Health Care Reform

A Compliance Guide for Employers

Prepared by:

Christine M. Moehl
Employee Benefits Attorney

Saalfeld Griggs PC

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Health Care Reform Overview

On June 28, 2012, the U.S. Supreme Court released its highly-anticipated ruling on the Patient Protection and Affordable Care Act (also known as "health care reform" or the "ACA"). The Court found the majority of the ACA to be constitutional and only placed limits on the federal government's attempt to expand the Medicaid program. Many employers had adopted a "wait-and-see" approach while the Supreme Court considered the constitutionality of the ACA. The decision has now spurred those employers to action. This analysis is intended as a guide for employers of all sizes to provide them with information regarding the impact that the ACA will have from 2012 through its full implementation in 2018.

The stated goal of health care reform is to provide the American people with "strong consumer protections, more coverage options, and lower costs."[1] The law imposes new requirements on all sectors of the health insurance marketplace, including individuals, insurance companies, and employers. For individuals, health care reform imposes a penalty on individuals who do not have health coverage (i.e., the "individual mandate"), and it also creates state health insurance exchanges through which individuals can obtain the requisite health coverage. For insurance companies, health care reform imposes minimum standards of coverage and also requires guaranteed availability and renewability of that coverage. For employers, health care reform encourages sponsorship of group health plans through a variety of "sticks and carrots." The ACA also requires employers to comply with new tax withholding and reporting requirements.

Full implementation of the ACA's provisions will not be complete until 2018. In 2010, several insurance reforms took effect, such as coverage for adult children up to age 26 and restrictions on annual and lifetime limits. The Small Employer Tax Credit also became available in that year. The original law has been modified significantly over the last two years. Several provisions of the ACA have been put on indefinite hold (such as the nondiscrimination rules for fully-insured group health plans) or have been repealed all together (such as the Form 1099 reporting requirement for businesses that purchase over $600 from a single vendor). Regulators and lawmakers will continue to make modifications to the ACA in future years. However, if the ACA maintains its key provisions, 2014 will mark the culmination of health care reform as state health insurance exchanges become operational and the individual mandate takes effect. 2014 will also mark an important year for employers because that year the "Play or Pay" penalty is scheduled to take effect. Finally, in 2018 the "Cadillac Plan" tax becomes effective, subjecting generous health care plans to a new excise tax.

Which Employer-Sponsored Health Plans Are Affected?

Health care reform affects all "group health plans" sponsored by employers. For purposes of the ACA, the definition of a group health plan is broad and includes both fully-insured and self-insured major

[1] http://www.healthcare.gov/law/timeline/index.html (as visited on 6/30/12)

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medical plans, including mini-med and limited benefit plans. It also applies to other employer-sponsored health plans, such as employee assistance programs (EAPs), certain wellness plans, and most health reimbursement arrangements (HRAs). Some group health plans are specifically exempt from health care reform, such as plans that cover only one person and retiree-only plans. Most (but not all) stand-alone dental and vision plans are also exempt from health care reform.

Employer To-Do:
Identify all employer-sponsored health plans that may be affected by health care reform. This list should include all health and welfare plans, such as EAPs, flexible spending accounts (FSAs), wellness plans, supplemental benefit programs, etc. Seek assistance from qualified plan advisors to determine whether any of the plans are exempt from the requirements of health care reform, or to make certain that grandfathered plans do not lose their status.

Grandfathered Plans

Another notable exception in health care reform applies to "grandfathered" plans. Grandfathered plans are excluded from some of the health care reform requirements. To be a grandfathered plan, the plan must have been in existence on March 23, 2010 and must have elected to be treated as a grandfathered plan. Certain changes in plan terms can cause a plan to lose its grandfather status.

Employer Timelines

In most cases, an employer's size dictates which provisions of health care reform apply and when. Generally, larger employers have more immediate responsibilities under the ACA. The following charts contain timelines that illustrate the dates that key provisions of the ACA will take effect, and which employers will be affected. The charts cover all employers, but are broken down into two separate categories: employers that do not offer major medical plans, and employers that do.

