

What You Need to Know: Welfare Plans in 2009 – New Laws and Drafting Tips

Teleconference
Presentation materials
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Dial in number: (800) 762-7308

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What You Need to Know: Welfare Plans in 2009 – New Laws and Drafting Tips

MARCH 26, 2009 TELECONFERENCE AGENDA

- I. Introduction of panel and the Firm's ERISA practice
- II. Federal COBRA Premium Subsidy for Involuntary Terminations
 - A. Overview
 - B. Amount and Duration of Subsidy
 - C. Assistance Eligible Individuals
 - D. Involuntary Termination
 - E. Notice Requirements
 - F. Reimbursement Procedure
- III. Children's Health Insurance Program (CHIP) Reauthorization Act and Centers for Medicare and Medicaid (CMS) Reporting Changes
- IV. Drafting Tips
 - A. Plan language requiring exhaustion of administrative remedies
 - B. Plan statute of limitations and venue.
 - C. Plan definition of "spouse"
- V. Q&A

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What You Need to Know: Welfare Plans in 2009 – New Laws and Drafting Tips

Lynn Feder

Bob Ferencz

Priscilla Ryan

Stewart Shepherd

Federal COBRA Subsidy Overview

- American Recovery and Reinvestment Act of 2009 (ARRA), signed into law on 2/17/09.
- Federal government subsidizes 65% of up to 9 months of COBRA premiums for certain employees whose employment is involuntarily terminated on or after 9/1/08 and before January 1, 2010.
- Generally effective for COBRA premiums for COBRA coverage on and after 3/1/09.

Subsidy

- The federal subsidy is available only for “assistance eligible individuals” (“AEIs”) who are covered under certain health plans on the day before coverage otherwise would end because the employment of the covered employee who enrolled the “AEIs” is terminated involuntarily (other than for gross misconduct).
 - Applies to employer-sponsored health plans subject to COBRA or similar state laws and to federal and state health plans.
- “AEI” is required to pay only 35% of amount “AEI” would otherwise be required to pay for COBRA coverage.

Examples

1. COBRA monthly premium is \$800

- Employer pays 0
- Employee pays \$280 (35% x \$800)
- Federal government pays \$520 (65% x \$800)

2. COBRA monthly premium is \$800

- Employer pays \$640 (80% x \$800)
- Employee pays \$ 56 (35% x (\$800-\$640))
- Federal government pays \$104 (65% x (\$800-\$640))

Maximum Period of Subsidy

The subsidy begins on the first period of COBRA coverage occurring on or after 2/17/09 (generally March 1, 2009) and ends on the earliest of:

1. 9 months thereafter,
2. when the COBRA coverage period would otherwise end (generally 18 months after the loss of group health coverage), and
3. when the individual becomes eligible for coverage under (a) another group health plan (*e.g.*, spouse's plan) or (b) Medicare (individual must notify the plan in writing if he becomes eligible under another plan or for Medicare).

Assistance Eligible Individual

An individual who is eligible for COBRA coverage as a result of an employee's involuntary termination of employment on or after 9/1/08 and before 1/1/10 and who elects COBRA coverage (when first offered or during the extended election period).

What is an Involuntary Termination of Employment?

- Layoff
- Employment termination “for cause”
- Constructive discharge
- Reduction in force
- Disability
- Death

Federal Subsidy Not Available to High Income Individuals

- Entire subsidy will be recaptured (by increased federal income tax in the amount of subsidy received) if the taxpayer's modified adjusted gross income is \$145,000 or more (\$290,000 for joint returns).
- If a taxpayer's modified adjusted gross income is between \$125,000 - \$145,000 (\$250,000 - \$290,000 for joint returns), a portion of the subsidy will be recaptured.

Example 1: COBRA premium that is ordinarily required to be paid by employee (a single taxpayer) is \$400, and the employee's modified AGI is \$130,000. Without the cap, the federal subsidy would be \$260.

