The Religious Liberty Challenge to American-Style Social Insurance

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This Article argues that escalating religious challenges to the Affordable Care Act ("ACA") form a major new vector in the campaign against social insurance in the United States. Where early constitutional challenges urging a libertarian ethos of "you're on your own" largely failed, religious claimants are succeeding with a traditionalist entitlement to "take care of your own as you see fit." In a mounting series of lawsuits, objectors challenge requirements that employers and insurers provide comprehensive, nondiscriminatory coverage of sexual and reproductive health services. They demand freedom to define their own communities and choose which medical needs they will support. They revive the notion of personal responsibility largely repudiated by health reform and add a moralized twist. The result is discrimination against marginalized groups, coercion of workers, and loss of democratically determined rights.

Bridging political economy and religion law scholarship, this Article attributes religious claimants' successes to the ACA's distinctively American accommodationist and market-first structure. Concessions that facilitated the

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Act's passage in Congress now grant a foothold for religious objectors eager to rewrite the insurance social contract in the courts. Religious exemptions refragment the social collective — by family, firm, medical need, and religious belief. We are no longer "all in it together," as the ACA would have it; we are separate and apart.

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INTRODUCTION

It is conventional wisdom that constitutional challenges to the Affordable Care Act ("ACA") have failed, and health reform's "we're in this together"[1] ethos is now entrenched.[2] But where early lawsuits based on a libertarian "you're on your own"[3] ideal have fizzled out,[4] a new wave of religious claims with a traditionalist message of "take care of your own as you see fit" is succeeding.[5] Scholars and pundits alike have failed to recognize these challenges as a threat to social insurance in the United States.

In this series of lawsuits, employers and individuals are invoking the Religious Freedom Restoration Act ("RFRA")[6] against the ACA. They attack regulations requiring health plans to cover evidence-based

[1] JARED BERNSTEIN, ALL TOGETHER NOW: COMMON SENSE FOR A FAIR ECONOMY 6 (2006) (contrasting "you're on your own" with "we're in this together" as approaches to economic regulation); *see* Jared Bernstein, *YOYOs, WITTs, and Socialists*, WASH. POST (July 2, 2018), https://www.washingtonpost.com/news/posteverything/wp/2018/07/02/yoyos-witts-and-socialists/ [https://perma.cc/K3BD-83ZP] (applying these approaches to social insurance).

[2] *See, e.g.*, Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495 (2020) (describing the entrenchment of the ACA following political and legal challenges). The Supreme Court twice upheld the mandate that individuals purchase health insurance coverage. California v. Texas, 141 S. Ct. 2104, 2119-20 (2021); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012) [hereinafter *NFIB*]. The Court refused to foreclose expansion of Medicaid, although it made expansion optional for states. *NFIB*, 567 U.S. at 588. And it rejected attempts to strip subsidies from federally facilitated exchanges. King v. Burwell, 576 U.S. 473, 497 (2015).

[3] *See* BERNSTEIN, *supra* note 1, at 3. For libertarian arguments against the ACA, see, for example, Randy E. Barnett, *Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional*, 5 N.Y.U. J.L. & LIBERTY 581 (2010); Richard A. Epstein, *Obamacare: An Unconstitutional Misadventure*, HOOVER INST. (Mar. 26, 2012), https://www.hoover.org/research/obamacare-unconstitutional-misadventure [https://perma.cc/8HVK-JY9B].

[4] *See* cases cited *supra* note 2.

[5] *See infra* Part II.A.

[6] Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (codified at 42 U.S.C. § 2000bb(b)) (providing that the federal government may only substantially burden a person's exercise of religion when the burden "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest").

preventive services (the "preventive services mandate")[7] and prohibiting sex discrimination in benefit design (the "nondiscrimination rule").[8] Initially, plaintiffs focused on carving out exemptions allowing particular employers to exclude contraception from their workers' health benefit plans.[9] Recently, they expanded their objections to a growing list of services, including sterilization, gender-affirming care, pregnancy termination, medication to prevent HIV transmission, and other preventive services for infections transmitted through sexual contact and drug use.[10] Objectors describe these services

[7] *See infra* notes 91–94 and accompanying text.

[8] *See infra* notes 95–98 and accompanying text.

[9] Hundreds of cases were filed. Three reached the Supreme Court. *See, e.g.*, Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657 (2020) (upholding regulation with broad "moral" exemption for employers); Zubik v. Burwell, 578 U.S. 403 (2016) (evaluating the accommodation process); Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (accommodating for-profit and non-profit employers alike). RFRA cases against the contraceptive mandate continue.

[10] *See, e.g.*, Religious Sisters of Mercy v. Becerra, 55 F.4th 583 (8th Cir. 2022) (gender transition-related care); Franciscan Alliance, Inc. v. Becerra, 47 F.4th 368 (5th Cir. 2022) (gender affirming care, sterilization, and abortion); Braidwood Mgmt. Inc. v. Becerra, 666 F. Supp. 3d 613 (N.D. Tex. 2023) (pre-exposure prophylaxis ("PrEP") medications that prevent HIV transmission); Christian Emps. All. v. U.S. Equal Opportunity Comm'n, No. 1:21-CV-195, 2022 WL 1573689 (D.N.D. May 16, 2022) (gender transition-related care). The *Braidwood* plaintiffs, whose appeal is currently pending in the Fifth Circuit, initially lodged religious objections to a long list of services they described as "consequences of a patient's choice to engage in drug use, prostitution, homosexual conduct, or sexual promiscuity." Complaint at 29, Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-cv-00283-O) [hereinafter *Braidwood Mgmt.* Complaint]. The identified services included STI prevention counseling and screening for adults and adolescents, specific screening tests for chlamydia, gonorrhea, hepatitis B, hepatitis C, HIV, HPV, and syphilis, as well as immunizations for HPV. *Id.* In their amended complaint, their RFRA claim focused exclusively on PrEP, but plaintiffs' motion for summary judgment sought (unsuccessfully) to restore their full list of objections. Braidwood Mgmt. Inc. v. Becerra, 627 F. Supp. 3d 624, 637 n.3 (N.D. Tex. 2022). In addition to their RFRA claims, plaintiffs challenged the preventive services mandate in its entirety, claiming that Congress's reliance on advisory bodies violates the Appointments Clause, the Vesting Clause, and the nondelegation doctrine. *See Braidwood Mgmt.*, 627 F. Supp. 3d at 634. The district court granted summary judgment for plaintiffs on the Appointment Clause claim with respect to the US Preventive Services Task Force ("USPSTF"). *Braidwood Mgmt.*, 627 F. Supp. 3d at 647, 654. These broader claims resonate with the theories of insurance we discuss but are beyond the scope of this Article.

as "deeply harmful" to health.[11] They refuse to provide collective support, saying people should bear the "consequences" of their immoral behavior.[12] And now, some plaintiffs, no longer content with exemption, seek blanket injunctions to block these regulations for all insurance plans.[13]

Framing these attacks as matters of religious liberty alone has hidden the extent to which they reopen questions about belonging and obligation that the ACA aimed to settle. To understand the stakes, consider that insurance — in any form — profoundly shapes our understanding of what we owe each other as members of a shared society.[14] In the absence of regulation, commercial insurance typically reflects what is known as actuarial fairness.[15] It divides us based on age, sex, reproductive capacity, and other risk factors.[16] It excludes services that some of us might need but others definitely will not — assigning

[11] *See* First Amended Complaint at 3, Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (No. 7:16-CV-00108-O) [hereinafter *Franciscan All.* Complaint].

[12] *Braidwood Mgmt.* Complaint, *supra* note 10, at 29.

[13] *See infra* notes 147–153 and accompanying text.

[14] Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 46 (1999) [hereinafter Stone, *Moral Hazard*] ("Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation."); *see also* Brian J. Glenn, *God and the Red Umbrella: The Place of Values in the Creation of Institutions of Mutual Assistance*, 10 CONN. INS. L.J. 277, 306 (2004) ("[F]orms of mutual assistance created by a polity are profoundly and intimately related to the very definition of who they are as a people."); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1498 (2010) ("[I]nsurance policies and the insurance systems of industrialized nations tend . . . to take on the role of social institutions.").

[15] Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 290 (1993) [hereinafter Stone, *Struggle*] ("Actuarial fairness — each person paying for his own risk — is . . . a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of mutual aid.").

[16] *See, e.g.*, Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, 37 J.L. MED. & ETHICS 103, 106 (2009) (describing health insurance underwriting based on a wide range of factors related to health status or risk).

personal responsibility for costs of pre-existing illness or pregnancy, for example.[17]

The ACA reformed health insurance by rejecting actuarial fairness and enacting the principle of social solidarity.[18] Relying on private markets and employers, the ACA created a distinctively American form of social insurance — highly privatized but (nearly) universal and (mostly) progressive.[19] It entitled the sick to access, the poor and middle class to subsidies, and all enrollees to comprehensive and nondiscriminatory benefits, thereby transforming "individual misfortunes into common problems."[20] We gained rights to call upon employers, insurers, and other individuals for support — and corresponding obligations to provide it — justified by our mutual interdependence as social citizens.[21] But the ACA's reliance on private entities left our nascent social insurance system exposed to legal challenges.

This Article argues that religious liberty challenges to the ACA exploit and unsettle core features of social insurance in the United States. Religious objectors advance alternative conceptions of the community constituted through insurance, of the conditions deserving of support, and of the allocation of responsibility for risk. Their "take care of your own" approach adopts the rhetoric of mutual interdependence while demanding the freedom to define their own communities and choose which medical needs they will support. Their arguments revive notions of personal responsibility largely repudiated by health reform and add a moralized twist. The result of the exemptions they have won is discrimination against marginalized groups, coercion of workers, and loss of democratically determined rights. The impact extends beyond reproductive and sexual health care and beyond workers who have lost coverage due to the religious views of their employers. Religious

[17] *See id.*

[18] RUUD TER MEULEN, SOLIDARITY AND JUSTICE IN HEALTH AND SOCIAL CARE 181 (2017) ("[T]he Affordable Care Act can be regarded as an act of solidarity with vulnerable people in the US.").

[19] *See* sources cited *supra* notes 46–47.

[20] JACOB S. HACKER, THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM 30 (2019).

