant's advice seems too good to be true, it probably is. We urge providers to be vigilant and to exercise judgment when selecting and relying on consultants."

*The full text of the Special Advisory Bulletin is available at the OIG website at: [www.oig.hhs.gov/frdalrt/consultants.htm](http://www.oig.hhs.gov/frdalrt/consultants.htm).*

### THE CURRENT LIABILITY INSURANCE MARKET: DIFFICULT TIMES FOR PURCHASERS

*By: Zachary A. Fryer*

The past year has seen the liability insurance market become an extremely hard market for purchasers. The terrorist attacks of September 11 have caused the largest insured losses in history, draining insurance companies of capital in the United States and overseas. While there are no reports of any insurance companies becoming insolvent directly as a result, the capital drain has reduced the affected insurers' capacity to write policies. In addition, the market had already been hardening before September 11 due to factors such as the poor performance of the stock markets (investment returns affect insurance company finances and therefore premiums), increasing medical malpractice liability verdicts and settlements in many states, and large losses for long term care liability, particularly in Florida. As a result, insurers are raising premiums to rebuild their capital and are being especially cautious about the risks they will underwrite. Purchasers of insurance must contend with much higher premiums and, in many cases, reduced coverage. Self-insurance and captive

insurance programs become more attractive in a hard market, but can also be more challenging to operate as the excess loss coverage and reinsurance needed for many programs is also affected by the market.

For health care providers, the December 12 announcement by The St. Paul Companies that it would withdraw from the medical malpractice market has also had a substantial impact. St. Paul had been the largest underwriter of medical malpractice coverage in the U.S., yet its CFO has stated that the economics of medical malpractice coverage were such that the company did not believe it could have made adequate returns had it continued to offer medical malpractice insurance. The withdrawal is being accomplished by not renewing policies upon expiration and not writing any new policies; while there are no immediate cancellations, the renewal season is already underway for many of those in health care, creating some urgency. The removal of such a major insurer from the market will likely prompt other malpractice carriers to raise rates and may have an effect on the availability of malpractice coverage for some physicians, particularly those in high-risk specialties and areas of high claim severity or frequency, as well as for hospitals and other health facilities.

Physicians, hospitals, and other parties involved in health care have several options in the current hard market. One option is to accept the most favorable commercial coverage that is available, understanding that a substantially increased premium may be charged for more limited coverage than before. For physicians, there may be new life in some of the physician-focused insurers which were formed in response to the malpractice insurance crises of the 1970's and the 1980's. Hospitals which have self-insurance or captive insurance programs already in place are likely considering themselves fortunate, as such programs often reduce the market problem.

#### HMS&C HEALTH CARE ATTORNEYS IN THE NEWS

William M. Cassetta, a member of the HMS&C Health Care Department, was one of three persons recently recognized as a major contributor to the Cayman Islands local captive insurance industry at the IBC's 7th Annual Executive Forum on Captives. The event was attended by over 200 insurance industry executives. The presentation was made by the Hon. Financial Secretary, George McCarthy who expressed his appreciation for Mr. Cassetta's ongoing support of the Cayman's insurance industry. In October, Mr. Cassetta was also one of three individuals recognized on behalf of the Cayman Islands for his expertise and knowledge of the captive insurance industry at the 2001 American Society for Healthcare Risk Management's Annual Conference and Exhibition.

These hospitals may consider retaining more risk through their existing programs. Hospitals and physician groups which do not have captive insurance programs may wish to assess the potential benefits and costs of forming a captive. While a captive is not a solution which can be in place overnight, it can have substantial long term benefits if carefully managed.

All health care organizations and practitioners, whether using commercial insurance, self-insurance, or a captive insurance program, should continue to take steps to reduce their liability exposure. While a thorough discussion of this topic is outside the scope of this article, reducing liability exposure may involve assessing current practices and implementing procedures to ensure that the best medical and management practices are used and to ensure that clear and timely documentation is made of care delivery. In this hard market, insurers are very interested in an insured's risk management program, and the existence of a sound risk management strategy may allow for reduced rates, or may even be essential to obtaining coverage at all. Minimization of risk is also valuable with captive insurance and self-insurance programs, where the insured can benefit directly if it successfully reduces liability costs. Your risk manager or your insurance broker or consultant should be able to assist you in determining appropriate steps to take in improving your current risk management program.

*For information regarding Honigman Miller Schwartz and Cohn's captive insurance practice, please contact Julie Robertson at 313-465-7520 (e-mail: [jrobertson@honigman.com](mailto:jrobertson@honigman.com)), William Cassetta at 313-465-7348 (e-mail: [wmc@honigman.com](mailto:wmc@honigman.com)) or William Hochkammer at 313-465-7414 (e-mail: [woh@honigman.com](mailto:woh@honigman.com)).*

## **HHS COMMITTEE MEETS TO ADDRESS REGULATORY REFORM**

*By: Cynthia F. Reaves*

On January 7-8, 2002, the Health and Human Services Advisory Committee on Regulatory Reform (the "Committee") held its first meeting as part of recent efforts on the part of the Department of Health and Human Services ("HHS") to reach out to health care plans and providers. Secretary Thompson announced the formation of the Committee on December 26, 2001.