Employers That Do Not Offer Major Medical Plans

Number of Employees

	1 - 25	26 - 50	51 - 100	101 - 200	201 - 249	250+
2012	Simple Cafeteria Plan Available					
						Form W-2 Reporting
2013	Flexible Spending Account Limit					
	State Health Insurance Exchange Notices					
	Additional Medicare Tax on Higher-Income Individuals					
2014	Shared Responsibility for Individuals, *aka* "Individual Mandate"					
			Shared Responsibility for Employers, *aka* "Play or Pay" Penalty			

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Employers That Offer Major Medical Plans

Number of Employees

	1 - 25	26 - 50	51 - 100	101 - 200	201 - 249	250+
2012	Small Business Tax Credit					
	Simple Cafeteria Plan Available					
	Nondiscrimination Requirement for Fully-Insured Plans (on hold pending further regulations)					
	Summary of Benefits & Coverage (SBC)					
	Additional Standards for Claims & Appeals / External Review					
						Form W-2 Reporting
	Full Coverage of Women's Preventive Health Care Services					
	Medical Loss Ratio Rebates					
2013	Flexible Spending Account Limit					
	State health insurance Exchange Notices					
	Fees for Research on Patient-Centered Outcomes					
	Additional Medicare Tax on Higher-Income Individuals					
2014	Limit on Waiting Periods					
					Automatic Enrollment (may be delayed until 2015 or later)	
			Shared Responsibility for Employers, *aka* "Play or Pay" Penalty (only applicable if the employer-sponsored coverage is "unacceptable")			
2018	"Cadillac Plan" Tax					

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2012 Employer Checklist & To-Dos

Small Business Tax Credit

Beginning in 2010, certain small employers that offer health insurance coverage to their employees became eligible for a tax credit of up to 35% of the health insurance premiums that they pay on their employees' behalf. There are three requirements that an employer must satisfy to be eligible for the tax credit:

- The employer must have no more than 25 full-time equivalent (FTE) employees during the tax year.
- The employer's FTEs must have average annual wages that do not exceed $50,000.
- The employer must pay at least 50% of the premiums for the group health insurance coverage.

The maximum tax credit is available for employers with no more than 10 FTEs and average wages of $25,000 or less. The credit is phased out for employers with between 11 and 25 FTEs and average wages between $25,000 and $50,000.

How to Count FTEs:
For purposes of the small business tax credit, an employer must count its FTEs as follows:

1. Exclude the following: a. owners, b. family members of owners, and c. seasonal employees who worked fewer than 120 days.
2. Identify each employee who is not excludable under #1, above, and add the employee's total hours of service for the year (not exceeding 2,080) to the total hours of service of all other non-excludable employees.
3. Divide the total hours in #2, above, by 2,080. The result is the employer's FTE count.

Employer To-Do:
Employers should consult with their CPAs or other tax professionals to determine whether they qualify for this tax credit. As noted above, this tax credit has been available since 2010. However, according to the U.S. Government Accountability Office, only about 10% of all employers that were eligible for the credit actually claimed the credit on their 2010 returns.

Simple Cafeteria Plans

Beginning in 2011, employers with fewer than 100 employees were eligible to sponsor a simple cafeteria plan. Simple cafeteria plans are exempt from the nondiscrimination requirements that apply to regular cafeteria plans. The nondiscrimination requirements often limit the amount that highly compensated individuals (i.e., owners and other key employees) can defer into the plan. Employers that sponsor simple cafeteria plans must make an employer contribution to the plan that is either: (1) a non-elective contribution equal to at least 2% of an employee's wages for the year; or (2) a matching contribution equal to the lesser of: (a) 6% of the employee's wages for the year; or (b) two times the amount of the employee's cafeteria plan deferrals for the year. The employer may exclude all employees who are under age 21, have worked less than one year, or have worked less than 1,000 hours per year.

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Employer To-Do:
Business owners who find themselves limited under the current cafeteria plan nondiscrimination rules should analyze whether a simple cafeteria plan would allow them to contribute more on a tax-efficient basis.