[21] For a discussion of the meaning of "social citizenship," see *infra* notes 55–58 and accompanying text.

exemptions fragment the collective — along axes of morality, familiarity, and medical need. They delegitimate the ideal of a "we" that cuts across society and undermine the very foundation of social insurance.

Part I demonstrates that the ACA created a form of social insurance by subsidizing and regulating employer-sponsored plans, public programs, and individual market plans.[22] A web of reciprocal obligations now connects the government, social citizens, insurers, and employers. This new social insurance system adopts solidarity as its guiding principle — seeking to distribute health care according to medical need and to spread costs broadly across a diverse community.[23] The ACA's ban on health status discrimination and its expansion of Medicaid — which determine *who* has access to insurance — are widely understood to reflect this commitment.[24] We expand beyond this previous literature and identify benefit design — which determines *what* insurance covers — as an underappreciated mechanism of social solidarity.[25]

Part II argues that religious liberty claims are succeeding in part by exploiting the privatized structure of American social insurance. In the markets, legislative exemptions have fueled an unanticipated boom in health care sharing ministries, which permit members of Christian denominations to share medical costs free from regulatory protections.[26] In the courts, religious objectors take advantage of the

[22] *See* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. & ETHICS 411, 411-12 (2020).

[23] *See* Stone, *Struggle*, *supra* note 15, at 289-91.

[24] *E.g.*, Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 201-08 (2008).

[25] A few legal scholars have discussed benefit design as a manifestation of solidarity. *See, e.g.*, Fuse Brown et al., *supra* note 22, at 414-15 (describing HHS's "resort to state definitions for federal essential health benefits" as a "solidarity-diluting concession"); Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471, 1505 (2020) (arguing that the contraception mandate cases impact "the ACA's efforts toward solidarity" in the form of "access to core, uniform healthcare services").

[26] JOANN VOLK, EMILY CURRAN & JUSTIN GIOVANNELLI, THE COMMONWEALTH FUND, HEALTH CARE SHARING MINISTRIES: WHAT ARE THE RISKS TO CONSUMERS AND INSURANCE MARKETS? 4 (2018), https://www.commonwealthfund.org/sites/default/files/2018-08/Volk_hlt_care_sharing_ministries.pdf [https://perma.cc/NRT6-LGGXLGGX].

fact that Congress failed to adopt a unified rationale for benefit design, even as it committed to the principle of solidarity. As health law scholar Allison Hoffman has argued, while Congress largely prioritized health promotion and financial protection with the ACA, it preserved a limited role for personal responsibility for chosen risks.[27] This conceptual pluralism helped in the political process, but, we argue, has made the law more vulnerable in the courts — allowing litigants to dispute the government's justifications for benefits coverage and to embrace and amplify personal responsibility. For objectors, reproductive and sexual health needs are individual choices undeserving of collective support. Just below the surface is the notion that sex should carry consequences — disease, infection, or pregnancy.

Part III demonstrates that, unlike the libertarian challengers to the individual mandate and exchange subsidies, religious objectors do not repudiate solidarity. Rather, they resist obligations to society and propose to organize aid on their own terms. Their arguments assert a traditionalist communitarianism where care is provided between purportedly like-minded people who know each other within families, workplaces, or religious groups. These communities defy the egalitarian aspirations of the ACA in favor of hierarchical relationships of father over family, boss over subordinates. Within these groups, objectors revive the principle of actuarial fairness that the ACA rejected and moralize it by assigning religious judgments to risk factors.

Part IV contends that the campaign for religious exemptions lays bare the costs of relying on private employers for social support. When courts authorize employers to impose their religious beliefs on a diverse workforce, they deprive workers of equitable benefits, but they also invite employment discrimination.[28] By exercising greater discretion over *what* will be covered in their benefits plans, employers determine

[27] Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873, 1880, 1890, 1908-09 (2011).

[28] On the interplay between benefits and eligibility discrimination, see generally Mary L. Heen, *Nondiscrimination in Insurance: The Next Chapter*, 49 GA. L. REV. 1 (2014) (discussing current and historical patterns of discrimination by insurance companies with respect to eligibility, rates, and benefits and proposing legislative reform that addresses benefit discrimination as well as eligibility and rate discrimination).

who is within the collective. Those most likely to need the objected-to care — individuals already marginalized by gender, sexual orientation, and religion — may find themselves barred from the workplace or subordinated within it. Employer control over the private lives of workers swells beyond the time and place of work.[29] Benefits become contingent on the firm's religion, rather than an entitlement of social citizenship.

This Article bridges previously siloed literatures on religion law and the political economy of health care.[30] Experts in insurance, social programs, and political economy have tended to treat religious liberty claims as distinct from other suits against the ACA.[31] They may assume that religious exemptions are limited in scope, number, and impact. And they may not appreciate the scale of the challengers' ambition to remake social insurance according to the moralistic judgments of a minority. Where such scholars have intervened, they have typically viewed

[29] *See* ELIZABETH ANDERSON, PRIVATE GOVERNMENT: HOW EMPLOYERS RULE OUR LIVES (AND WHY WE DON'T TALK ABOUT IT) 48-49 (2017) (arguing U.S. employers are authoritarian).

[30] Scholars of law and political economy highlight how law "is the mediating institution that ties together politics and economics." Jedediah Britton-Purdy, Amy Kapczynski & David Singh Grewal, *Law and Political Economy: Toward a Manifesto,* L. & POL. ECON. PROJECT (Nov. 6, 2017), https://lpeproject.org/blog/law-and-political-economy-toward-a-manifesto/ [https://perma.cc/SPN5-ZBT3]; *see also* Angela Harris & James J. Varellas, *Law and Political Economy in a Time of Accelerating Crises*, 1 J. L. & POL. ECON. 1, 1-2, 5 (2020). On the political economy of the ACA, see, for example, Gluck & Scott-Railton, *supra* note 2; David L. Noll, *Administrative Sabotage*, 120 MICH. L. REV. 753 (2022); Gabriel Scheffler, *Equality and Sufficiency in Health Care Reform*, 81 MD. L. REV. 144 (2021). On the political economy of health care access and public health more broadly, see Ximena Benavides, *The Law and Political Economy of Healthcare in the United States*, *in* MARKETS, CONSTITUTIONS, AND INEQUALITY 54-55, 57-59 (Anna Chadwick, Eleonora Lozano-Rodríguez, Andrés Palacios-Lleras & Javier Solana, eds., 2022); Michael Harvey, *The Political Economy of Health: Revisiting Its Marxian Origins to Address 21st-Century Health Inequalities*, 111 AM. J. PUB. HEALTH 293, 294 (2021).

[31] For an exception, see Joanna Wuest & Briana S. Last, *Church Against State: How Industry Groups Lead the Religious Liberty Assault on Civil Rights, Healthcare Policy, and the Administrative State*, 52 J.L. MED. & ETHICS 151, 152 (2024) (tracing the involvement of conservative religious liberty litigation shops in a variety of challenges to health law and the administrative state).

religious exemptions as implicating civil rights[32] — segregated from the core concerns of insurance regulation.[33]

By situating religious challenges to the ACA within the political economy of health insurance, we bring a fresh perspective to debates that have largely been the purview of scholars of religious liberty.[34] While the Supreme Court's turbocharged religious liberty doctrine offers a partial explanation of objectors' successes,[35] we provide an additional one: the ACA's preservation of employer-based insurance

[32] *E.g.*, Martha Minow, *Walls or Bridges: Law's Role in Conflicts Over Religion and Equal Treatment*, 48 B.Y.U. L. REV. 1581, 1593-95 (2023) (discussing *Franciscan Alliance* and *Braidwood Management* as clashes between religious liberty and equal treatment). For a cross-section of analysis of religious liberty litigation against the sex nondiscrimination rule, see Heather A. McCabe & M. Killian Kinney, *LGBTQ+ Individuals, Health Inequities, and Policy Implications*, 52 CREIGHTON L. REV. 427, 442, 444 (2019); Amy Post, Ashley Stephens & Valarie K. Blake, *Sex Discrimination in Healthcare: Section 1557 and LGBTQ Rights After* Bostock, 11 CALIF. L. REV. ONLINE 545, 555-56 (2021); Naomi Seiler, Amanda Spott, Mekhi Washington, Paige Organick-Lee, Aaron Karacuschansky, Gregory Dwyer, Katie Horton & Alexis Osei, *Gender Identity, Health, and the Law: An Overview of Key Laws Impacting the Health of Transgender and Gender Non-Conforming People*, 16 ST. LOUIS U. J. HEALTH L. & POL'Y 171, 194-96 (2023); Kristen Underhill, *Perceptions of Protection Under Nondiscrimination Laws*, 46 AM. J.L. & MED. 21, 30 (2021).

[33] *E.g.*, Gluck et al., *supra* note 25, at 1500-07 (categorizing *Hobby Lobby* and *Franciscan Alliance* as cases concerning contraception and civil rights in a part on "hundreds of other challenges in federal court" as distinguished from "the existential challenges: *NFIB, King*, and *Texas*"); Jasmine E. Harris, *Cultural Collisions and the Limits of the Affordable Care Act*, 22 AM. U. J. GENDER SOC. POL'Y & L. 387, 388 (2014) (describing contraceptive cases as "residual questions" from *NFIB*).

[34] For representative scholarship discussing the church-state issues, see B. Jessie Hill, *Religious Nondelegation*, 54 LOY. U. CHI. L.J. 511, 520-22 (2023); Douglas Laycock, *Religious Liberty and the Culture Wars*, 2014 U. ILL. L. REV. 839, 851-63 (2014); Christopher C. Lund, *Religious Exemptions, Third-Party Harms, and the Establishment Clause*, 91 NOTRE DAME L. REV. 1375, 1379-80 (2016). *See generally* THE RISE OF CORPORATE RELIGIOUS LIBERTY (Micah Schwartzman, Chad Flanders & Zoe Robinson, eds., 2015) (presenting works from a variety of scholars discussing the rise of corporate religious liberty in American law).

