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Editor's Overview

This month's article by Lindsey Chopin discusses Affordable Care Act ("ACA") litigation. Just five years old, the Supreme Court has considered issues related to the ACA numerous times. Two of those decisions addressed challenges to the constitutionality of the Act, and one addressed the viability of the ACA's contraception mandate as applied to certain religious employers. There also have been numerous lower court decisions addressing the ACA's impact including its impact on retiree health benefits and the mental health parity act.

As always, be sure to review the section on Rulings, Filings, and Settlements of Interest including: the Supreme Court's decisions on same-sex marriage and the implications for employee benefit plan sponsors; the Supreme Court's decision in *King v. Burwell*; the Supreme Court's denial of review in a loss causation case; and other notable cases addressing issues related to venue selection provisions; union retiree health benefits; and information on the proposed claw-back requirements under the Dodd-Frank Act.

The Affordable Care Act Litigation Five Years Later*

By Lindsey H. Chopin

When the Patient Protection and Affordable Care Act ("ACA" or the "Act") was signed into law on March 23, 2010, the first lawsuit challenging it was filed within minutes. Five years later, ACA litigation still rages on. The U.S. Supreme Court itself has considered issues directly impacting the Act four times. These cases have spanned across a wide variety of issues including Congress's authority to enact the ACA, the viability of the Act's contraceptive mandate as applied to certain religious employers, and the availability of premium assistance for individuals who purchase coverage through a federal insurance exchange. In addition, circuit and district courts are frequently being asked to rule on ACA related issues. Though the cases being litigated in the lower courts vary greatly in their substance, a few notable areas of litigation include the ACA's applicability to retiree-only benefit plans, ERISA interference with benefit claims arising from workforce realignment, and an increase in claims asserted under the Federal Mental Health Parity and Addiction Equity Act (the "Federal Parity Act").

SCOTUS Review of the ACA

Congressional Authority to Enact the ACA

The first (and likely best known) challenge to the ACA was lodged by twenty-six states, among others, who argued that Congress exceeded its authority by establishing: (i) the individual mandate, *i.e.*, the Act's provision imposing a penalty on individuals who fail to purchase health insurance, and (ii) the Medicaid expansion provisions, *i.e.*, the Act's requirement that states to expand Medicaid eligibility from those falling under the poverty line to those falling under 133% of the poverty line at the risk of losing federal Medicaid funding. On June 28, 2012, the Court upheld the individual mandate as constitutional on the ground that it is within Congress' authority under the Tax and Spend Clause. The Court, however, held that the Act's Medicaid eligibility expansion provisions were unconstitutional because the government cannot coerce states to expand Medicaid by threatening to withhold existing federal Medicaid funds.[1]

Religious Freedom Restoration Act

In 2014, the Court reviewed two of the numerous lawsuits challenging the ACA's requirement that group health plans and insurers cover, without cost-sharing, contraceptives and/or abortifacients. In a 5-4 decision, the Court determined that the federal government, acting through Health and Human Services (HHS), overstepped its bounds by requiring faith-based private, for-profit employers to pay for certain forms of birth control that those employers argued contradicted their religious beliefs in violation of the Religious Freedom Restoration Act of 1993 ("RFRA").[2] The majority held that the law imposed a substantial burden on religious beliefs, requiring the owners of Hobby Lobby to engage in conduct that "seriously violates their [sincere] religious beliefs." The Court stated that, even assuming that the government does have a compelling interest to, among other things, promote "public health" and "gender equality" by providing contraceptive coverage for women, there were less restrictive alternatives for the government.

In the same week as the *Hobby Lobby* decision, the Court issued an injunction that allowed Wheaton College to challenge the process by which a religious organization applies for an accommodation to the ACA based on religious beliefs and at the same time only inform HHS in writing that "it is a nonprofit organization that holds itself out as religious and has religious objections to providing coverage for contraceptive services." [3] Wheaton College argued that the act of applying itself impermissibly burdens its exercise of religion. The process entails completing a form, certifying the corporation as an "eligible organization," and sending copies to health insurance providers who would then exclude contraceptive coverage from that corporation's plan and provide separate payments to plan participants without any cost to the employer. The issue is currently pending before the Seventh Circuit.