Nondiscrimination Requirements for Fully-Insured Plans

This provision will apply nondiscrimination rules to fully-insured group health plans. Prior to the ACA, only self-insured group health plans were subject to nondiscrimination rules. The nondiscrimination rules generally prohibit plan features that favor highly compensated individuals with regard to eligibility and/or benefits. For example, many fully-insured health plans currently extend family coverage to owners of the business, while extending employee-only coverage to non-owners. Under the ACA, these types of plan designs will be precluded. This provision of the ACA was scheduled to become effective in 2010. However, enforcement of this provision is delayed pending issuance of clarifying regulations by the IRS.

Employer To-Do:
At present, no action is required to comply with this provision. Employers should anticipate the release of future regulations, and should consult with their advisors to determine the impact those regulations will have on their plans.

Summary of Benefits & Coverage (SBC)

All employers with group health plans must provide new enrollment disclosures, called SBCs, to their plan participants.

Effective Date: The SBCs must be provided for the first open enrollment on or after September 23, 2012. This means that employers with calendar-year plans must begin preparing their SBCs very soon in order to have them available for 2013 open enrollment. SBCs must also be provided to new enrollees in the plan on or after September 23, 2012.

Format: The SBCs must conform to the Department of Labor's (DOL) template, which can be found at www.dol.gov/ebsa/pdf/correctedsbctemplate.pdf. The SBCs are four pages, double-sided, and must be provided for each "benefit package" offered by the employer. For example, if an employer offers coverage for both a PPO and an HMO, both of these "benefit packages" need a separate SBC.

Non-English Language Translation Assistance Requirement: Employers with employees residing in a county where 10% or more of the population is literate in the same non-English language must include a statement on their SBCs that describes how employees may obtain translation assistance in that language. The employer must also provide a translated version of the SBC upon request. A list of the counties covered by this rule can be found at www.cciio.cms.gov/resources/factsheets/clas-data.html. In Oregon, employers with employees residing in Marion, Morrow, or Hood River counties must provide translation assistance.

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Penalties for Failure to Provide: The penalties for failing to provide an SBC is significant – up to $1,000 per violation per participant – along with an additional excise tax of $100 per day per participant. Luckily, a "good faith" compliance standard will apply during the first year that the requirement is in place.

Who is Responsible for the SBCs? Ultimately, the employer is responsible for complying with the SBC requirement. However, in the case of fully-insured plans, the insurance carrier will likely provide the SBC to the employer. In the case of self-insured plans, most employers will rely on their third-party administrators (TPAs) to comply with the SBC requirement.

Employer To-Do:
Employers should identify each "benefit package" for which an SBC is required, and should ask for assurances from their insurance carrier or TPA that the SBC will be prepared prior to the next open enrollment. Employers with employees residing in Marion, Morrow or Hood River counties should confirm that the SBC includes a translation assistance statement in Spanish, and that a translated version of the SBC is available for open enrollment.

Additional Standards for Claims & Appeals / External Review

All health and welfare plans are required to have procedures in place that employees can follow when making claims or filing appeals. These procedures are generally dictated by the DOL. Although several changes to the claims and appeals procedures under the ACA had earlier effective dates, the DOL only required "substantial compliance" with these reforms. Beginning in 2012, the DOL will begin enforcing "strict" compliance with the new claims and appeals procedures. Basically, the new procedures require employers to provide "culturally and linguistically" appropriate notices, and also expand the content requirements for denial notices. Model notices are available at www.dol.gov/ebsa/healthreform/. Cultural and linguistic appropriateness is generally determined in the same manner (and in the same counties) as discussed in the SBC section, above. In addition, claimants now have the right to review their files and present evidence and testimony on their claims. The switch to strict compliance with these reforms will begin on the first day of the plan year beginning on or after January 1, 2012.

Employer To-Do:
Employers should ensure that their Summary Plan Descriptions (SPDs) have been updated to reflect the new standards for claims and appeals, and that the SPDs inform participants about external review procedures. They should also confirm that the proper denial notices are being distributed to participants and that non-English language statements are included on the notices, if necessary.

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Form W-2 Reporting

Employers that filed 250 or more Form W-2s in 2011 will be required to report the aggregate cost of employer-sponsored health coverage on all 2012 Form W-2s. The purpose of this new rule is to educate plan participants on the value of their employer-provided health coverage. No amount reported on the Form W-2 as the cost of group health coverage will result in additional taxes to either the employee or employer.