[35] *E.g.*, Michael C. Dorf, *Federal Judge Accepts Extravagant Complicity Claim to Exempt Company from Obligation to Provide Lifesaving Medicine*, VERDICT (Sept. 13, 2022), https://verdict.justia.com/2022/09/13/federal-judge-accepts-extravagant-complicity-claim-to-exempt-company-from-obligation-to-provide-lifesaving-medicine [https://perma.cc/EYQ3-TVQFTVQF]; Jenny Samuels, *Religious Exemptions Are Becoming the Rule*, HARV. L. REV. BLOG (Apr. 6, 2023), https://harvardlawreview.org/blog/2023/04/religious-exemptions-are-becoming-the-rule/ [https://perma.cc/8DQU-92TP92TP].

created an opportunity to reopen debates over the bounds of the collective and our obligations to one another. And the Act's ambivalence regarding the conditions that trigger collective obligations left it vulnerable to resistance. We conclude that the dynamics of religious liberty challenges must prompt a deeper examination of how the relevant collective for social insurance is formed, of where that community directs its efforts (whether toward promoting health, protecting finances, or remedying brute luck), and of how power relations within the collective shape these choices.

I. SOCIAL INSURANCE, AMERICAN STYLE

The reforms of the Affordable Care Act redistributed risks, reallocated responsibility, and, in so doing, moved the health insurance market toward a "peculiarly American form of social insurance."[36] In Section A, we explain that social insurance creates an inclusive and reciprocal form of solidarity between equal citizens (in the sense of social, not legal, citizenship). In Section B, we join other health and insurance law scholars in arguing that the ACA definitively rejected actuarial fairness and instead adopted solidarity as its organizing principle. Although the ACA preserved the primacy of private insurance, it regulated and subsidized employment-sponsored plans, public programs, and the market for individual insurance in a way that begins to resemble a social insurance system.[37] In Section C, we expand beyond this previous literature and identify benefit-design requirements as an

[36] Wendy K. Mariner, *Health Insurance Is Dead; Long Live Health Insurance*, 40 AM. J.L. & MED. 195, 214 (2014).

[37] Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1578-59 (2011) (describing the ACA as putting health insurance in the United States "on track to become a form of social insurance"); Barry R. Furrow, *Health Reform and Ted Kennedy: The Art of Politics . . . and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL'Y 445, 453-54 (2011) (discussing the ACA as "moving private health insurance closer to quasi-social insurance"); John V. Jacobi, *The Ends of Health Insurance*, 30 UC DAVIS L. REV. 311, 319 (1997) (describing "the slow evolution of American insurance law toward a complex public/private model of universal health coverage"); Sidney D. Watson, *Embracing Justice Roberts' "New Medicaid,"* 6 ST. LOUIS U. J. HEALTH L. & POL'Y 247, 248 (2013) (arguing that changes to Medicaid render it "the foundation block of a multi-layered social insurance system").

underappreciated mechanism by which social insurance promotes solidarity.

A. Social Insurance and Solidarity Among Citizens

Through contract, insurance (whether for property, liability, income replacement, or health care) offers a collective response to individual risks.[38] In her groundbreaking work, political scientist Deborah Stone identified "two fundamentally different logics" of insurance contracts: actuarial fairness and solidarity.[39] According to actuarial fairness, it is unfair for people at lower risk to subsidize those at higher risk — each person should be covered on terms tailored to an individualized risk assessment.[40] This principle, which is at the heart of commercial insurance, slices "communities into ever-smaller, more homogeneous groups."[41] The solidarity principle, by contrast, seeks to distribute support according to need and to spread costs broadly across a diverse community of people.[42]

The choice between these approaches structures health insurance eligibility, rates, and benefits. For example, on the principle of actuarial fairness, plans may exclude some members because they are likely to require more than average amounts of health care. Or, on a solidarity principle, they may welcome everyone regardless of medical history.

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[38] Stone, *Moral Hazard*, *supra* note 14, at 16 ("The basic premise of insurance is collective responsibility for harms that befall individuals, because insurance pools people's savings to pay for individuals' future losses."); *see also* Turo-Kimmo Lehtonen & Jyri Liukko, *The Forms and Limits of Insurance Solidarity*, 103 J. BUS. ETHICS 33, 36 (2011) (noting that insurance solidarity means "shared responsibility among a group of people").

[39] Stone, *Struggle*, *supra* note 15, at 290. Stone's work built on previous scholarship on actuarial fairness. *See, e.g.*, Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 960 (1963) (discussing actuarial fairness in terms of welfare economics). Commercial insurers have used notions of actuarial fairness to defend risk-based underwriting against accusations of discrimination based on race, disability, gender, and sexual orientation. *See* Gert Meyers & Ine Van Hoyweghen, *Enacting Actuarial Fairness in Insurance: From Fair Discrimination to Behaviour-Based Fairness*, 27 SCI. AS CULTURE 413, 423 (2017).

[40] Stone, *Struggle*, *supra* note 15, at 293.

[41] *Id.* at 290.

[42] *Id.* at 290-91.

Health plans may charge premiums based on actuarial calculations. Or they may set premiums at the level of the collective (a group of employees or other purchasers) without drawing distinctions based on risk. They may tailor benefits to an individual's needs — excluding, for example, maternity care from plans for people who can't get pregnant — or design universal benefits to serve the needs of all members of the group.

Commitment to the solidarity principle is essential to social insurance.[43] Social insurance programs collectivize a variety of risks, including health care costs and income loss as a result of old age, disability, or lay-offs.[44] Definitions of social insurance vary. Some experts limit the category to government-sponsored programs that are publicly financed and administered, such as Medicare in the United States.[45] Others, as we do here, define social insurance more broadly to include schemes in which private employers and insurers are generously subsidized and heavily regulated.[46]

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[43] *See* TER MEULEN, *supra* note 18, at 109 ("[S]olidarity has been a leading principle in the design of public health [care] systems.").

[44] MITCHELL BARNES, LAUREN BAUER, WENDY EDELBERG, SARA ESTEP, ROBERT GREENSTEIN & MORIAH MACKLIN, THE SOCIAL INSURANCE SYSTEM IN THE U.S.: POLICIES TO PROTECT WORKERS AND FAMILIES 2-5 (2021). Federal spending on health care programs (including Medicare, Medicaid, the Children's Health Insurance Program, and ACA subsidies) now surpasses spending on social security (which provides income support for retirees, people with disabilities, and their dependents), and the gap between the two is expected to expand. CONG. BUDGET OFF., THE 2023 LONG-TERM BUDGET OUTLOOK 16 (2023).

[45] *See, e.g.*, BARNES ET AL., *supra* note 44, at 2, 6 (defining social insurance to include Medicare, Medicaid, and subsidies for the ACA individual exchange plans but not employer-based insurance). It is worth noting that even Medicare is not entirely publicly administered. *See* Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 UC DAVIS L. REV. 2149, 2163, 2176, 2181-82 (2021) ("Publicly financed health care programs rely heavily on private contractors to perform the basic functions of health coverage.").

[46] *See, e.g.*, Baker, *supra* note 37, at 1579 ("The Affordable Care Act embodies a social contract of health care solidarity through private ownership, markets, choice, and individual responsibility."); Michael J. Graetz & Jerry L. Mashaw, *Constitutional Uncertainty and the Design of Social Insurance: Reflections on the Obamacare Case*, 7 HARV. L. & POL'Y REV. 343, 353 (2013) ("In the United States, we provide social insurance through a complex mixture of mandatory and voluntary mechanisms, financed through both public and private budgets . . . .").

Social insurance in this broader sense is distinguished from free-market commercial insurance by several characteristic features.[47] First, social insurance requires democratically determined government action.[48] This intervention may take the form of subsidies to ensure insurance is available and affordable and regulations to ensure that it is accessible and inclusive. Second, social insurance aims to be both universal (encompassing all or most citizens) and progressive (exacting contributions according to means and providing benefits according to needs).[49] Finally, social insurance "is designed to pursue societal purposes that could not or would not be achieved through individual contracting in private insurance markets."[50] It transforms insurance from an individual (or group) contract into a social contract.[51]

Social insurance tends to demand the reciprocal and mutual solidarity of equal citizens.[52] For the most part, obligations are owed to strangers — what Seyla Benhabib calls "the generalized other" as opposed to the "concrete other" whose identity is known and who is familiar.[53] Rights to call upon others for support — and corresponding obligations to provide it — are justified by our mutual interdependence as fellow citizens, not only as identifiable neighbors, family members, friends, or coworkers.[54]

By "citizens," we refer to social citizenship, which overlaps with but is distinct from political or legal citizenship.[55] While political citizenship

[47] *See generally* Theodore R. Marmor, *Social Insurance and American Health Care: Principles and Paradoxes*, 43 J. HEALTH POL., POL'Y & L. 1013 (2018) (contrasting commercial and social insurance).

[48] *See* Graetz & Mashaw, *supra* note 46, at 350.

[49] *Id.* at 357.

[50] *Id.*; *see also* Isabel Ortiz, *The Case for Universal Social Protection*, 55 FIN. & DEV. 32, 33 (2018) (listing as goals inclusive growth, human development, and political stability as well as safeguarding people during economic crisis).

[51] Graetz & Mashaw, *supra* note 46, at 350.

[52] TER MEULEN, *supra* note 18, at 94 (describing "equality, reciprocity and mutuality" as typical of social insurance solidarity).

[53] SEYLA BENHABIB, SITUATING THE SELF: GENDER, COMMUNITY AND POSTMODERNISM IN CONTEMPORARY ETHICS 149, 158 (1992).

[54] TER MEULEN, *supra* note 18, at 168 (describing social insurance as recognizing "a moral responsibility towards the well-being of other human beings").