Tax Subsidy Litigation

Most recently, the Court ruled on June 25, 2015 that premium assistance is available for individuals enrolling in federally-established Marketplaces and not just to those who enroll in state-established Marketplaces.[4] This dispute arose because the relevant provision in the ACA states that the amount of premium assistance one receives is based on the premium paid by a taxpayer enrolled through a "[Marketplace] established by the State." Based on this language, some courts held that the absence of plain language in the ACA authorizing subsidies to individuals covered on federal exchanges meant no subsidies were available. In other cases, courts held that while there is no ACA language that explicitly authorizes the subsidies, the "context" of the statute permitted subsidies in federal Marketplaces. The Court's decision was highly anticipated because, a ruling that the IRS had exceeded its authority by authorizing subsidies in federal Marketplaces, would be disastrous for the ACA and the millions of lower paid people who are currently receiving subsidies under federal exchanges. It also would have meant that pay-or-play penalties, which are triggered only if subsidies are received by full-time employees, would not apply with respect to individuals residing in the 36 states that have federal rather than state-run Marketplaces.

The Supreme Court ruled in favor of the federal government and determined that the ACA's language is ambiguous and that its overall statutory scheme indicated that premium assistance is not limited to individuals purchasing coverage on state-run Marketplaces. The Court determined that a statutory interpretation that premium assistance is available only to individuals purchasing coverage on state-run Marketplaces would effectively eliminate two of the ACA's three major reforms (*i.e.*, tax credits and the coverage mandate) in states with federally-run Marketplaces. Without those market reforms, the insurance market in states with federally-run Marketplaces would face "death spirals," particularly where insurance companies continued to be subject to guaranteed issue and community rating requirements. That result, the Court decided, could not have been the intent of Congress.

Additional and Novel Issues Arising from the ACA

Retiree Health Benefits

An issue has arisen concerning whether the ACA applies to "retiree only" only welfare plans. ERISA § 732(a)(1), a pre-ACA provision, provides that group health plans having "less than two participants who are current employees" on the first day of a given plan year are exempt from all of the group health plan requirements of ERISA (except for the standards relating to benefits for mothers and newborns present in ERISA § 711). Because retiree only plans have less than two current employees, they have traditionally been exempt from ERISA's group health plan requirements under this provision.

A federal district court in California recently considered the impact of the ACA on this provision. In *King v. Blue Cross Blue Shield of Illinois*, the plaintiff (the spouse of a retired employee and participant in the plan) challenged a plan amendment that set a $500,000 lifetime benefit maximum. Plaintiff argued that the amendment violated the ACA and the Public Health Service Act (PSHA). In support, she pointed to the fact that the ACA amended the PSHA to ban lifetime benefit maximums in group health plans. The ACA also amended ERISA to state that various provisions, including the lifetime benefit maximum ban, apply to group health plans.

The district court disagreed and held that the ACA's lifetime coverage limit ban does not repeal by implication the general exception to the requirements for small or retiree-only group health plans present in ERISA. Therefore, plaintiff's plan, which covered only retirees and thus had no active employee participants, qualified as a small plan under ERISA § 732(a) and was exempt from the group plan requirements imposed by the ACA. The decision is currently on appeal to the Ninth Circuit.[5]

Workforce Realignment

In response to the ACA's employer mandate, sometimes known as the "pay or play" mandate, some employers may consider reorganizing their workforce to avoid ACA's reach. For example, employers may reduce employees' hours to below 30 hours per week to avoid having "full-time" employees under ACA or to lessen their penalties. However, ERISA Section 510 makes it unlawful for any person to discriminate against a participant or beneficiary by interfering with the attainment of any right to which such participant may become entitled under" the Plan or ERISA.