Employers of all sizes should note that although the W-2 reporting requirement currently applies to employers that issued 250 or more W-2s in 2011, once further regulations are released this requirement will apply to employers of all sizes.

Employer To-Do:
Employers that utilize an outside payroll service should confirm that their service has access to the necessary information to comply with this requirement. If an employer does "in-house" payroll, the system will need to be modified to track and report the cost of employer-sponsored health coverage.

Full Coverage for Women's Preventive Health Care Services

Effective for plan years beginning on or after August 1, 2012 (i.e., January 1, 2013 for calendar-year plans), group health plans must cover certain women's preventative health care services without cost-sharing or deductibles. Such services include wellness visits and contraception prescriptions and counseling (subject to a religious-employer exemption). It also includes domestic violence counseling.

Employer To-Do:
Employers should ensure that their plan documents and participant communications are amended to conform to these new requirements.

Medical Loss Ratio Rebates

This provision applies to fully-insured medical plans only. Insurance carriers must issue rebates to employers that sponsor such plans if the "medical loss ratio" for the group health plan exceeds a certain threshold. Employers may start receiving these rebates as early as July 2012. To complicate matters, the Employee Retirement Income Security Act (ERISA) provides that if employees pay any portion of the premium, then a proportionate share of the rebate must be allocated for their benefit. Because the rebates are generally taxable if distributed to the employee or retained by the employer, in most cases employers will want to set up accounting policies that use the rebates to reduce future premium costs. The rebates are likely to be small, and the accounting involved with allocating them between employer and employee may be tedious. As a practical matter, the easiest and most cost-efficient way to apply the rebates may be to credit the entire rebate to the employee premium cost.

Employer To-Do:
Employers should establish accounting policies that specifically address how loss ratio rebates will be processed and allocated, if and when they are received.

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2013 Employer Checklist & To-Dos

Flexible Spending Arrangement (FSA) Limit

Effective for plan years beginning on or after January 1, 2013, participants in health FSAs will no longer be able to make salary deferral contributions in excess of $2,500 per year. This limit will be adjusted for inflation in future years, and is only applicable to salary deferral contributions in FSAs, not to employer contributions.

Employer To-Do:
Employers that sponsor health FSAs must: (1) ensure that communications to participants in the FSA reflect the $2,500 limit for the plan year beginning after January 1, 2013; and (2) ensure that the FSA plan document is amended for the limit by the end of 2014.

State Health Insurance Exchange Notices

Beginning March 1, 2013, employers will be required to give their employees notice regarding their state's health insurance exchange. The state health insurance exchanges created under the ACA are government-organized marketplaces designed to help individuals and employers (initially small employers) shop for health insurance. The exchanges are intended to facilitate clear comparisons of price, benefits, and quality between available health plan options. Each state has until January 1, 2014 to create a fully-operational exchange. If a state elects not to create its own exchange (as is the case with Texas), then a federally-designed exchange will be implemented in its place. In addition to providing information regarding the state exchange, the employer notices that are required to be issued by March 1, 2013 must also provide information about an employee's eligibility for a premium tax credit or employer cost-sharing. The DOL is expected to release further guidance on this notice requirement. Accordingly, the effective date of this provision may be delayed.

Employer To-Do:
Employers do not need to take action now, and should stay tuned for further guidance.

Fees for Research on Patient-Centered Outcomes

From 2012 until 2019, health insurance issuers and sponsors of self-funded group health plans will be assessed an annual fee to fund a new nonprofit corporation, the "Patient-Centered Outcomes Research Institute" (PCOR). The PCOR fee for 2012 is $1 times the average number of plan participants during 2012. In 2013, the fee increase to $2 times the average number of plan participants, and is then subject to adjustment in future years. For self-insured plans, the employer is responsible for paying the fee and must report via an IRS Form 720 by July 31 of each year. This means that sponsors of self-insured, calendar-year plans must pay the fee on or before July 31, 2013 for the plan year ending December 31, 2012. For fully-insured plans, health insurance issuers are responsible for paying the fee, although the cost will likely be passed on to the employer and employees via higher premiums.