The employer may charge the employee a COBRA premium no more than \$140. Under a statutory formula, 25% of the subsidy (\$65) will be recaptured.

Thus, the federal subsidy would only be \$195.

Example 2: Same facts as above, except the employee's modified AGI is \$142,000. 85% of the federal subsidy (\$221) will be recaptured.

Thus, the federal subsidy would only be \$39.

Individual May Waive Federal Subsidy

- Must notify employer of waiver
- Waiver is permanent

Must an AEI Elect the Same Health Coverage Option the “AEI” had on the Day Before the Qualifying Event?

- Yes, unless the employer decides to permit “AEIs” to enroll in other coverage options that are not more costly than the “AEI’s” existing coverage option.
- The other coverage options offered to “AEIs” must also be offered to active employees and may not be limited to only dental, vision, counseling, referral services, FSAs, or employer on-site medical facility providing primarily first-aid, prevention and wellness care.
- The “AEI” has 90 days after the date of receiving the notice to elect to switch coverage options (the period to elect COBRA is 60 days after receiving invoice).

What if a Qualified Beneficiary Receives the Subsidy But is Not Entitled to it?

- If not entitled to it because modified adjusted gross income is in excess of the cap:
 - the qualified beneficiary must repay the subsidy by means of his or her tax return for the year;
 - there is no penalty or interest amount.
- If not entitled to it because eligible under another plan or Medicare:
 - penalty equal to 110% of subsidy;
 - unclear how the penalty will be collected, but likely through the tax return.

What if a Qualified Beneficiary Would Like to be Treated as an “AEI” but is Denied?

- QB may request an expedited review of the denial by the U.S. Department of Labor.
- DOL must make a determination in within 15 business days.
- DOL is developing an appeals process and an application form.
- If the DOL denies the QB’s request, the QB has a right to file a lawsuit, but the DOL’s determination must be granted deference.

DOL Model Notices

DOL has published four model notices

1. General Notice (full version) for all individuals who were required to receive COBRA election notices on or after 9/1/2008 and before 1/1/2010 (even if employment not voluntarily terminated) AND who either have not yet been provided a COBRA election notice or were provided a COBRA election notice on or after 2/17/2009 that didn't include the ARRA information.
2. General Notice (abbreviated version) for those who had a qualifying event on or after 9/1/2008 and currently have COBRA coverage.
3. Alternative Notice – for those who became eligible for state law continuation coverage.
4. Extended Election Period Notice.

Who is Entitled to the Extended Election Period?

- ARRA provides that each individual who does not have a COBRA coverage election in effect on 2/17/09, but who would be an “AEI” if such an election were then in effect, has 60 days after receiving the required notice to elect COBRA coverage.
- Are other qualified beneficiaries who had a qualifying event on or after 9/1/08 now entitled to an extended COBRA election opportunity?
 - ◆ ARRA provides that the regular COBRA notification requirements are not treated as satisfied unless such QBs receive notice of the federal COBRA subsidy and any election for AEIs to receive a less costly coverage option.
 - ◆ DOL has stated that as a result, the end of the 60-day period for electing COBRA coverage will not occur until 60 days after such QBs receive the required notice.
- Must provide by 4/18/2009.

How Does an “AEI” Elect to be Treated as an “AEI”?

- The model notices include a form for “AEIs” to complete and return to the plan.
- The form, “Request for Treatment as an Assistance Eligible Individual” makes it clear that an individual cannot now be treated as an “AEI” if she was ever eligible for coverage under another group health plan on or after 2/17/2009 (even if on the date of the election she is no longer eligible for such coverage).

Effect of Election During Extended Election Period

Individual who elects COBRA coverage during the extended election period is entitled to COBRA coverage and the federal subsidy as of March 1, 2009.

- Not entitled to the federal subsidy before 3/1/09.
- Does not extend COBRA continuation period.

Example: "AEI" was involuntarily terminated on 9/20/08 and lost group health plan coverage as of 9/30/08.

The 18-month COBRA period expires on 3/31/10.