Litigation under Section 510 has already arisen in the Southern District of New York based on allegations such workforce realignment.[6] In *Marin*, the plaintiff filed a class action complaint under ERISA § 510 on behalf of approximately 10,000 current and former Dave & Busters employees. The plaintiff alleges that the defendant "engaged in a nationwide effort to 'right size' the number of full-time employees, thus permitting Defendant to avoid the costs associated with the ACA." Specifically, the Complaint alleges that Dave & Busters' plan required its workers to average at least 28 hours per week to be classified as a full-time employee and to be eligible for coverage. Plaintiff alleges that Dave & Busters reduced the number of working hours to reduce the number of full-time employees and cause its employees to lose eligibility under the plan. Plaintiff is seeking reinstatement to full-time employee status, restoration of the right to participate in the plan, lost wages and benefits, restitution of the costs of health insurance secured to replace the coverage lost, and attorney's fees and costs for all 10,000 putative class members.

Federal Mental Health Parity and Addiction Equity Act

The Federal Mental Health Parity and Addiction Equity Act (the "Federal Parity Act"), which is enforced through ERISA, like many similar state parity laws, mandates that financial requirements (*e.g.*, copayments, coinsurance, or deductibles) and treatment limitations (*e.g.*, limitations on the frequency of treatment, number of outpatient visits, or amount of days covered for inpatient stays) applicable to mental health benefits generally can be no more restrictive than the requirements and limitations applied to non-mental health medical benefits. The reach of the Federal Parity Act was expanded with the passage of the ACA because, though it already applied to large employer plans, beginning in 2014, it applies to small group and individual market plans created after March 23, 2010. This expansion may give rise to an increase in litigation under the Federal Parity Act.

Indeed, parity has been at issue in an increasing number of cases.

- The mother of a five-year-old child diagnosed with autism spectrum disorder recently filed a class action complaint after her son was denied coverage for applied behavioral analysis treatment.[7] She filed on behalf of all those enrolled in ERISA-governed plans for which a Blue Cross entity was granted authority to make coverage decisions and have been denied coverage for such treatments. Plaintiff claims that Defendants violated ERISA, and both the federal and state parity laws,

by denying coverage for mental health care in accordance with generally accepted medical guidelines, similarly to how medical and surgical coverage is offered.

- A district court denied a motion to dismiss and ruled that plaintiffs could proceed with their putative class action complaint claiming that the plan administrator breached its fiduciary duty by developing and applying treatment standards that were allegedly more rigorous than generally accepted standards of care in the mental health community.[8] At issue in this case is the coverage for mental illness and substance abuse-related out-patient treatment.

- In two federal court cases filed in Washington, the courts approved class settlements providing for prospective modifications for coverage of mental health treatments and multi-million dollar settlement funds to reimburse class members for denied treatments.[9] At issue in those cases, were claims that defendants improperly denied coverage for treatment of applied behavioral analysis and neurodevelopmental therapy for children diagnosed with autism spectrum disorder.

- A federal district court in California declined to certify a class of plaintiffs who were denied coverage for residential treatment services for severe mental health conditions. The court determined that the putative class was far too broad in that it sought to cover "every participant/beneficiary in a Blue Shield ERISA plan who was denied coverage, based on a policy exclusion, for any form of 'residential treatment' for any form of mental illness or behavioral disorder."[10] Because such putative class members varied so widely, class treatment was not proper.