[55] *See* T. H. MARSHALL, CITIZENSHIP AND SOCIAL CLASS AND OTHER ESSAYS 1-38 (1950) (articulating the theory of social citizenship as a third dimension of citizenship

is defined by rights to vote, to hold certain offices, and to travel on a U.S. passport, social citizenship is defined by eligibility for collective support for basic necessities (such as health care or income support).[56] A social insurance program may be crafted to leave out some political and legal citizens, typically justified by an argument that they are not adequately needy or "deserving" of collective support.[57] Conversely, social insurance may include some denizens who lack political or legal citizenship, thereby granting them social citizenship.[58]

B. The ACA as an American Form of Social Insurance

Prior to the ACA, the American health insurance system reflected "two discordant visions," torn between actuarial fairness and the

alongside political and civil rights); William E. Forbath, *Caste, Class, and Equal Citizenship*, 98 MICH. L. REV. 1, 1 (1999) (describing social citizenship as an egalitarian constitutional tradition rooted in the Reconstruction and expounded by proponents in the Progressive Era); Andrew Hammond, *Territorial Exceptionalism and the American Welfare State*, 119 MICH. L. REV. 1639, 1647-52 (2021) (relying on social citizenship as a framework for assessing welfare programs in U.S. territories); Desmond S. King & Jeremy Waldron, *Citizenship, Social Citizenship and the Defence of Welfare Provision*, 18 BRIT. J. POL. SCI. 415, 431-32 (1988) (discussing the social citizenship in the context of "New Right" welfare reform in Britain).

[56] *See* Irene Bloemraad, Will Kymlicka, Michèle Lamont & Leanne S. Son Hing, *Membership Without Social Citizenship? Deservingness & Redistribution as Grounds for Equality*, 148 DAEDALUS 73, 74 (2019).

[57] *Id.* at 74 (arguing that increased access to "legal citizenship" by "racial, sexual, and religious minorities and immigrants" has often increased contestation over "the distribution of welfare resources, in part due to a rigidification of moral boundaries based on perceptions of deservingness").

[58] U.S. citizenship is not an eligibility requirement for (highly subsidized and heavily regulated) employer-based or individual insurance. Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFFS. 235, 248 (2019). Public health care programs exclude most undocumented immigrants and many permanent residents, but some noncitizens are eligible. *Id.* at 249-56; ABIGAIL F. KOLKER & ELAYNE J. HEISLER, CONG. RSCH. SERV., R47351, IMMIGRANTS' ACCESS TO HEALTH CARE 12, 14 (2022). Noncitizens also contribute to social insurance programs, including by paying taxes, Makhlouf, *supra* note 58, at 298, and providing health and social care services, Leah Zallman, Karen E. Finnegan, David U. Himmelstein, Sharon Touw & Steffie Woolhandler, *Care for America's Elderly and Disabled People Relies on Immigrant Labor*, 38 HEALTH AFFS. 919, 919 (2019).

solidarity principle.[59] Parts of the market operated on the solidarity principle. Medicare and Medicaid represented a societal commitment to insure the elderly, people with qualifying disabilities, and certain categories of the "deserving poor," such as children and pregnant women.[60] Under the Health Insurance Portability and Accountability Act of 1996, employer-sponsored insurance promoted solidarity within workplaces by mandating that rates be set at the level of the group (known as "community rating") and by restricting the exclusion of coverage for preexisting conditions.[61] The federal government lent (and continues to lend) collective support to this model by heavily subsidizing employer-sponsored plans through favorable tax treatment.[62] Although decisions to offer insurance to one's employees or to take up an employer's offer of insurance were voluntary, risks were pooled broadly so that healthy people subsidized the costs of caring for the sick.[63]

In contrast, the individual insurance market was premised on actuarial fairness. People who did not have access to employer-based plans or public programs had to purchase plans closely tailored and priced to their individual health risks.[64] Instead of subsidizing others, a healthy person would pay an amount proportionate to her anticipated needs. She joined a pool — or collective — of persons with risks of

[59] Jacobi, *supra* note 37, at 312-14; *see also* Stone, *Struggle*, *supra* note 15, at 289.

[60] Furrow, *supra* note 37, at 454 ("Prior to the ACA, the U.S. health insurance system already had significant social insurance features, including Medicare, Medicaid, and workers' compensation.").

[61] Jill Quadagno, *Institutions, Interest Groups, and Ideology: An Agenda for the Sociology of Health Care Reform*, 51 J. HEALTH & SOC. BEHAV. 125, 131 (2010) (noting that "the solidarity principle" is represented in large employers' plans); Timothy Stoltzfus Jost, *A Mutual Aid Society?*, 42 HASTINGS CTR. REP. 14, 15 (2012) (describing employee groups as reflecting mutual aid).

[62] CONG. BUDGET OFF., THE DISTRIBUTION OF MAJOR TAX EXPENDITURES IN THE INDIVIDUAL INCOME TAX SYSTEM 14 (2013), https://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf [httpshttpshttps://perma.cc/9662-4HXD4HXD] (noting $250 billion a year in tax expenditures toward employer-sponsored insurance).

[63] Graetz & Mashaw, *supra* note 46, at 355.

[64] *See generally* KATHRYN LINEHAN, NAT'L HEALTH POL'Y F., UNDERWRITING IN THE NON-GROUP HEALTH INSURANCE MARKET: THE FUNDAMENTALS (2009) (describing health insurer underwriting practices in the nongroup market prior to the ACA).

illness and injury similar to hers. The result was that people with preexisting conditions often found themselves unable to purchase insurance unless they had access to an employer-sponsored plan.[65] Women routinely paid more than men or were denied coverage based on their capacity to become pregnant.[66] This market represented the "rejection of public responsibility altogether" in favor of individual responsibility.[67]

Across the employer and individual insurance markets, many health plans excluded important services or imposed high cost-sharing.[68] State legislatures adopted a patchwork of coverage mandates (such as maternity care and certain cancer screenings), but their authority over employer-based health insurance was limited by federal preemption.[69] Congress only occasionally intervened to impose a federal floor — for example, requiring parity between mental and physical health coverage.[70]

The Affordable Care Act definitively chose solidarity over actuarial fairness.[71] The ACA expanded eligibility for insurance by amending public programs[72] and requiring individual market insurers to issue

[65] *See generally* Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV 73, 76 (2005) (discussing health insurance discrimination against people with preexisting conditions prior to the ACA).

[66] Heen, *supra* note 28, at 444.

[67] David A. Super, *The Modernization of American Public Law: Health Care Reform and Popular Constitutionalism*, 66 STAN. L. REV. 873, 922-23 (2014).

[68] Lois K. Lee, Alyna Chien, Amanda Stewart, Larissa Truschel, Jennifer Hoffman, Elyse Portillo, Lydia E. Pace, Mark Clapp & Alison A. Galbraith, *Women's Coverage, Utilization, Affordability, and Health After The ACA: A Review of the Literature,* 39 HEALTH AFFS. 387 (2020) (empirical study comparing health insurance benefits for women's health before and after the ACA).

[69] Tom Murphy, *Why Insurance Denies Your Claim, But Pays Your Neighbor's*, AP (Sept. 8, 2016), https://www.statnews.com/2016/09/08/health-insurance-coverage-aca/ [https://perma.cc/B8WB-TNFLTNFL].

[70] 29 U.S.C. § 1185a (2018); Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 674 (2003) (reviewing "federal and state laws [that] promote moral fairness and prohibit particular types of discrimination in health insurance").

[71] Fuse Brown et al., *supra* note 22, at 412 (describing aspects of the ACA that "simultaneously signal the emergence of a new approach emphasizing a social solidarity ethic and pave the way for its fuller realization in social solidarity outcomes").

[72] *See* 42 U.S.C. § 1396a(e)(14)(I)(i).

coverage to any eligible individual.[73] It prohibited insurers from discriminating based on health status.[74] The price of insurance would no longer be determined by health status but by ability to pay.[75] For people unable to afford health insurance (the vast majority of the uninsured),[76] subsidies brought them into the health insurance collective.[77] Congress, moreover, set out to end the moral judgment inherent in covering only the "deserving poor" by expanding Medicaid to reach all legal citizens (and some documented immigrants) living below 138% of the federal poverty level.[78]

Although its framers failed to secure truly universal coverage, the ACA created a distinctively American form of social insurance.[79] The ACA

[73] 42 U.S.C. § 300gg-1.

[74] *Id.*; § 300gg(a)(1)(A).

[75] The Act allows limited actuarial fairness in the form of differential premiums based on family size, geographic region, age (up to a 3:1 ratio), and tobacco use (up to a 2:1 ratio). § 300gg(a)(1)(A).

[76] In the years leading up to the ACA's passage, too-high costs and job loss were the most common reasons given by people who were uninsured. John A. Graves & Sharon K. Long, *Why Do People Lack Health Insurance?*, URBAN INST., https://www.urban.org/sites/default/files/publication/50831/411317-Why-Do-People-Lack-Health-Insurance-.PDF (last visited Sept. 14, 2024) [https://perma.cc/9GN2-FJJ6]. Affordability continues to be the most common reason cited by people who are uninsured. *See* Jennifer Tolbert, Patrick Drake & Anthony Damico, *Key Facts About the Uninsured Population*, KFF figure 7 (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/4NSS-YCJ9].

[77] Baker, *supra* note 37, at 1596 (arguing that these components now "distribute the risk of future healthcare costs among the U.S. population").

[78] Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH, POL'Y, L., & ETHICS 67, 70 (2015); *see generally* MADELINE GUTH, RACHEL GARFIELD & ROBIN RUDOWITZ, KAISER FA. FOUND., *THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA* (2020) (discussing the impact of Medicaid expansion); Mark A. Hall, *Approaching Universal Coverage with Better Safety-Net Programs for the Uninsured*, 11 YALE J. HEALTH, POL'Y, L. & ETHICS 9 (2011) (accord).

[79] This move is incomplete in several important ways. *See* Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1960-61 (2011) (discussing failure to include undocumented immigrants and its waiting periods for documented immigrants); Makhlouf, *supra* note 58, at 248; Govind Persad, *Expensive Patients, Reinsurance, and the Future of Health Care Reform*, 69 EMORY L.J. 1153, 1162 (2020) (observing that "the United States' health care system is characterized by narrow rather than broad sharing" with divisions between marketplace plans, Medicaid, and employer-based insurance and between states); Lindsay F. Wiley, Elizabeth Y. McCuskey,

aims for access without regard to risk, affordability irrespective of income, and benefits comprehensive enough to provide financial protection and health promotion. Its reforms create reciprocal obligations between the government, social citizens, insurers, and employers. Medicaid expansion, individual marketplace subsidies, and continued tax exemption for employer-based insurance represent a commitment from all taxpayers to a baseline of insurance affordability.[80] Individuals have distinct solidaristic duties — to obtain adequate health insurance and pay their fair share of rates.[81] The reforms move toward treating everyone as mutually vulnerable to health care costs and equally entitled to support.[82] In so doing, it implements the "social" in social insurance.