The purpose of the Committee is to develop recommendations for Secretary Thompson concerning changes that should be made to reduce the regulatory burden in health care and respond faster to the concerns of patients, health care providers, state

and local governments, other institutions and other individuals affected by HHS rules while maintaining high quality standards for patient care. The Committee was charged with the task of developing immediate, short-term, and long-term goals and objectives to accomplish this task. Importantly, Secretary Tommy G. Thompson urged the Committee to develop recommendations for administrative adjustments that could be made without the necessity of legislative intervention. The Committee is expected to complete its initial work by Fall 2002 with a formal report to the Secretary. However, Thompson has suggested that the Committee report on any suggestions in the interim.

During its first meeting, the Committee discussed a broad range of regulatory topics including:

- The need to clarify and simplify communications so as to be more accessible and understandable (e.g., regulations written in "plain English");
- The desire to develop a more collaborative and educationally based relationship among providers and HHS, rather than one which is merely enforcement-focused;
- Specific issues for which a "best practices" approach would be useful: EMTALA, E&M documentation guidelines, and CLIA; and
- Better management of the frequency of reporting.

In addition to holding regional hearings and additional public meetings, the Committee is seeking public comment, and HHS recently published a request for such input. Individuals and organizations are encouraged to submit ways to reduce current burdens imposed by existing HHS regulations. Areas under consideration include: (1) health care delivery; (2) health care operations; (3) development of pharmaceuticals and other medical products; and, (4) biomedical and health services research.

Comments must be submitted no later than 5:00pm on March 5, 2002 and are limited to only five pages (although additional attachments may be included, there is no guarantee that they will be read or reviewed). The Committee is asking those making comments to be as specific as possible and focus on concerns related to burdens imposed by regulations or regulatory processes rather than the underlying statutes. In this regard, HHS has indicated a desire to focus on manageable interventions which could be implemented without going through the entire rulemaking process.

*If you have any questions or would be interested in submitting comments to the Department of Health and Human Services please contact Cynthia F. Reaves at (313) 465-7000.*

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## OF GENERAL INTEREST

### QUALIFIED TUITION PROGRAMS: SECTION 529 PLANS

*By: Ann T. Hollenbeck*

Recent tax legislation has enhanced the tax benefits available to participants in Qualified Tuition Programs, also commonly referred to as Section 529 Plans. These plans allow a donor to make gifts to a Section 529 Plan for the college or vocational education of a designated beneficiary. Because of the important tax benefits, funding a Section 529 account may be one of the best college savings plans available today and the most effective way for individuals to use their annual gift tax exclusion. As many of us in the Health Care Department have recently completed the time-consuming task of investigating this college savings alternative for our children and grandchildren, we felt it would be beneficial to share our expertise with our health care clients who may be considering a Section 529 Plan as a savings option for their children and grandchildren.

Funds deposited in a Section 529 Plan are invested in an account for the designated beneficiary in a state-sponsored savings plan with the expectation that the funds and the earnings will be withdrawn by the beneficiary for the costs of higher education. There is no income limitation that prohibits participation by a donor or a beneficiary. Additionally, while the beneficiary is often the donor's child or grandchild, there is no requirement that the beneficiary be related to the donor. Typically, the contributions to these state-sponsored Section 529 Plans are invested in mutual funds administered by professional money managers. For example, the plan offered by the State of Michigan is administered by TIAA-CREF. Numerous differences exist among the 30-plus state-sponsored Section 529 Plans, which makes the selection process important, as most plans are open to non-residents.

Some of the universally favorable aspects of a Section 529 Plan are as follows:

***Tax Free Growth.*** The most important tax benefit of a Section 529 Plan is that all earnings on the investment will be distributed to the beneficiary free from federal income tax, provided that the funds are used for Qualified Higher Education Expenses. Qualified Higher Education Expenses include tuition, room and board (for at least half-time students), fees, books, supplies, and equipment necessary for attendance at an eligible institution (typically any accredited post-secondary educational or vocational institution).

***Gift Tax Exclusion.*** Gifts to a Section 529 Plan may qualify for the \$11,000 annual gift tax exclusion. A special feature allows a donor to apply both the current annual gift tax exclusion and the subsequent four years' annual exclusion to contribute up to \$55,000 tax-free in one year. Although federal law does not impose total contribution limits, most state plans impose limitations on total contributions. Michigan prohibits contributions for a designated beneficiary once his or her account balance reaches \$125,000. Other states allow contributions up to an aggregate account value of as much as \$260,000.