View From Proskauer

Despite an onslaught of challenges from day one, the ACA remains largely intact. Indeed, large scale attacks on the Act as a whole—such as those lodged in *NFIB v. Sebelius* and *King v. Burwell* have been unsuccessful. Despite this overall resilience, courts have not hesitated to find and apply tailored exemptions to the act, such as the religious exemptions for faith-based private, for-profit employers or the *King* court's finding that the ACA does not apply to retiree only health plans. Given the even-handed approach being taken to such litigation, it is uncertain what the future will bring. However, now that the initial challenges to overall validity of the ACA are winding down, novel challenges, such as the Section 510 claim in *Marin*, and renewed vitality of existing laws, such as the Federal Parity Act, may remain the norm as the ACA continues to affect employers, insurers, providers, and individuals nationwide.

Rulings, Filings, and Settlements of Interest

The U.S. Supreme Court Finds a Constitutional Right to Same-Sex Marriage: Implications for Employee Benefit Plan Sponsors

By Roberta Chevlowe

- On June 26, 2015, the U.S. Supreme Court issued a historic decision in Obergefell v. Hodges, holding that the Fourteenth Amendment's Due Process and Equal Protection Clauses require states to allow same-sex marriage and to recognize same-sex marriages performed in other states. The decision comes exactly two years to the day from the Court's decision in Windsor defining "spouse" to include same-sex spouses for purposes of federal law.

  As a result of the Court's decision, the existing 14 state bans on same-sex marriage are invalid, and same-sex spouses are entitled to all of the rights extended to opposite-sex spouses under both federal and state law.

  From an employee benefits perspective, it appears that Obergefell may most significantly impact sponsors of insured health and welfare plans in states that currently ban same-sex marriage. Employers and other plan sponsors in those states will be required to offer insured benefits to same-sex spouses because state insurance law will require that the term "spouse" be interpreted to include them. Based on government guidance issued following the Windsor decision, it seems unlikely that the decision would have retroactive effect, though such claims are possible.

  For sponsors of self-insured benefit plans, a question may exist as to whether Obergefell directly impacts a sponsor's decision not to provide health coverage to same-sex spouses (because state law does not apply to such plans). However, it would appear that there would be heightened risks under federal and state discrimination laws for plans that define "spouse" in a manner that is inconsistent with the federal and state definitions, particularly since the Court held that marriage is a fundamental right under the Constitution, and an ERISA preemption defense likely would be weaker in this new climate.

  It is also noteworthy that, as a result of the Court's decision, there will no longer be imputed income for state tax purposes with respect to employer-provided health coverage for same-sex spouses, allowing for consistent administration in all states in which an employer operates. Since Windsor, there have not been federal tax consequences with respect to these benefits, but some states continued to impute

income for state tax purposes.

Finally, with respect to federally-regulated benefits such as qualified retirement plans and Code Section 125 benefits (for example, flexible spending accounts), the Court's decision does not necessarily warrant any change, since those plans have been required, since Windsor, to recognize same-sex spouses. Of course, plan language should be reviewed for consistency with the decision, and employers in some states may find that there are new spouses seeking benefits under those plans. There also will be some administrative and enrollment issues, similar to when Windsor was decided.

Employers, particularly those operating in states that currently ban same-sex marriage, should review their benefit plans and policies and consider whether any changes need to be made in light of Obergefell. Some employers may also reconsider their domestic partner benefits programs now that same-sex couples have the right to marry and have their marriage recognized across the entire country.

We expect that there will be guidance from the U.S. Department of Labor and the Internal Revenue Service regarding the employee benefit plan issues that emanate from Obergefell, so stay tuned.

***King v. Burwell* – Supreme Court Upholds Premium Subsidies under Federally-Run Marketplaces; ACA Remains (Mostly) Unfazed**

By Paul M. Hamburger, Robert Projansky and Damian A. Myers

- On June 25, 2015, the United States Supreme Court released its much anticipated *King v. Burwell* decision regarding the validity of premium assistance issued by Federally-run Marketplaces. Chief Justice Roberts, writing for the 6-3 majority, agreed with the Internal Revenue Service's (IRS) interpretation that premium assistance under the Patient Protection and Affordable Care Act of 2010 (the "ACA") is available to individuals who purchase coverage on both State-run and Federally-run Marketplaces. With the Supreme Court's King ruling, the provisions of the ACA have prevailed in two of four key challenges (the Court upheld the individual mandate, but rejected a requirement that states expand Medicaid, in *National Federation of Independent Business v. Sebelius* and rejected the contraceptive mandate in *Burwell v. Hobby Lobby Stores, Inc.*).