The distinctively American nature of this social insurance comes from its heavy reliance on private insurers and employers. Insurers must issue policies and charge equal rates to all comers, without regard to their health risks. Employers retain a major role. As their "shared responsibility" in this system, employers must either offer workers insurance that complies with the ACA's regulations or pay a tax.[83] This requirement harnesses our cultural acceptance of insurance through workforce participation, long a feature of American health care.[84] It "move[s] the paradigm from discretionary employment insurance to a

Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction,* 55 UC DAVIS L. REV. 657, 664-65, 672 (2021) (arguing that structural racism, individualism, fiscal fragmentation, privatization, and deference to federalism remain obstacles to universal social insurance and criticizing the ACA for its inadequate commitment to health justice).

[80] *See* Fuse Brown et al., *supra* note 22, at 412 (discussing "collective financing and administration schemes built on a principle of mutual aid" as reflecting national solidarity).

[81] Baker, *supra* note 37, at 1596. Effective 2019, Congress zeroed out the tax penalty for failing to maintain insurance coverage but left the mandate in place. 26 U.S.C. §§ 5000A(a), (c)(2)(B)(iii), (c)(3)(A) (2018).

[82] Super, *supra* note 67, at 930 ("Apart from undocumented immigrants, the ACA recognizes all people's need for health care — and on surprisingly equal terms.").

[83] 26 U.S.C. § 4980H(c)(1) (2018).

[84] Theodore R. Marmor & Jerry L. Mashaw, *Understanding Social Insurance: Fairness, Affordability, and the "Modernization" of Social Security and Medicare*, 15 ELDER L.J. 123, 126-27 (2007).

form of social insurance requiring total participation."[85] Together, these reforms operationalize a message that "we are all in this together."[86]

C. Promoting Solidarity Through Benefit Design

Questions of eligibility (who is covered) and rate setting (at what price) are at the heart of social insurance schemes.[87] Scholars have paid less attention to benefits. As our analysis of the ACA (and religious challenges to it) shows, decisions about what is covered and the process by which coverage determinations are made also define the "social" in social insurance.

Several ACA provisions work together to collectivize and guarantee more comprehensive benefits. Consumer protections prohibit insurers from imposing annual and lifetime limits on benefits.[88] Individual plans must offer a package of "essential health benefits" modeled on a standard employer-based group plan.[89] And regulations harmonize coverage across public and private plans.[90]

Of particular relevance to our project, the ACA's preventive services mandate requires all private health plans to provide first-dollar coverage for preventive services without copayments, coinsurance, or deductibles.[91] This provision has been particularly important for reproductive and sexual health care. HHS regulations require insurers

[85] Furrow, *supra* note 37, at 455.

[86] Mariner, *supra* note 24, at 205; *see also* BARBARA PRAINSACK & ALENA BUYX, SOLIDARITY IN BIOMEDICINE AND BEYOND 45 (2017) ("[S]olidarity is most fruitfully understood as something that is enacted, and not as an abstract value, normative ideal, or inner sentiment.").

[87] Baker, *supra* note 37, at 1579 ("[T]o be considered social insurance in the traditional sense, the insurance must be compulsory and easily available, and the price must bear some relation to the ability to pay."); Graetz & Mashaw, *supra* note 46, at 351 (defining social insurance as "mandatory insurance, with subsidies to those at high risk (through some combination of tax revenues and the premiums of those with lower risks)").

[88] 42 U.S.C. § 300gg-11 (2018).

[89] *Id.* § 18022.

[90] Wiley, *supra* note 45, at 2185 (discussing the harmonization of regulatory requirements applicable to privatized Medicaid and Medicare plans with those applicable to individual insurance exchange plans).

[91] 42 U.S.C. § 300gg-13 (2018).

and employers to cover FDA-approved contraceptive methods (including oral contraceptives, intrauterine devices ("IUDs"), emergency contraceptives, and sterilization).[92] Plans must also include screening tests, prevention counseling, and dozens of vaccinations, including the HPV vaccine, which protects against a common sexually transmitted infection that causes cervical and other cancers.[93] In 2019, PrEP, a daily medication that prevents HIV, joined the list of mandated services.[94]

In addition, the ACA's nondiscrimination rule requires equitable and inclusive benefit design. Under Section 1557 of the ACA, health insurers participating in ACA marketplaces and employers who receive support from federal health care programs must refrain from designing coverage so as to discriminate based on race, color, national origin, age, disability, and, for the first time under federal law, sex.[95] As is widely recognized, the statutory language also reaches sexual orientation, gender identity, and pregnancy discrimination.[96] The nondiscrimination rule means, for example, that "an explicit, categorical (or automatic) exclusion or limitation of coverage for all health medications and services related to gender transition is unlawful on its face" in that it "systematically denies services and treatments for transgender individuals."[97] It also probably

[92] *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS. ASS'N, https://www.hrsa.gov/womens-guidelines (last visited Dec. 13, 2023) [https://perma.cc/YAP6-JJR3].

[93] *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, KFF (Feb. 28, 2024), https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/ [https://perma.cc/R8YK-KDGN].

[94] *Prevention of Acquisition of HIV: Preexposure Prophylaxis*, U.S. PREVENTIVE SERVS. TASK FORCE (Aug. 22, 2023), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis [https://perma.cc/KYE9-6GXK].

[95] 42 U.S.C. § 18116 (2018).

[96] This interpretation of "sex" was significantly bolstered by *Bostock v. Clayton County*, which held that sexual orientation and gender identity discrimination are forms of sex discrimination under Title VII of the Civil Rights Act, a workplace statute that courts look to in construing other civil rights laws. 590 U.S. 644, 644 (2020).

[97] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31429 (May 18, 2016). Although the 2016 Rule was reversed by the Trump Administration, the Biden Administration has proposed to largely reinstate the 2016 rule. Katie Keith, *HHS Proposes Revised ACA Anti-Discrimination Rule*, HEALTH AFF. FOREFRONT (July 27, 2022)

prohibits exclusion of contraceptive methods, independent of the preventive services mandate.[98] Beyond health care programs, employers generally bear duties of nondiscrimination under Title VII of the Civil Rights Act in offering and designing benefits.[99]

These benefit-design requirements foster what bioethicist Ruud ter Meulen describes as "solidarity in the sense of mutual recognition."[100] Individuals' health needs vary considerably, such that designing inclusive benefits is necessarily complex and perhaps indeterminate. The recognition of these varying needs does not mean that all demands for support have equal moral weight. It does mean, however, that decisions about benefits and coverage must be based on participatory processes that represent the collective.[101]

Consistent with the social insurance programs of other liberal democracies, the ACA mitigates the tension between solidarity and individualism by adopting a reflective and participatory approach.[102]

https://www.healthaffairs.org/content/forefront/hhs-proposes-revised-aca-anti-discrimination-rule. Numerous courts have endorsed this interpretation of Section 1557. *See* Scott v. St. Louis Univ. Hosp., 600 F. Supp. 3d 956, 964-65 (E.D. Mo. 2022); C.P. *ex rel.* Pritchard v. Blue Cross Blue Shield, 536 F. Supp. 3d 791, 796 (W.D. Wash. 2021); Tovar v. Essentia Health, 342 F. Supp. 3d 947, 953 (D. Minn. 2018). Others have done so under Title VII. *E.g.*, Lange v. Houston Cnty., 608 F. Supp. 3d 1340, 1359-60 (M.D. Ga. 2022); Fletcher v. Alaska, 443 F. Supp. 3d 1024, 1030-31 (D. Alaska 2020).

[98] *E.g.*, Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1271-72 (W.D. Wash. 2001) (holding that exclusion of contraceptives while offering comprehensive prescription benefits violates prohibitions on sex discrimination under Title VII of the Civil Rights Act). It is less clear whether exclusion of abortion constitutes sex discrimination under Section 1557. Title IX of the Education Amendments, which Section 1557's language references, excludes requiring any educational program "to provide or pay for any benefit or service, including the use of facilities, related to an abortion." 20 U.S.C. § 1688 (2018). But the HHS rule did not include such an exception, and objectors have argued that it requires abortion coverage. *Franciscan All.* Complaint, *supra* note 11, at 11.

[99] *See* U.S. EQUAL EMP. OPPORTUNITY COMM'N, *Employee Benefits*, *in* EEOC COMPLIANCE MANUAL (2020).

[100] TER MEULEN, *supra* note 18, at 102. *Cf.* Michael Walzer, *Welfare, Membership, and Need*, *in* LIBERALISM AND ITS CRITICS 200, 204 (Michael J. Sandel ed., 1984) ("Goods must be provided to needy members because of their neediness, but they must also be provided in such a way as to sustain their membership.").

[101] TER MEULEN, *supra* note 18, at 171-72 (arguing that solidarity as recognition can guide fair distribution of benefits and burdens).

[102] *See* TER MEULEN, *supra* note 18, at 102.

Democratic processes set priorities. The idea is to make visible and negotiable the criteria and bounds of exclusion.[103] As part of this process, we may come to appreciate that certain exclusions cannot be politically or morally justified.[104] Social solidarity here operates as a communicative practice in which individuals create a "we" by considering the generalized other — a fellow citizen who may be differently situated by virtue of age, disability, gender, sexuality, or other identities.[105]

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The reforms of the ACA moved the United States toward a new paradigm of American-style social insurance. While needlessly complex and incomplete, health insurance after the ACA covers health risks for the population more uniformly, dependably, and affordably than ever before. Across eligibility, rate-setting, and benefits, it rejects actuarial fairness in favor of social solidarity among equal citizens.

II. RELIGIOUS CHALLENGES AND THE ACA'S CONCEPTUAL PLURALISM

Unlike the (unsuccessful) high-profile challenges to the ACA's individual mandate and subsidies, religious-liberty-based arguments have been treated as marginal to the project of social insurance in America.[106] But they, too, contest the development of social insurance

[103] PRAINSACK & BUYX, *supra* note 86, at 32 (noting that this form of solidarity acts as a "coping mechanism" for differences, ensuring "that difference does not turn into inequality").