The federal subsidy is available through 11/31/09.

Who Receives the Reimbursement?

- Self-insured health plans – employer.
- Fully-insured health plans – employer.
- Fully-insured health plan subject to state continuation requirements – insurer.
- Multiemployer plans – the plan.

How Is the Subsidy Paid?

- Employer absorbs the amount of the federal subsidy until the employer can recoup the amount from its payroll taxes.
- Employer recoups the amounts “advanced” by subtracting such amounts from its payroll tax deposits or claims the amounts as an overpayment at the end of the quarter on Form 941. (revised to require the reporting of premium assistance payments made by the employer and number of individuals receiving assistance)
- Employer may not recoup the 65% subsidy from payroll taxes until the “AEI” pays the remaining 35%.

Must Any ARRA Required Notices be Delivered Before April 18, 2009?

Yes. ARRA General Notices are required to be given to all qualified beneficiaries with qualifying events after February 17, 2009 and before March 5, 2009 within the regular 44-day COBRA notice period.

Example: Qualifying event occurred on February 18, 2009. Notice period ends on April 3, 2009 (the 44th day after the qualifying event).

Action Items

- Contact your COBRA administrator to determine what responsibilities for the ARRA notices it will shoulder.
- Identify all qualified beneficiaries with qualifying events on or after 9/1/08 who did not receive COBRA election notices or who received a COBRA notice on or after February 17, 2009 that did not include ARRA information.
 - Send General Notice to all such qualified beneficiaries.
- Identify all former employees whose employment was involuntarily terminated on or after 9/1/08 and who do not have a COBRA election in effect on 2/17/09 and their related qualified beneficiaries.
 - Send Extended Election Period Notice to all such qualified beneficiaries.
 - Develop process to implement subsidy by May 1, 2009 and determine how to apply excess premiums paid in March and April.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Overview

- Background
 - CHIP provides health insurance coverage to low-income, uninsured children who do not qualify for Medicaid.
 - Each state has its own CHIP program jointly funded by both the state and the federal government.
- CHIPRA, enacted February 4, 2009
 - Reauthorizes CHIP through September 2013
 - Provisions affecting employer-sponsored health plans:
 - CHIPRA adds two new special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).
 - CHIPRA provides a premium assistance subsidy under an employer health plan for CHIP-eligible individuals provided that the employer pays at least 40% of the cost of plan coverage.

CHIPRA

Special Enrollment Rights

- Effective April 1, 2009, the following events trigger special enrollment rights under HIPAA for employees or dependents who are eligible for coverage but not currently enrolled:
 - 1) Termination of the employee's or dependent's Medicaid or CHIP coverage due to loss of eligibility.
 - 2) Employee or dependent becoming eligible for a premium assistance subsidy (as created by CHIPRA) for coverage under the employer's group health plan.
- The special enrollment election period for both of these events is 60 days
 - The 60-day period is measured from the date of termination of coverage or the date of eligibility for the premium subsidy.
 - This is longer than the 30-day election period that applies to other HIPAA special enrollment events (i.e., loss of group health plan coverage or acquiring a new dependent).

CHIPRA: Special Enrollment Rights Action Items

Beginning on April 1, 2009, group health plans (and related cafeteria plans) must permit special enrollment for the two new special enrollment events created by CHIPRA.

Action Items

- Modify plan procedures as necessary to comply.
- Review plan documents and summary plan descriptions for group health plans, as well as change in status rules under cafeteria plans, to determine if amendments are required.
- Any amendments should be effective as of April 1, 2009.

Note: Plans may not require amendments if they do not otherwise contain detailed special enrollment language (e.g., plans that may incorporate these rules by reference to HIPAA).