  The primary issue in King was whether the statutory language of the ACA authorized the IRS's interpretation that premium assistance is available to individuals who purchased insurance coverage through Federally-run Marketplaces.

The ACA added Section 36B to the Internal Revenue Code (the "Code"), which provides that the amount of premium assistance is based on the premium paid by a taxpayer enrolled through a "[Marketplace] established by the State under Section 1311" of the ACA. Section 1311 of the ACA provides that States must establish a Marketplace, but if no Marketplace is established by the deadline (January 1, 2014), Section 1321 of the ACA requires the Department of Health and Human Services (HHS) to establish "such [Marketplace]" within the State.

The petitioners (those challenging the IRS's interpretation) argued that Code Section 36B is unambiguous, stating that to receive premium assistance, an individual must enroll in a Marketplace established by the State and the IRS had no authority to interpret the statute otherwise. The respondents (the IRS, HHS and Department of Labor) also argued that the language of the ACA is unambiguous while coming to the opposite conclusion – based on Section 1321 and other sections of the ACA, a Marketplace established by a State includes a Marketplace established by the Federal government due to the State's failure or decision not to establish its own. The district court dismissed the petitioners' action holding that the language in Code Section 36B unambiguously made premium assistance available to individuals purchasing coverage on any Marketplace. Affirming the district court, the Fourth Circuit held that the language was ambiguous, but judicial deference to the IRS's interpretation of the language was required under Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

The Supreme Court ruled in favor of the Federal government, holding that although the language in Code Section 36B is ambiguous, the ACA's overall statutory scheme and the structure of Code Section 36B itself indicate that premium assistance is not limited to individuals purchasing coverage on State-run Marketplaces. In reaching its decision, the Court rejected the framework under Chevron because the availability of premium assistance in states with Federally-run Marketplaces presented an issue of such "deep economic and political significance" that Congress would not have delegated to regulators.

Instead, the Court conducted its own analysis and determined that a statutory interpretation that premium assistance is available only to individuals purchasing coverage on State-run Marketplaces would effectively eliminate two of the ACA's three major reforms (i.e., tax credits and the coverage mandate) in states with Federally-run Marketplaces. Without those market reforms, the insurance market in states with Federally-run Marketplaces would face "death spirals," particularly where insurance companies continued to be subject to guaranteed issue and community rating requirements. That result, the Court decided, could not have been the intent of Congress. Therefore, the Court affirmed the Fourth Circuit, albeit

on different grounds, and interpreted Code Section 36B as applying to both State-run and Federally-run Marketplaces.

The King decision is significant in the sense that, absent further state or Congressional action, a decision in favor of the petitioners could have significantly impacted the insurance marketplace, subsidies and the individual and employer mandates in the affected states. However, standing alone, the implications on ACA implementation are minimal. For the time being, ACA implementation will move forward, individuals meeting income requirements throughout the country will remain eligible for premium assistance and employers will remain subject to the employer mandate.