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Employer To-Do:

Employers with self-insured health plans should budget for this additional cost beginning in 2013. Because the fee is assessed per participant *per plan,* employers with component plans (e.g., one plan covering emergency services and a separate plan covering preventive care) may wish to consider bundling those plans to avoid multiple fees. Employers with fully-insured plans do not need to take any action at this time, but may consider bundling their component plans to avoid higher premiums.

Additional Medicare Tax on Higher-Income Individuals

The ACA increases the employee portion of the Medicare tax (currently equal to 1.45% of wages) by an additional 0.9%. This additional tax applies to wages paid on or after January 1, 2013. Unlike the current Medicare tax, this additional tax is only imposed on higher-income individuals. Employers are required to withhold this amount from any wages paid to an individual in excess of $200,000.

Employer To-Do:

Employers should coordinate with their payroll providers or in-house payroll staff to make sure that the new Medicare tax will be applied to wages earned after January 1, 2013 in excess of $200,000.

2014 and Beyond Employer Checklist & To-Dos

Limit on Waiting Periods

Beginning in 2014, employees must be allowed to participate in employer-sponsored group health plans within 90 days after employment. This rule does not affect an employer's ability to exclude employees from participation on some other basis (e.g., part-time employees).

Employer To-Do:

Beginning in 2014, employers that impose a waiting period in excess of 90 days must amend their plans and revise their employee communications.

Automatic Enrollment

Pending further guidance from the IRS, this provision of the ACA may not become effective until 2014 or later. Once it does become effective, employers with more than 200 employees must automatically enroll all newly-eligible employees in their group health plan once the employee becomes eligible for the plan. Employees can still affirmatively elect to opt out of the group health plan if otherwise permissible.

Employer To-Do:

Employers do not need to take action now, and should stay tuned for further guidance.

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Shared Responsibility for Individuals (the "Individual Mandate")

One of the most controversial provisions of the ACA is scheduled to become effective in 2014. The individual mandate requires individuals to carry "minimum essential" health coverage for themselves, their dependents, and their spouses. Those who do not are subject to a penalty. To avoid the penalty, individuals can obtain the requisite health insurance coverage through a government-sponsored plan (e.g., Medicare or Medicaid), an employer-sponsored group health plan, or an individual insurance policy.

Certain individuals are exempt from the penalty, such as individuals who cannot afford coverage (defined as individuals who cannot secure coverage that costs less than 8% of their household income), and individuals who have a gap in coverage for less than three months per year.

Calculating the Penalty: Individuals who do not obtain the requisite health coverage will be required to pay a penalty for each month that they (or their dependents or spouses) remain uninsured. The penalty is the greater of:

1. A percentage of the taxpayer's "applicable income" (1% in 2014, 2% in 2015, and 2.5% thereafter), or
2. A flat dollar amount per uninsured individual (annual amounts are $95 in 2014, $325 in 2015, and $695 in 2016). The penalty for dependents under age 18 is 50% of the annual flat dollar amount, and the total family penalty is capped at 300% of the annual flat dollar amount.

Premium Assistance Credit: In order to provide individuals and families with the opportunity to purchase health insurance through the state health insurance exchanges, the ACA establishes a premium assistance credit for individuals. To be eligible for the credit, an individual must have a household income between 100% and 400% of the federal poverty level.

Employer To-Do:
Although employers are not directly affected by the individual mandate, they may want to familiarize themselves with the specifics in order to answer questions that they may receive from their employees.

Shared Responsibility for Employers ("Play or Pay" Penalty)

Beginning in 2014, all employers with 50 or more FTEs may be subject to the "Play or Pay" penalty. The applicable penalty depends on whether the employer offers no group health plan, or offers a group health plan that is considered under the ACA to be "unaffordable" or that does not meet "minimum essential coverage" standards.

Employers that offer group health coverage: Employers that employ over 50 FTEs will not be subject to penalties under this provision unless the health plan offered is considered to be unaffordable or does not meet minimum essential coverage. "Unaffordable" coverage is defined as coverage that:

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a. Does not pay for at least 60% of an employee's covered expenses, or
b. Has an employee-paid premium in excess of 9.5% of the employee's household income.