[104] *See* JODI DEAN, SOLIDARITY OF STRANGERS: FEMINISM AFTER IDENTITY POLITICS 102 (1996) (describing "reflective solidarity" as encouraging questioning that "calls on us to respect the other in her difference" and "to take accountability for the exclusions within already given practices and interpretations").

[105] TER MEULEN, *supra* note 18, at 102; *see also* Hunter, *supra* note 79, at 1956 (arguing that ACA "creates the potential for broad public conversation — as has never before occurred in the United States — regarding the question of what the relationship should be between membership in the American community and meaningful access to health care").

[106] *Cf.* Holly Fernandez Lynch & Gregory Curfman, *Bosses in the Bedroom: Religious Employers and the Future of Employer-Sponsored Health Care*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES 154 (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017) (problematizing private employer role in insurance provision); Elizabeth Sepper, *Contraception and the Birth of Corporate Conscience*, 22 AM. U. J. GENDER,

through the democratic process. And they have had considerable success, in part because they exploit the conceptual pluralism embedded in the ACA's benefit-design regulations.

In Section A, we argue that religious objections to the ACA are escalating. In the markets, health care sharing ministries ("HCSMs") — which unite members of Christian denominations to share medical costs free from insurance regulation — have grown to unanticipated size.[107] In the courts, objectors have taken a trajectory from more modest requests for accommodation to bold demands to remake the market for everyone.[108] In Section B, we explain that the lack of a unified rationale for health insurance benefits has made the ACA more vulnerable to religious attack. Drawing on Hoffman's framework, we analyze how participants in debates over religious exemptions assert alternative and often-conflicting theories of what insurance should do: promote health, protect financial security, or mitigate brute luck.[109]

A. The Campaign for Religious Exemptions

The invocation of religion against the ACA began with two legislative exemptions from the individual mandate to purchase health insurance.[110] The first exemption covers members of long-standing religious sects, like the Amish, that have recognized objections to

SOC. POL'Y & L. 303 (2014) (arguing that religious liberty challenges to contraception required understanding the nature of health benefits and the social insurance function of the ACA).

[107] VOLK ET AL., *supra* note 26, at 2 (mapping state laws exempting HCSMs from state insurance regulation); *id.* at 4 (discussing the reported spike in enrollment in HCSMs since 2010 and the lack of independent data tracking enrollment).

[108] *See infra* notes 115–118, 122–139 and accompanying text.

[109] Hoffman, *supra* note 27, at 1873.

[110] Initially, two religious exemptions were granted to individuals. Jeffery R. Mullen, *Religion and the PPACA: An Analysis of Non-Secular Line Drawing Within the Health Insurance Mandate*, 14 RUTGERS J.L. & RELIGION 149, 150-51 (2012) (reviewing the initial two exemptions). A third exemption added in 2018 applies to individuals who rely exclusively on faith healing. 26 U.S.C. § 5000A(d)(2)(A)(i)(II) (2018); Substance Use-Disorder Prevention that Promotes Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, § 4003, 132 Stat. 3959 (2018).

insurance and take care of dependents within the community.[111] The second — which has created an expansive loophole — is for individuals who join HCSMs.[112] HCSMs are entities that collect monthly payments and offer a means for paying medical bills, but disclaim providing insurance.[113] They tend to categorically exclude an array of reproductive and sexual health care, mental health benefits, treatment for substance use disorders, and "injuries resulting from the abuse of drugs and alcohol."[114] Unlike the first exemption, which is tailored to religious objections to participating in insurance, the HCSM exemption requires only that ministry members "share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs."[115]

At the time that Congress exempted their members from the individual mandate, HCSMs were not thought to be dangerous to the ACA's social insurance scheme. They had not held wide appeal, and only people very committed to the religious beliefs of the ministry were

[111] 26 U.S.C. §§ 5000A(d)(2)(A)(i)(I), 1402(g) (2018). This exemption "is patterned on, and substantially identical to, an existing religious conscience exemption to laws requiring workers to pay taxes for Social Security." Mullen, *supra* note 110, at 150-51. An additional exemption was signed into law in 2018 for individuals who object to accepting medical services because they rely exclusively on faith healing. § 5000A(d)(2)(A)(i)(II) (2018).

[112] 26 U.S.C. § 5000A(d)(2)(B) (2018).

[113] *Id.* For a description of HCSMs before the ACA's passage, see generally Benjamin Boyd, *Health Care Sharing Ministries: Scam or Solution?*, 26 J.L. & HEALTH 219 (2013).

[114] Rachel E. Sachs, *Religious Exemptions to the Individual Mandate: Health Care Sharing Ministries and the Affordable Care Act*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES 145-46 (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017).

[115] 26 U.S.C. § 5000A(d)(2)(B)(ii)(II) (2018); Charlene Galarneau, *Health Care Sharing Ministries and Their Exemption from the Individual Mandate of the Affordable Care Act*, 12 J. BIOETHICAL INQUIRY 269, 279 (2015) (noting that it is not clear what this common set of beliefs requires and that "HCSMs represent themselves both as inclusive of a wide range of Christian beliefs and as more narrowly defined by evangelical Christian beliefs").

predicted to join.[116] But HCSMs have grown dramatically, from approximately 100,000 members in 2010 to around 1.7 million today.[117]

In some states, the HCSM exemption may have destabilized risk pools in the exchanges.[118] The (sometimes) lower costs and skimpier coverage of the ministries tend to attract healthier people, who anticipate that they will not need as much insurance as exchange plans provide.[119] HCSM members, however, need not hold religious beliefs that preclude them from obtaining insurance coverage in the future.[120] Thus, when they become ill or need more comprehensive coverage, they may draw on Medicare, Medicaid, or local government resources, or they may leave for ACA-compliant plans.[121]

These legislative exemptions — though broad — have been insufficient to resolve religious objections to the ACA. The HCSM

[116] Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 44 (2011).

[117] Kevin Eastman, Joseph S. Ruhland & Alan Eastman, *Regulation of Health Care Sharing Ministries*, 29 J. INS. REG. 189, 190 (2010) (citing a contemporaneous trade association website for the statement that HCSMs "currently serve more than 100,000 members residing among all 50 states"); Markian Hawryluk, *At Least 1.7M Americans Use Health Sharing Arrangements, Despite Lack of Protections*, KFF HEALTH NEWS (June 14, 2023) https://kffhealthnews.org/news/article/health-sharing-arrangements-ministries-protections-risks/ [https://perma.cc/VU28-MS6F].

[118] James R. Salzmann, *Statutory Millennialism: Establishment and Free Exercise Concerns Arising from the Health Care Sharing Ministry Exemption's 1999 Cutoff Date*, 91 S. CAL. L. REV. 303, 305 (2018); *See* Sachs, *supra* note 114, at 153 (predicting that this might happen). In some states, membership is significant relative to the individual market. COLO. DEP'T OF REGUL. AGENCIES, HEALTH CARE SHARING PLANS AND ARRANGEMENTS IN COLORADO 4 (2021) (noting that membership in HCSMs reporting to the state was approximately thirty percent of the individual market); VOLK ET AL., *supra* note 26, at 5 (reporting that Alaska has an estimated 10,000 HCSM members compared to 20,000 on the individual market).

[119] Carolyn Schwarz, *Freed from Insurance: Health Care Sharing Ministries and the Moralization of Health Care*, 268 SOC. SCI. & MED. 1, 2 (2021) [hereinafter Schwarz, *Freed from Insurance*] (estimating in 2018 that HCSMs' monthly fees were between $119 to $422 less than the monthly cost of unsubsidized insurance plans on the exchanges).

[120] Salzmann, *supra* note 118, at 311 (observing "potential for abuse").

[121] Galarneau, *supra* note 115, at 272. Anyone eligible for exchange plan coverage may enroll during an annual open enrollment period, which typically lasts several months. VANESSA C. FORSBERG, CONG. RSCH. SERV., OVERVIEW OF HEALTH INSURANCE EXCHANGES 9-11 (Mar. 17, 2023).

exemption creates an avenue for individuals to opt out of health insurance plans that cover benefits they deem objectionable.[122] But because the ACA does not recognize HCSMs as an exception to the employer mandate, any large employer that financed ministry membership instead of health insurance for its employees would have to pay additional taxes.[123] Moreover, some individuals and employers wish to purchase real health insurance plans, but exclude certain benefits required by the ACA.

And so, shortly after the ACA's enactment, the clash between religion and social insurance moved to the administrative realm and the courts, with the focus shifting to benefit design. In 2013, the Obama administration finalized a rule carving out religious exemptions from the requirement to provide contraceptive coverage, which became known as the "contraceptive mandate."[124] Under this rule, houses of worship were exempted altogether.[125] Religiously affiliated non-profit employers — such as universities and social service providers — could secure an accommodation that maintained access to contraceptives for employees through a separate plan.[126] For-profit employers had to comply.[127]

Employers filed hundreds of court challenges to the 2013 Rule, resulting in a trilogy of Supreme Court cases. In *Burwell v. Hobby Lobby*, the Court concluded that the Religious Freedom Restoration Act required the government to accommodate objecting for-profit

[122] *See supra* note 112 and accompanying text.

[123] The tax is assessed based on the number of employees who use government subsidies to purchase insurance on the exchanges. *See* Amy Skinner, *Sharing Ministries and ICHRA: Good Together?*, TAKE COMMAND (Jan. 31, 2023), https://www.takecommandhealth.com/blog/health-care-sharing-ministries-ichra [https://perma.cc/GN8F-W6HH]; *see also* Danielle Paquette, *'Christians Are Just Healthier': One Family's Cost-Sharing Alternative to Obamacare*, WASH. POST (Aug. 29, 2014, 8:51 AM), https://www.washingtonpost.com/news/storyline/wp/2014/08/29/christians-are-just-healthier-one-familys-cost-sharing-alternative-to-obamacare/ [https://perma.cc/54FQ-EY36] (reporting that Samaritan HCSM, which employs about 130 people, used an HCSM and planned to pay the additional taxes).

[124] Coverage of Preventive Services Under Patient Protection and Affordable Care Act, 78 Fed. Reg. 8456 (Feb. 6, 2013).

[125] *Id.* at 8459.

[126] *Id.* at 8461.