CHIPRA:

Special Enrollment Rights - Action Items

Special Enrollment Notice

- Background
 - Under HIPAA regulations, special enrollment notices must be provided to employees at or before the time an employee is initially eligible to enroll in the group health plan.
 - May be a stand-alone notice or may be included in the plan's summary plan description (provided it meets the timing requirement).
- Action Items
 - By April 1, 2009, plan sponsors should update special enrollment notices to include the two new special enrollment events created by CHIPRA.
 - The HIPAA regulations include a model special enrollment notice, but the DOL does not expect to update the model notice by April 1 to reflect the two new special enrollment events created by CHIPRA (although the DOL may update the model notice at some other date in the future).

CHIPRA

Premium Assistance Subsidy

- Effective April 1, 2009, states are permitted under CHIP to offer a premium assistance subsidy.
 - Available to low-income children (and, in some cases, their parents).
 - Subsidy covers the cost of coverage under employer-sponsored health plans.
 - Subsidy is available only if elected.
- Employer-sponsored health plans must meet the following requirements to qualify for the subsidy:
 - Employer contribution for such coverage must be at least 40%;
 - Coverage must be “creditable coverage”;
 - Coverage must be offered in a nondiscriminatory manner; and
 - Plan must not be a health flexible spending account or a high deductible health plan.
- Subsidy may be provided as a direct reimbursement to either the employer or the employee.
 - Employer may choose to opt-out of directly receiving the subsidy payment by notifying the state.

CHIPRA: Premium Assistance Subsidy Employer Obligation –Notice Requirement

- The statute requires employers to provide written notice to their employees describing the available subsidy opportunities.
 - An employer is required to provide this notice if it maintains a group health plan in a state where a premium assistance subsidy is offered.
- The Department of Labor and Department of Health and Human Services are directed to develop model notices by February 4, 2010.
- Notice requirement is effective beginning first plan year after the model notices are issued.

CMS Reporting Requirements

General Overview

- Medicare, Medicaid and SCHIP Extension Act of 2007:
 - Added mandatory reporting requirements for group health plans.
 - Purpose: to provide the Centers for Medicare & Medicaid Services (CMS) with information needed to coordinate benefits with Medicare.
- Mandatory reporting requirement generally applies to third-party administrators and insurance companies.
- Plan sponsors of group health plans will not have reporting obligations (unless the plan is self-insured and self-administered).
- “Group health plan” includes health reimbursement arrangements, but does not include stand-alone dental or vision plans or health care flexible spending accounts.

CMS Reporting Requirements Required Data

- Information is required for “active covered individuals” for whom Medicare will be secondary payer:
 - For 2009, generally individuals who are: above age 55; under age 55 but known to be entitled to Medicare; on kidney dialysis; or recipients of a kidney transplant.
 - On January 1, 2011, age 55 is lowered to age 45.
- Key required data : Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN)
 - Effective 1/1/09, must report HICN or SSN for participants who are (i) current employees or (ii) covered dependents who enroll on or after 1/1/09.
 - Effective 1/1/11, must report HICN or SSN for covered dependents who were enrolled before 1/1/09.
- CMS has specified a list of other required data
 - Includes (but not limited to): name, date of birth, gender, effective date of coverage, and type of coverage for each “active covered individual”; employer name and size; and policy number.
 - Third party administrators and insurers will already have some of the required information in their records.

CMS Reporting Requirements Action Items for Plan Sponsors

- Plan sponsor action items:
 - Discuss with third-party administrator or insurance company what additional information is needed.
 - Collect required data for current participants and for future participants on an on-going basis.
- Potential issue: no social security number (e.g., a child dependent without a SSN).

Claims Procedures

- ERISA § 503 requires every employee benefit plan to have a claims procedure.
- The Department of Labor has issued regulations to explain the operation of internal claims procedures. 29 C.F.R. § 2560.503-1.