Coverage that does not meet the "minimum essential coverage" standard is coverage that includes only limited-scope benefits (e.g., dental-only coverage or catastrophic policies).

An employer that offers either unaffordable coverage or coverage that does not meet the minimum essential standard (i.e., "unacceptable" coverage) will be subject to a penalty if at least one full-time employee declines the unacceptable coverage and obtains a Premium Assistance Credit (see above under the Individual Mandate) to obtain coverage through the state health insurance exchange.

The monthly penalty assessed to an employer offering unacceptable coverage is based only upon the full-time employees who receive the Premium Assistance Credit, not FTEs. For every such employee, the monthly penalty is equal to $250. However, the total penalty is capped at the amount that the employer would have paid if it did not offer any group health coverage (see below).

Employer To-Do:
Employers should work with their plan advisors to determine if the group health coverage that they offer is considered acceptable coverage for purposes of avoiding the "Play or Pay" penalty tax. If it is not, then employers may consider modifying their coverage options prior to 2014.

How to Count FTEs:
For purposes of the "Play or Pay" penalty, an employer must count its FTEs as follows:

1. Exclude all seasonal employees who worked fewer than 120 days.
2. Identify each employee who is not excludable under #1 and who worked over 30 hours per week in any given month. Each such employee is equal to one FTE.
3. Not counting the employees excluded under #1 and the employees counted under #2, add up the hours of service in the month for the remaining employees and divide it by 120.
4. Add the number of FTEs in #2 and #3. This is the total FTE count for the month.
5. Average the monthly FTE count for the prior year.

Further guidance is expected regarding fluctuating workforces and the treatment of owners.

Employers that do not offer group health coverage:
Employers that employ over 50 FTEs and that do not offer group health coverage are subject to a penalty under this provision if at least one of their full-time employees receives a Premium Assistance Credit and obtains insurance from the state health insurance exchange.

The monthly penalty assessed to an employer offering no coverage is based on the employer's actual full-time employees (not FTEs). The monthly penalty is equal to the number of full-time employees (minus 30) multiplied by $167.

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Employer To-Do:
Employers should estimate the penalty that they will pay under this provision if they do not offer group health coverage to their employees, and then compare this amount to the cost of offering acceptable coverage. One important consideration in this regard is that the cost of sponsoring a group health plan is a deductible business expense, while a penalty payment is not.

"Cadillac Plan" Tax

Beginning in 2018, an important revenue raiser under the ACA will be the 40% excise tax imposed on high-cost health coverage, often referred to as the "Cadillac Plan" tax. This provision taxes the portion of the cost of an employee's employer-sponsored health coverage that exceeds a certain threshold amount ($10,200 for individual coverage and $27,500 for family coverage). These amounts are adjusted for age, gender, and future increases in health care costs. If the employer-sponsored health coverage is fully-insured, then the insurance carrier is responsible for paying the excise tax. If the coverage is self-insured, then the employer is responsible for paying the excise tax. The stated objectives of this provision are to raise revenue and to reduce demand for high-cost health coverage, thereby encouraging insurers and employers to control health care costs.

Employer To-Do:
Employers will be unaffected by this provision until 2018. Beginning in 2018, employers that sponsor "Cadillac Plans" should consider whether the plans will continue to make economic sense for either the employer or the employee.

The Future of Health Care Reform

Politicians in Washington D.C. will continue to debate – and posture over – the viability of the ACA. Undoubtedly, the outcome of the presidential race in November will be crucial in determining the ACA's ultimate fate. However, following the Supreme Court's ruling two weeks ago, employers no longer have the luxury of adopting a "wait-and-see" approach. Employers must strive for full compliance with the ACA's provisions as they become effective, especially with regard to those provisions that are already effective or will become so in 2013. In fact, DOL audits of health and welfare plans now require employers to demonstrate that they have complied with the ACA provisions in effect. Employers that cannot demonstrate compliance will face significant penalties for noncompliance.

Employer To-Do:
Employers of all sizes should work with their plan advisors to construct a comprehensive health care reform action plan that ensures compliance with these complicated rules. If you would like assistance in developing a health care reform action plan that is tailored to the specifics of your business, please contact Christine Moehl at 503-399-1070, or email her at cmoehl@sglaw.com.

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