[127] *Id.* at 8462.

corporations because it had chosen to accommodate non-profit religious organizations.[128] Employers then claimed that the process of requesting an accommodation itself violated their free exercise of religion and demanded total exemption.[129] In *Zubik v. Burwell*, the Supreme Court — short one vote following Justice Scalia's death — remanded the case for additional negotiation.[130] Objectors ultimately prevailed in the regulatory process: in 2018, the Trump Administration finalized a rule with a broad "moral" exemption available to for-profit employers.[131] In *Little Sisters of the Poor v. Pennsylvania*, the Court upheld the 2018 Rule.[132]

In *Hobby Lobby*, the Court scolded the government that the impact on women of expanding the accommodation would be "precisely zero."[133] But six years later in *Little Sisters of the Poor*, the Court approved an exemption that the Trump Administration estimated would immediately strip coverage from between 70,500 and 126,400 women.[134] The numbers of individuals affected are likely many times larger than these early estimates.[135]

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[128] 573 U.S. 682, 730-31 (2014).

[129] Zubik v. Burwell, 578 U.S. 403 (2016).

[130] *Id.* at 410.

[131] Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57536 (Nov. 15, 2018).

[132] Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, 591 U.S. 657, 687 (2020).

[133] *Burwell*, 573 U.S. at 693. For analysis of harms to Hobby Lobby's employees, see Nelson Tebbe, Richard C. Schragger, & Micah J. Schwartzman, *Hobby Lobby's Bitter Anniversary*, BALKINIZATION (June 30, 2015), https://balkin.blogspot.com/2015/06/ [https://perma.cc/3HSE-DFBKDFB].

[134] *Little Sisters of the Poor*, 591 U.S. at 711 (Ginsberg, J., dissenting) (citing the 2018 Rule, 83 Fed. Reg. at 57578-57580).

[135] Consider that 152,883 teachers work in Catholic elementary, middle, and secondary schools; the vast majority are likely to be women (and this number does not include the numerous non-teaching employees). *Catholic Education*, U.S. CONF. OF CATH. BISHOPS, https://www.usccb.org/offices/public-affairs/catholic-education (last visited July 23, 2024) [https://perma.cc/97HF-96WY]. Catholic higher education served roughly 950,000 students; we can assume at least half are women and some percentage rely on student insurance. Joseph A. McCartin, *Confronting the Labor Problem in Catholic Higher Education: Applying Catholic Social Teaching in an Age of Increasing Inequality*, 37 J. CATH. HIGHER EDUC. 71, 75 (2018). Liberty University, which objects to covering at least some contraceptive methods, enrolls 110,000 students annually. Timothy Jost, *Implementing*

Additional preventive services requirements have come under fire. In *Braidwood Management v. Becerra*, several Christian-owned, for-profit employers and individuals have raised religious objections to a range of preventive services.[136] Individual plaintiffs seek the right to "purchase health insurance that excludes or limits coverage of PrEP drugs, contraception, the HPV vaccine, and the screenings and behavioral counseling for [STIs] and drug use."[137] The employers' claims emphasize resistance to PrEP and STI screening and counseling. So far, the plaintiffs have prevailed on their RFRA claim against the PrEP mandate.[138]

Religious objections also extend to civil rights protections — in particular, the prohibition on sex discrimination in benefit design. Again, employers have sued and won. In *Franciscan Alliance v. Becerra*, the court exempted a chain of Catholic health care facilities and the purported 18,000 members of the Christian Medical and Dental Association from obligations to cover sterilization, pregnancy termination, and gender-affirming care in their employee health benefit plans.[139] In *Religious Sisters of Mercy v. Becerra*, the Eight Circuit upheld a permanent injunction against enforcing the ACA's nondiscrimination rule or Title VII of the Civil Rights Act to require coverage of gender transition services against the Catholic Medical Association, Catholic Benefits Association, and a number of health care chains.[140] And in *Christian Employers Alliance v. EEOC*, another court granted an injunction with regard to coverage for gender transition services to any

Health Reform: Contraception Coverage and the Liberty University Case, HEALTH AFFS. BLOG (May 23, 2013), https://www.healthaffairs.org/content/forefront/implementing-health-reform-contraception-coverage-and-liberty-university-case [https://perma.cc/9P7C-EJZ2].

[136] Braidwood Mgmt. Inc. v. Becerra, 627 F. Supp. 3d 624, 633-34 (N.D. Tex. 2022). Some plaintiffs initially objected to covering a long list of screening, counseling, vaccination, and treatment services for infections that are typically transmitted through sexual contact or drug use. They dropped these objections from their amended complaint, then (unsuccessfully) sought to revive it on a motion for summary judgment. These additional objections could be the basis of a future suit. *See supra* note 10.

[137] *Braidwood Mgmt.*, 627 F. Supp. 3d at 633.

[138] *Id.* at 655.

[139] 227 F. Supp. 3d 660, 674 (N.D. Tex. 2016).

[140] 55 F.4th 583, 609 (8th Cir. 2022).

"present or future" members of an association of non-profit and for-profit employers with "Christian values."[141]

Across these lawsuits, plaintiffs have asserted — and courts have endorsed — an increasingly scrupulous notion of complicity. In the initial contraceptive challenges, for-profits successfully argued that it was irrelevant that they were not themselves required to buy or use contraceptives, as they sincerely objected to paying, arranging, or contracting for those services.[142] Then the non-profit challengers ratcheted up the idea of complicity. Under the 2013 Rule's accommodation, these employers did not have to pay, arrange, or contract for contraceptive coverage.[143] Yet, they claimed that their religious convictions forbade contracting with companies that provide such coverage separately.[144] And in *Little Sisters of the Poor*, Justices Alito and Gorsuch endorsed the notion that even asking an employer to sign a self-certification of exemption renders it complicit by triggering a process through which employees may eventually obtain contraceptive coverage.[145] It seems that in the view of many courts, even highly remote participation in the activities of others substantially burdens religious freedom.

Commentators often defend accommodations for religious objectors — even to health and safety regulations — as relatively inconsequential. But, here, religious objectors have not been content with accommodation and have stepped up their demands. The claims, moreover, proceed in a doctrinal landscape that has become

[141] Christian Emps. All. v. EEOC, No. 1:21-CV-195, 2022 WL 1573689, at *9 (D.N.D. May 16, 2022).

[142] *E.g.*, Korte v. Sebelius, 735 F.3d 654, 685 (7th Cir. 2013) ("[T]he religious-liberty violation at issue here inheres in the *coerced coverage* of contraception, abortifacients, sterilization, and related services, *not* — or perhaps more precisely, *not only* — in the later purchase or use of contraception or related services.").

[143] Religious Employer Exemptions and Accommodations for Health Coverage Established or Maintained or Arranged by Eligible Organizations, 78 Fed. Reg. 8462 (Feb. 6, 2013) (codified at 45 C.F.R. § 147.131(b)).

[144] *E.g.*, Priests for Life v. U.S. Dep't of Health & Hum. Servs., 772 F.3d 229, 237 (D.C. Cir. 2014); Univ. of Notre Dame v. Sebelius, 743 F.3d 547, 557 (7th Cir. 2014).

[145] Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, 591 U.S. 657, 694-96 (2020) (Alito, J., concurring).

dramatically more welcoming of religious objections.[146] And we are now seeing courts asked to take down programs wholesale.

Consider the series of lawsuits involving some of the plaintiffs in the *Braidwood* case. Initially, they won a permanent injunction barring the government from enforcing the contraceptive mandate.[147] But this injunction did not satisfy objectors, because the mandate made "it financially unappealing for insurers to offer contraceptive-free policies" to them.[148] So, they claimed, the very existence of the mandate constituted injury.[149] The government objected that the earlier injunction had "already freed insurers to offer health insurance without contraceptive coverage;" any injury resulted from those insurers' independent choices.[150]

Nonetheless, the court sided with the objectors. The plaintiffs suffered injury so long as enforcement existed anywhere in the market; after all, "the Contraceptive Mandate is not called the Contraceptive Suggestion."[151] Without a mandate, it was plausible that "the insurance market would return to its pre-ACA conditions to meet demand for policies that do not cover these products."[152] Ultimately, the court decided that the plaintiffs' request for a blanket injunction was barred by res judicata because they had brought an earlier suit against the

[146] In a decade, the Court has reinterpreted nearly every aspect of RFRA. It also has expanded the reach of the Free Exercise Clause. *See* Fulton v. City of Philadelphia, 593 U.S. 522, 535-36 (2021) (requiring exemption due to an imagined (and never used) exemption regime); Tandon v. Newsom, 593 U.S. 61, 62 (2021) (holding that any secular exception in a law requires religious exemption); Masterpiece Cakeshop, Ltd. v. Colo. C.R. Comm'n, 584 U.S. 617, 648-49 (2018) (dramatically broadening definition of animus).

[147] DeOtte v. Azar, 393 F. Supp. 3d 490, 514 (N.D. Tex. 2019).

[148] *See* Kelley v. Azar, No. 4:20-CV-00283-O, 2021 WL 4025804, at *4 (N.D. Tex. Feb. 25, 2021). Because Braidwood Management self-insures and does not contract with an insurance company to cover its employees, the *DeOtte* injunction sufficed to allow its plan to exclude contraceptive coverage. Other plaintiffs who purchase coverage from insurers continued to challenge the mandate.

[149] *Id.* For a similar argument from a small employer not subject to the employer mandate and unable to purchase a plan that excluded contraception under an injunction, see Annex Med., Inc. v. Burwell, 769 F.3d 578, 581 (8th Cir. 2014).

[150] *Kelley*, 2021 WL 4025804, at *4.

[151] *Id.* at *5.

[152] *Id.*

contraceptive mandate.[153] But its favorable disposition toward this remedy seems likely to spur additional demands. No longer satisfied with targeted injunctions, some objectors aspire to remake the market through the courts.

B. The ACA's Conceptual Pluralism as Vulnerability

Seen through the lens of political economy, religious challenges to the ACA's benefit-design regulations manifest a deep disagreement over the risks for which our society should assume collective responsibility. Objectors do not reject health insurance per se. Indeed, many profess a religious commitment to provide health benefits to their employees.[154] And individual plaintiffs seem to want to purchase ACA-compliant insurance, rather than enroll in an HCSM.[155] But thorny questions remain about which conditions trigger the collective's obligation to provide aid. The litigants offer divergent answers to the question: what is health insurance for? That is, which risks should it cover, and why?