Supreme Court Denies Review of Fourth Circuit Loss Causation Case

By Lindsey Chopin

- The U.S. Supreme Court recently declined to grant *certiorari* to review the Fourth Circuit's decision in *RJR Pension Investment, et al. v. Tatum*, 761 F.3d 363 (4th Cir. 2014). As we previously reported here, a divided panel of the Fourth Circuit held that, because the plaintiff proved that the plan fiduciaries acted imprudently by liquidating the stock fund without the benefit of a proper investigation, the burden of proof shifted to defendants to show that a prudent fiduciary *would* have made the same decision. In so ruling, the Court reversed the lower court decision, which had found in favor of defendants because they demonstrated that a prudent fiduciary *could* have made the same decision. Defendants asked the Supreme Court to review: (1) whether the Fourth Circuit properly concluded that the burden of proving loss causation shifts to defendants upon a showing a imprudence, and (2) if the burden does shift, whether an ERISA fiduciary can be held liable despite a finding that the challenged investment decision was ultimately objectively prudent, *i.e.* that a prudent fiduciary could have made the same decision. The Court's order denying *certiorari* may be found at *RJR Pension Investment, et al. v. Tatum*, No. 14-656, 2015 WL 2473481 (Jun. 29, 2015).

SCOTUS Invites Solicitor General to Submit Its View on ERISA Venue Selection Provisions

By Joseph Clark

- We previously reported that a split Sixth Circuit panel enforced a venue selection clause in an ERISA plan. In so ruling, the Court rejected the U.S. Department of Labor's attempt to regulate by amicus brief and reasoned that the Department's brief was "an expression of mood." The Department, according to the Sixth Circuit:

(i) had no more experience than the Court with respect to determining whether federal statutes prohibit venue selection, and (ii) had not previously pursued an enforcement action, promulgated a regulation, or issued interpretive guidance relating to an ERISA plan's venue selection clause. Observing that Congress could have proscribed such clauses if it chose to do so, the Court found that "[i]t is illogical to say that, under ERISA, a plan may preclude venue in federal court entirely [via an arbitration clause], but a plan may not channel venue to one particular federal court."

With a petition for certiorari pending, the U.S. Supreme Court has asked the Solicitor General to file a brief expressing the government's views on whether "ERISA's special venue provision, § 1132(e)(2), and a plaintiff's choice of venue under that provision, may be abrogated by a more restrictive venue-selection clause in an ERISA plan." The case is Smith v. Aegon Cos Pension Plan, 769 F.3d 922 (6th Cir. 2014), petition for cert. filed, (U.S. Mar. 13, 2015) (No. 14-1168).

GM Not Obligated to Make $450 Million Contribution to Fund Union Retiree Health Benefits

By Lindsey Chopin

- The Sixth Circuit held that GM was not obligated to contribute $450 million to fund retiree health benefits for UAW members because the most recent contract between the UAW and GM extinguished GM's former obligation to contribute. In response to earlier litigation between the UAW against GM to recover retiree health benefits and a bankruptcy reorganization, GM established a trust to fund UAW retiree health benefits and agreed to make a one-time $450 million payment to the trust. Thereafter, GM filed for Chapter 11 bankruptcy and sold all of its assets and liabilities to the "New GM." Days after the sale was approved, New GM and the UAW entered into a new settlement which: (1) did not mention the $450 million payment, and (2) established a new benefits agreement. When the UAW sought the $450 million payment, New GM refused to pay, arguing in part that the agreement did not require such a contribution.

  The district court granted summary judgment in favor of New GM, finding that the $450 million contribution obligation did not survive GM's reorganization. On appeal, the Sixth Circuit disagreed, finding that the obligation did survive because the purchase agreement associated therewith passed on all liabilities arising under the UAW Collective Bargaining Agreement, which included the obligation to make the $450 million contribution. However, the Court nonetheless determined that New GM was not obligated to pay because a subsequent settlement agreement between GM and the UAW was properly construed as having extinguished GM's former

obligation. The Court pointed out that the settlement agreement did not mention the obligation and made clear that it superseded, extinguished, and/or released GM from all former obligations concerning retiree health benefits arising from the former UAW/GM litigation and settlement agreements and all GM bankruptcy proceedings. Accordingly, the Court affirmed the district court's granting of summary judgment and New GM was not bound to make the contribution. The case is Int'l Union, United Auto., Aerospace & Agr. Implement Workers of Am. v. Gen. Motors, LLC, 2015 WL 223950 (6th Cir. May 14, 2015).