Special Rules for Health and Disability Plans

- The claims procedure of a group health or disability plan will be reasonable only if:
 - There are no more than two levels of required appeals after a plan's adverse benefit determination.
 - If a plan establishes additional, voluntary levels of appeals:
 - It may not assert that the claimant has failed to exhaust administrative remedies if the claimant chooses not to pursue the voluntary appeal,
 - The plan must agree to toll the statute of limitations during the voluntary appeal,
 - The plan must provide a statement that the decision to pursue a voluntary appeal will have no effect on the claimant's rights to any other benefits under the plan.
 - The claims procedure may not require mandatory arbitration unless it is conducted as one of the two levels of appeals and the claimant is not prohibited from later challenging the decision. 29 C.F.R. § 2560.503-1(c)-(d).

Special Rules for Health and Disability Plans (cont.)

- Group Health Plans

- Must notify the claimant of the plan's adverse benefit determination within 72 hours after receipt of an urgent care claim, within 15 days after receipt of a pre-service claim and within 30 days after receipt of a post-service claim. 29 C.F.R. § 2560.503-1(f)(2).
- Must notify the claimant of the plan's appeal decision within 72 hours after receipt of an urgent care request for review, within 30 days of after receipt of an pre-service request for review, and within 60 days after receipt of a post-service request for review. 29 C.F.R. § 2650.503(i)(2).
- Must notify the claimant of the plan's adverse benefit determination within 45 days after receipt of the claim. 29 C.F.R. § 2560.503-1(f)(3).
- Must notify the claimant of the plan's appeal decision within 45 days after receipt of a request for review. 29 C.F.R. § 2650.503-1(i)(3).

The Next Step: Litigation

- What can be done to limit litigation?
 - Exhaustion of Claims Procedure Requirement
 - Contractual Statute of Limitations
 - Exclusive Jurisdiction

Exhaustion of Remedies: General Rules

- Recent cases generally have held that when a participant has notice of a claims procedure, the participant must exhaust that procedure before filing a claim in court.
- This is generally true even when the language describing the procedure does not indicate that the administrative process is mandatory. *E.g.*, *Wert v. Liberty Life Assurance Co.*, 447 F. 3d 1060 (8th Cir. 2006); *Greifenberger v. Hartford Life Ins. Policy*, 131 Fed. Appx. 756 (2nd Cir. 2005).
- The claims procedure does not have to be in the plan document or the summary plan description, but can be included in a letter initially denying participants' benefits. *E.g.*, *Wert v. Liberty Life Assurance Co.*, 447 F. 3d 1060 (8th Cir. 2006); *Spivey v. Southern Co.*, 427 F. Supp. 2d 1144 (N.D. Ga. 2006).

Exhaustion of Remedies: General Rules (cont.)

- However, at least one circuit implied that a plan must make it clear that exhausting the claims procedure is a prerequisite to the right to sue. The Seventh Circuit has held that a plan can be estopped from asserting an exhaustion defense if its documents mislead participants about the effect of foregoing administrative review and the claimant reasonably relies on them to his or her detriment. *Gallegos v. Mount Sinai Medical Center*, 210 F.3d 803 (7th Cir. 2000).
- *Lauth v. Prudential Insurance Co.*, 2006 WL 1302355 (N.D. Ill. 2006)
 - A plan had three allowable levels of appeal. Two were mandatory before a claimant could file an ERISA suit, and a third was voluntary. The language of the plan made it clear that filing a third appeal would not affect a claimant's right to sue under ERISA, but did not state that the first two appeals were mandatory.
 - The court believed this language failed to clearly explain that a claimant who fails to file the first two appeals may not file a suit under ERISA and precluded the defendant from asserting the exhaustion defense. The court believed that the plan language was misleading, and that the plaintiff had relied on those misleading statements to his detriment.

What Standard of Review Will a Court Use to Examine a Denial of Benefits?