***State Income Tax Deductions.*** Some states, including Michigan, allow a limited state income tax deduction for contributions made to the State's Section 529 Plan. Currently, Michigan offers an annual state income tax deduction for contributions made to a Michigan plan of up to \$5,000 for single filers, or \$10,000 for joint filers. There is no income limitation on this deduction.

***Flexibility of Beneficiary Designation.*** Donors may change beneficiaries without any tax consequences at any time by withdrawing the funds and rolling them over to another Section 529 account established for a different individual, so long as the individual is a member of the original beneficiary's family. This allows a donor to make adjustments, for example, if the original beneficiary does not need all of the funds for education (due to a scholarship, death or disability), by designating another family member as a beneficiary.

***Choice of Investment Strategy.*** Most state plans offer a choice of investment strategies ranging from high to low risk. Many plans offer a mix of investments that change over time as the beneficiary becomes closer to college age. If the donor is not satisfied with the investment performance of a chosen fund, a donor may roll over the Section 529 account once a year, to either another Section 529 fund within the same state or to another state's Section 529 Plan, without changing beneficiaries.

Section 529 Plans are not without their drawbacks. Most significantly, while funds not needed for education expenses may be withdrawn from a Section 529 Plan, a penalty will be imposed on all or a portion of the withdrawal and income taxes will be due on the withdrawn income. In addition, since the various state programs differ in important respects, care should be exercised in selecting a particular program. Lastly, be aware that brokers and banks are marketing these programs and often charge additional commissions for their services. These commissions can be avoided by applying directly to a state's Section 529 Plan administrator.

**SPEAKING ENGAGEMENTS**

HMS&C Attorneys frequently are asked to speak at conferences and seminars. A calendar of upcoming speaking engagements is provided below.

<i><u>Topic</u></i>	<i><u>Date(s)</u></i>	<i><u>Location</u></i>	<i><u>Speaker(s)</u></i>
Institute of Continuing Legal Education: "TBOR2 Intermediate Sanctions Regulations"	March 7-8, 2002	Troy, MI	Gerald M. Griffith
Institute of Continuing Legal Education: "Basic Tax-Exempt Law for Health Care Lawyers"	March 7-8, 2002	Troy, MI	Cynthia F. Reaves
American Health Lawyers Association Medicare and Medicaid Institute: "Continuing Cost Based Reimbursement Issues"	April 3-5, 2002	Baltimore, MD	Chris Rossman

Honigman Miller Schwartz and Cohn is a general practice law firm headquartered in Detroit, with an additional offices in Bingham Farms and Lansing, Michigan. Honigman Miller's staff of approximately 186 attorneys and more than 300 support personnel serves thousands of clients regionally, nationally and internationally. Our health care department includes the sixteen attorneys listed below who practice health care law on a full-time or substantially full-time basis, and a number of other attorneys who practice health care law part-time. Except as denoted below, attorneys in the health care department are licensed to practice law in the State of Michigan only.

William M. Cassetta	Patrick G. LePine	Linda S. Ross
Zachary A. Fryer	Stuart M. Lockman*	Chris E. Rossman
Gerald M. Griffith	Michael J. Philbrick	Valerie S. Rup
William O. Hochkammer	Cynthia F. Reaves****	Julie M. Schuetze***
Ann T. Hollenbeck	Julie E. Robertson**	Margaret A. Shannon
Carey F. Kalmowitz		

\* Licensed to practice law in Michigan and Florida, Florida board certified health law specialist.

\*\* Licensed to practice law in Michigan and Ohio.

\*\*\* Licensed to practice law in Michigan, Washington, DC and Massachusetts.

\*\*\*\* Licensed to practice law in Washington, DC; Michigan admission pending.

For further information regarding any of the matters discussed in this newsletter, or a brochure that more specifically describes our practice in health care law, please feel free to contact any of the attorneys listed above at our Detroit office by calling (313) 465-7000.

Honigman Miller Schwartz and Cohn's **Health Law Focus** is intended to provide information but not legal advice regarding any particular situation. Any reader requiring legal advice regarding a specific situation should contact an attorney. The hiring of a lawyer is an important decision that should not be based solely upon advertisements. Before you decide, ask us to send you free written information about our qualifications and experience.

Honigman Miller Schwartz and Cohn also publishes newsletters concerning antitrust, employee benefits, employment, environmental and tax matters. If you would like further information regarding these publications, please contact Lee Ann Jones at (313) 465-7224, via e-mail at [ljones@honigman.com](mailto:ljones@honigman.com), or visit the Honigman Miller Schwartz and Cohn web site at <http://law.honigman.com>.