SEC Announces Open Meeting on Proposed Clawback Requirements under Dodd-Frank Act

By Joshua Miller and Andrea Rattner

- The Dodd-Frank Wall Street Reform and Consumer Protection Act became law on July 21, 2010, introducing a variety of executive compensation-related regulations, including with respect to shareholder say-on-pay voting and independence requirements for members of the compensation committees and their advisers. Almost five years following the enactment of the Dodd Frank Act, the rules enacting the incentive compensation clawback provisions under Dodd Frank Act Section 954 have not even been proposed.

  That is expected to change next week, as the SEC issued notice yesterday of an open meeting on July 1 to consider whether to propose amendments under Section 10D of the Securities Exchange Act of 1934 to implement the Dodd Frank Act's clawback requirements. Please see the SEC's notice (available here) for further details with respect to the open meeting.

  Entitled "Recovery of Erroneously Awarded Compensation," Section 954 of the Dodd Frank Act generally directs the SEC to issue rules requiring the national securities exchanges and associations to prohibit the listing of any security of an issuer that has not developed and implemented policies regarding the recovery of excess incentive-based compensation paid to the issuer's executive officers if an accounting restatement is required as a result of material failure to comply with applicable financial reporting requirements, and to require issuers to disclose such incentive compensation recovery policies. Specifically, the clawback rules under Section 954 apply to incentive-based compensation (including compensatory stock options) received by any current or former executive officer of the issuer during the three-year period preceding the date on which such an accounting restatement is required, to the extent such compensation was based on the erroneous data and was in excess of what would have been received using the corrected data under the accounting restatement.

How the SEC proposes to resolve various ambiguities, uncertainties and open questions under the language of the Dodd Frank Act rules (as well as the initial proxy season in which compliance with those rules will be required) remains to be seen, but in any event certainly will impact how public companies structure their incentive compensation recoupment policies and practices. Although many companies – especially those in the Fortune 500 – have adopted some form of an incentive compensation clawback policy, a significant number of companies have deferred the adoption, review and/or update of their incentive compensation clawback provisions and policies pending SEC guidance on the Dodd Frank Act's clawback requirements since the adoption of the Dodd Frank Act. In any case, all public companies – even those companies that have such policies in place – will need to become familiar with the proposed (and ultimately the final) rules.

* Originally published in Bloomberg, BNA. Reprinted with permission.

[1] Nat.'l Federation of Indep. Business, et al. v. Sebelius, et al., 132 S.Ct. 2566 (2012).

[2] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014).

[3] *Wheaton College v. Burwell*, 134 S. Ct. 2806 (2014).

[4] *King v. Burwell*, No. 14-114, 2015 WL 2473448 (U.S. June 25, 2015).

[5] *King v. Blue Cross Blue Shield of Illinois*, No. 3:13-CV-1254, 2015 WL 2385684 (S.D. Cal. May 13, 2015), *appeal pending*, *King v. Blue Cross Blue Shield of Illinois*, Case No. 15-55880 (9th Cir. Jun. 9, 2015).

[6] *Marin v. Dave & Busters, Inc.*, Case No. 15-cv-3608 (S.D.N.Y. May 8, 2015).

[7] *Raygoza v. ConAgra Foods, Inc.*, No. 2:15-CV-3741, 2015 WL 2374095 (C.D. Cal. May 18, 2015).

[8] *Alexander v. United Behavioral Health*, No. 14-5337, 2015 WL 1843830 (N.D. Cal. Apr. 7, 2015).

[9] *K.M. v. Regence Blueshield*, No. 13-1214 (W.D. Wash. Apr. 22, 2015); *R.H. v. Premera Blue Cross,* No. 13-0097, Dkt. # 90 (W.D. Wash. Jan. 21, 2015).

[10] *Daniel F. v. Blue Shield of California*, 305 F.R.D. 115, 124 (N.D. Cal. 2014).

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