- An administrator's decision will be reviewed *de novo*, unless the plan clearly grants the administrator discretionary authority, in which case the administrator's decision will be subject to an arbitrary and capricious standard of review. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101(1989).
- Even when there is a clear delegation of authority, the recent *Glenn* decision requires courts to consider whether an administrator's conflict of interest as both the administrator and payor was a factor in his decision. *MetLife v. Glenn*, 129 S.Ct. 2343 (2008).
- Cases applying *Glenn* have made it clear that *Glenn* does not establish a heightened arbitrary and capricious standard of review, or create any special burden-of-proof rules, but requires courts to consider the conflict of interest as one factor in determining whether there has been an abuse of discretion. *Carden v. Aetna Life Ins. Co.*, 2009 WL 635419 (4th Cir. 2009); *Leger v. Tribune Co. Long Term Disability Benefit Plan*, 2009 WL 579246 (7th Cir. 2009); *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2nd Cir. 2008).

Limitations Period: Contractual Statute of Limitations

- ERISA contains no applicable limitations period, so courts look to applicable state law.
- Typically, courts will apply the statute of limitations for contract claims, which can be as long as ten years.
- Because welfare plans generally are treated as contract claims not subject to ERISA statutory protection, there is no reason not to include a “reasonable” limitation period in the plan.

When Does the Limitations Period Begin?

- There are two approaches:
 - Some plans provide that the limitations period begins to run as soon as the participant is required to file a proof of loss (e.g., if a plan requires proof of loss 60 days from injury, the limitations period will begin on the 60th day).
 - Others provide that the limitations period begins after the claimant has exhausted the claims procedure and the plan has issued its final appeal.

When Does the Limitations Period Begin? (cont.)

- Courts disagree about when limitations periods begin, and many are hesitant to enforce limitations periods that begin on the day the plan requires a proof of loss.
- Some courts have refused to consider a limitations period, regardless of the plan's language, until the plan has officially denied the claim and the claimant has exhausted the appeals procedure. Many courts fear that a plan will delay the internal claims procedure in order to prevent the claimant from bringing a timely ERISA suit. *White v. Sun Life Ins. Co.*, 488 F.3d 240 (4th Cir. 2007).
- This makes the application of a plan-specified statute of Limitations period uncertain.
- A limitations period that does not begin until after the plan has issued its final appeal is easier to measure, and is more likely to be enforced.

What is a “Reasonable” Limitations Period?

- Courts frequently uphold three-year limitations periods, even when the limitations period begins on the day the plan requires a proof of loss. *E.g.*, *Abena v. Metropolitan Life Ins. Co.*, 544 F. 3d 880 (7th Cir. 2008); *Burke v. PriceWaterhouseCoopers LLP*, 537 F. Supp. 2d 546 (S.D.N.Y. 2008).
- Courts have upheld limitation periods as short as 45 days, comparing the limitations period to the 30 or 60 days a party generally has to file an appeal in federal court. *Davidson v. Wal-Mart Associates Health & Welfare Plan*, 305 F. Supp. 2d 1059 (S.D. Iowa 2004). Courts are only willing to uphold these shorter limitations periods, however, when the plan provides that the limitations period does not begin until the claimant has exhausted all of his administrative appeals.

Exclusive Jurisdiction

- Courts almost universally uphold forum selection clauses.
 - *E.g., Sneed v. Wellmark Blue Cross & Blue Shield*, 2008 WL1929985 (E.D. Tenn. 2008) (stating that nearly all courts will uphold such provisions in ERISA cases); *Gipson v. Wells Fargo & Co.*, 563 F. Supp. 2d 149 (D.D.C. 2008) (holding that the threshold for invalidating forum selection clauses is high); *Klotz v. Xerox Corp.*, 519 F. Supp. 2d 430 (S.D.N.Y. 2007) (noting that almost every district court upholds forum selection clauses).
- These types of clauses have many benefits:
 - Plans can avoid “plaintiff-friendly” jurisdictions.
 - Provides for consistent judicial interpretation.
 - Convenient for plan administration.

Definition of Spouse

Legal Overview

- Federal Law -- Federal Defense of Marriage Act (DOMA) defines:
 - “Marriage” as a legal union between one man and one woman as husband and wife.
 - “Spouse” as a person of the opposite sex who is a husband or a wife.
- State Law
 - Massachusetts and Connecticut permit same-sex marriage (court cases also pending in California and Iowa and legislation pending in various states).
 - Some states grant status to same-sex partners equal to that of spouses (i.e., registered domestic partners, civil union partners).

Definition of Spouse

Implications for Welfare Plans

- An individual who is not a “spouse” under DOMA will not be a “spouse” for purposes of federal laws (i.e., HIPAA, COBRA, FMLA).
- All welfare benefits for a partner who is not a spouse within the meaning of DOMA will receive after-tax treatment for federal tax purposes, unless the partner qualifies as a tax “dependent” under Code § 152.
- States may require fully insured plans to give certain same-sex partners treatment equal to that of opposite-sex spouses (including benefit coverage and state taxation).

Definition of Spouse

Action Items For Employers

- Determine company's policy regarding benefits for same-sex partners.
- Review definition of spouse under welfare plans and SPDs to ensure:
 - 1) Intent to cover, or exclude, same-sex spouses and partners is clearly and accurately stated.
 - 2) Tax treatment is properly explained.
 - 3) Insurance policies (if any) are aligned with employer's policy and plan documents.

LYNN M. FEDER

Contract Counsel

Chicago
312/853-7697
312.853.7036 Fax
lfeder@sidley.com



PRACTICES

- Employee Benefits

AREAS OF FOCUS

ADMISSIONS & CERTIFICATIONS

- Illinois, 1998
- Wisconsin, 2003

EDUCATION

- The University of Chicago Law School (J.D., 1998, with honors)
- University of Illinois (B.S., 1991, highest honors)

LYNN M. FEDER is a counsel in Sidley's Chicago office and practices in the Employee Benefits group. She represents clients in connection with the establishment and administration of tax-qualified retirement plans, welfare plans, fringe benefits, cafeteria plans and non-tax qualified compensation arrangements. She regularly represents and advises clients regarding various compliance, administrative and design issues for their welfare benefit plan arrangements.

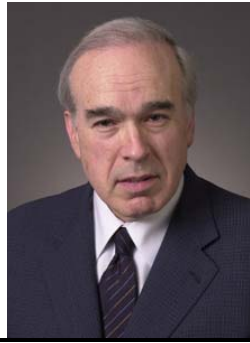
MEMBERSHIPS & AFFILIATIONS

- Certified Public Accountant in State of Illinois
- American Bar Association
- Wisconsin Bar Association

ROBERT A. FERENCZ

Partner

Chicago
312/853-7682
312.853.7036 Fax
rferencz@sidley.com



PRACTICES

- Employee Benefits
- ERISA Litigation
- Executive Compensation

ADMISSIONS & CERTIFICATIONS

- Illinois, 1973

EDUCATION

- The University of Michigan Law School (J.D., 1973, *magna cum laude*, Order of the Coif, Associate Editor, *Michigan Law Review*)
- University of Illinois (B.S., 1968)

ROBERT A. FERENCZ is a partner in Sidley's Chicago office who focuses on employee benefits, executive compensation, federal income tax and related matters. He is responsible for supervising the firm's nationwide employee benefits practice. He is a Certified Public Accountant in the State of Illinois.

MEMBERSHIPS & AFFILIATIONS

- American Bar Association
- Chicago Bar Association
- Member, Employee Benefits Committee of the Section of Taxation, American Bar Association
- Past Chairman, Employee Benefits Committee, Chicago Bar Association

PRISCILLA E. RYAN

Partner

Chicago
312/853-7072
312.853.7036 Fax
pryan@sidley.com



PRACTICES

- Employee Benefits
- ERISA Litigation
- Executive Compensation

AREAS OF FOCUS

- 401(k) Class Actions
- Administrative Claims
- Bankruptcy Issues Involving Pension and Welfare Plans
- Cash Balance Plan Class Action Litigation
- Department of Labor Investigations
- ERISA Appellate Litigation
- Fiduciary Counsel
- Labor, Employment and Employee Benefits Appeals
- Plan Document Counseling
- Retiree Health and Welfare Benefits

ADMISSIONS & CERTIFICATIONS

- U.S. Tax Court, 1985
- U.S. Court of Appeals, 7th Circuit, 2006
- U.S. District Court, N.D. of Illinois - General, 1982
- Illinois, 1982

EDUCATION

- Loyola University Chicago School of Law (J.D., 1982)
- Marquette University (A.B., 1969)

PRISCILLA E. RYAN is a partner whose practice is concentrated in employee benefits matters. Ms. Ryan represents large multi-national corporations and domestic corporations with multi-state operations on issues related to the design, implementation and administration of retirement plans, health plans, fringe benefits, equity-based compensation, deferred compensation and executive compensation. Ms. Ryan also regularly advises clients on ERISA fiduciary rules and has trained plan committees on their fiduciary responsibilities under ERISA. One aspect of her practice involves providing litigation support in ERISA class action lawsuits. Ms. Ryan has represented clients on a variety of matters before the Treasury Department, the Internal Revenue Service, the Department of Labor and the Pension Benefit Guaranty Corporation. Ms. Ryan is a co-chair of the firm's insurance committee, which is responsible for the administration of all the firm's insurance policies (other than malpractice insurance), including health and disability policies, as well as other employee welfare benefits.

Ms. Ryan is recognized as a leading lawyer, receiving the number one ranking in the 2009, 2008, 2007 and 2006 editions of *Chambers USA: America's Leading Lawyers for Business*. During 1988 and 1989, Ms. Ryan served as an attorney-advisor in the Office of Tax Policy of the U.S. Treasury Department.

Ms. Ryan has lectured on numerous employee benefit topics and has authored articles appearing in various tax and employee benefit periodicals, has been a member of the faculty of numerous professional seminars, including the annual Employee Benefits in Mergers & Acquisitions National Institute held each spring in New York City.

MEMBERSHIPS & AFFILIATIONS

- American Bar Association, Taxation Section
- Director, the ABA Tax Section's governing council

- Fellow of the American College of Employee Benefits Counsel
- Past Chair of the American Bar Association Tax Section's Employee Benefits Committee
- Past Chair of the ABA Joint Committee on Employee Benefits
- IRS Great Lakes Area Tax Exempt and Government Entities (TE/GE) Council
- International Pension and Employee Benefits Lawyers Association

STEWART R. SHEPHERD

Partner

Chicago
312/853-2654
312.853.7036 Fax
sshepherd@sidley.com



PRACTICES

- Employee Benefits
- Executive Compensation
- M&A and Private Equity

ADMISSIONS & CERTIFICATIONS

- California, 1973
- Illinois, 1976

EDUCATION

- The University of Chicago Law School
(J.D., 1973, with honors, Order of the Coif)
- Rockford College
(B.A., 1970, *magna cum laude*, Phi Beta Kappa)

STEWART R. SHEPHERD is a partner in the employee benefits and executive compensation practices in the Chicago office. Mr. Shepherd regularly advises clients regarding the fiduciary duty and prohibited transaction provisions of ERISA, including the structuring of administrative and investment committees of 401(k) and other retirement plans and the establishment of “best practices” procedures for plan fiduciaries. Mr. Shepherd also regularly advises clients regarding the employee benefits and executive compensation aspects of corporate mergers, acquisitions and restructurings.

Mr. Shepherd has practiced in the employee benefits area for over 30 years, concentrating on the employee benefits and executive compensation matters of large employers. Mr. Shepherd has extensive experience representing clients in disputes and negotiations with the Internal Revenue Service, Department of Labor and Pension Benefit Guaranty Corporation and in litigation under ERISA.

Mr. Shepherd is a published author and frequent speaker on employee benefits and executive compensation topics and is listed in *Chambers USA* in the Labor & Employment: Benefits & Compensation specialty.

MEMBERSHIPS & AFFILIATIONS

- Employee Benefits Committee of the American Bar Association Section of Taxation