As Allison Hoffman has argued, the ACA offers a pluralistic response to these questions — alternating between prioritizing health promotion, financial protection, and (in limited ways) brute luck remediation.[156] Through a close reading of court filings and judicial opinions, this Section shows that the religious objectors exploit this pluralism, asserting policy arguments in the courts that failed to prevail in Congress and the administrative process. It argues that the ACA's lack of firm commitment to health promotion and financial protection made it more vulnerable — allowing litigants to question the government's commitment to health promotion (subsection 1), to dispute financial protection as justification for preventive care (subsection 2), and to embrace and expand upon the ACA's concessions to a brute luck conception of insurance (subsection 3).

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[153] The opinion advised the plaintiffs to pursue an amendment to the earlier injunction. *See id.* at *8.

[154] *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 685 (2014).

[155] *See, e.g.*, Dierlam v. Trump, 977 F.3d 471, 477-78 (5th Cir. 2020) (noting that an individual objecting to purchasing insurance covering sterilization and contraception "says the sharing ministry is not a viable option for him").

[156] *See* Hoffman, *supra* note 27, at 1936-39.

1. Questioning Health Promotion

The health promotion theory holds that insurance should primarily prioritize improving health through high-quality, evidence-based care.[157] Unlike other approaches, coverage designed around health promotion is not focused on particularly costly services.[158] Nor does it differentiate between diseases resulting from unhealthy choices and those befalling a person at random.[159]

The ACA's preventive services mandate is the central exemplar of this approach.[160] Recognizing that even individuals with insurance skip or delay preventive care because of out-of-pocket costs, Congress required all insurance plans to cover preventive services without cost-sharing.[161] It specifically listed immunizations against infectious disease and women's preventive services,[162] with the expectation that family planning would be included.[163]

Cost-free coverage of preventive care promotes health on two levels — the individual and the population.[164] Take contraceptives. In the United States, nearly half of pregnancies are unintended.[165] Unintended pregnancies carry greater risk of low-birth-weight infants and preterm birth; contraception improves birth spacing to the benefit of parents

[157] *See id.* at 1890-91.

[158] *See id.* at 1902.

[159] *See id.* at 1892-93.

[160] *See id.* at 1890, 1904-05.

[161] *See* 42 U.S.C. § 300gg-13(a) (2018).

[162] *Id.* §§ 300gg-13(a)(2), 300gg-13(a)(4).

[163] *E.g.*, 155 CONG. REC. 12025, 12027 (2009) (statement of Sen. Gillibrand) ("[E]ven more preventive screening will be covered, including . . . family planning."); *id.* at 12025 (statement of Sen. Boxer) ("These health care services include . . . family planning services."); 155 CONG. REC. 12033, 12052 (2009) (statement of Sen. Franken) ("[A]ffordable family planning services must be accessible to all women in our reformed health care system.").

[164] For a review of the impact of the preventive services mandate, see generally Hope C. Norris, Haley M. Richardson, Marie-Anais C. Benoit, Beth Shrosbree, Judith E. Smith & A. Mark Fendrick, *Utilization Impact of Cost-Sharing Elimination for Preventive Care Services: A Rapid Review*, 79 MED. CARE RES. & REV. 175 (2022).

[165] Susheela Singh, Gilda Sedgh & Rubina Hussain, *Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes*, 41 STUD. FAM. PLAN. 241, 245 (2010).

and children.[166] It also prevents certain cancers, menstrual disorders, and pelvic pain.[167] The case for covering PrEP, STI screening and counselling, and vaccination is even stronger given the potentially exponential benefits for public health. As the government explained, with regard to HIV, "[a]ny individual who does not become infected also cannot transmit the virus to others, who in turn cannot transmit it to still others, and so on."[168] Through the preventive services mandate, insurers became "the first line of defense against HIV and AIDS"[169] and — as became clear during the Covid-19 pandemic — for the public's health more generally.[170]

Designing insurance around health promotion tends to emphasize scientific expertise and to evolve with the evidence. Thus, Congress assigned the task of recommending preventive services for coverage to expert advisory bodies — including the Health Resources and Services Administration ("HRSA") with input from the Institute of Medicine ("IOM").[171] Their review of the scientific evidence was to identify measures "shown to improve well-being and/or decrease the likelihood or delay the onset of a targeted disease or condition."[172]

In their suits, religious challengers first question whether the government actually committed to health promotion by enacting the ACA. In its contraception challenge, for example, Conestoga Wood argued that Congress "deemphasized the preventive services

[166] Jessica D. Gipson, Michael A. Koenig & Michelle J. Hindin, *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 STUD. FAM. PLAN. 18, 24 (2008); Jennifer A. Hall, Lorna Benton, Andrew Copas & Judith Stephenson, *Pregnancy Intention and Pregnancy Outcome: Systematic Review and Meta-Analysis,* 21 MATERNAL CHILD HEALTH J. 670, 678 (2017).

[167] Adolf E. Schindler, *Non-Contraceptive Benefits of Oral Hormonal Contraceptives*, 11 INT'L J. ENDOCRINOLOGY & METABOLISM 41, 41 (2013).

[168] Defendants' Brief in Support of Response to Plaintiffs' Motion for Summary Judgment and Cross-Motion for Summary Judgment at 58, Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-CV-00283-O).

[169] *Id.* at 4-5.

[170] *See Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, *supra* note 93 (explaining that Congress mandated coverage of COVID-19 vaccines and boosters within private insurance plans without the typical delay).

[171] *See* COMM. ON PREVENTIVE SERVS. FOR WOMEN, INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 16-18 (2011).

[172] *Id.* at 23.

requirement in general."[173] The proof, religious objectors claimed, lies in "the fact that the mandate derives from recommendations of the Institute of Medicine — a 'semi-private' organization."[174] As this argument goes, if Congress thought contraception "strictly necessary to promote public health," it would have listed it specifically.[175]

Second, even accepting health promotion as a priority, litigants contend that contraception, abortion, and gender-affirming care do not in fact promote health. Representative was Conestoga Wood's argument that the government's "asserted 'health' interests in preventing unintended pregnancy have a weak evidentiary foundation" and that "the government's evidence betrays uncertainty about a causal connection between unintended pregnancy and negative health consequences."[176] Amicus Women Speak for Themselves went further, warning that contraception makes women sick.[177] In this way, as Priscilla Smith has documented, objectors employed the rhetoric of scientific discourse to advance moral opposition to non-procreative sex.[178]

Disputing the health benefits of gender-affirming care has been a central focus of religious objectors. In *Franciscan Alliance*, for example, plaintiffs repeatedly described gender-affirming surgery as removing healthy tissue (reproductive organs and breasts).[179] They characterized hormone therapy and puberty blockers as harming "previously biologically healthy" patients and "inhibit[ing] normal growth and

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[173] Brief for Petitioners at 2, Conestoga Wood Specialties Corp. v. Sebelius, 573 U.S. 682 (2014) (No. 13-356) [hereinafter *Conestoga* Brief for Petitioners].

[174] Brief for Respondents at 46, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354).

[175] *Id.*

[176] *Conestoga* Brief for Petitioners, *supra* note 173, at 15; *see also* Legatus v. Sebelius, 901 F. Supp. 2d 980, 993 (E.D. Mich. 2012) ("Plaintiffs argue that the known negative medical side effects of oral contraception outweigh the positive health benefits . . . .").

[177] Brief for Amicus Women Speak Now at 22, 32-37, 2014 WL 316714, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354) (cataloging purported harms and arguing that "HHS does not devote sufficient attention to the possibility that increasing access to contraception might directly harm women's health").

[178] Priscilla J. Smith, *Contraceptive Comstockery: Reasoning from Immorality to Illness in the Twenty-First Century*, 47 CONN. L. REV. 971, 971 (2015).

[179] First Amended Complaint at 14-15, Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (No. 21-11174).

fertility."[180] Pointing to studies rejected by mainstream medical experts, they alleged "potentially harmful psychological effects" from treatment.[181]

Judges siding with challengers frequently acknowledge health promotion as the goal of benefit mandates, but then deny that the disputed services promote health. For example, dissenting from the Third Circuit's opinion refusing to enjoin the contraceptive mandate, Judge Jordan distinguished contraceptives as "one fatal dish" in "a litany of laudatory things" mandated by the ACA.[182] The D.C. Circuit similarly found unconvincing the government's argument that the mandate prevents "negative health consequences for both the woman and the developing fetus" and suggested that contraceptives instead may harm women's health.[183]

The *Hobby Lobby* majority likewise appeared willing to accept health promotion as a legitimate (or potentially compelling) goal but seemed skeptical that contraceptives promote health. The Court indicated that an insurance mandate need not "necessarily fall if it conflicts with an employer's religious beliefs."[184] It distinguished "[o]ther coverage requirements, such as immunizations" as "supported by *different*

[180] *Id.* at 30 (quoting *Position Statement: Transgender Identification*, CHRISTIAN MED. & DENTAL ASS'NS 5, https://cmda.org/article/transgender-identification-ethics-statement/ (last visited Sept. 15, 2024) [https://perma.cc/8BMS-8BXW]).

[181] *Id.* at 31 (quoting *Position Statement: Transgender Identification*, *supra* note 180, at 5). *Contra* Diana M. Tordoff, Jonathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youth Receiving Gender-Affirming Care*, 5 JAMA NETWORK OPEN 1, 1 (2022) (finding that gender-affirming care reduced depression and suicidality over one year); Anna I.R. van der Miesen, Thomas D. Steensma, Annelou L.C. de Vries, Henny Bos & Arne Popma, *Psychological Functioning in Transgender Adolescents Before and After Gender Affirmative Care Compared with Cisgender General Population Peers*, 66 J. ADOLESCENT HEALTH 699, 699-704 (2020) (reporting that gender-affirming care may be associated with fewer emotional and behavioral problems).

[182] Conestoga Wood Specialties Corp. v. Sebelius, No. 13-1144, 2013 WL 1277419, at *7 (3d Cir. Feb. 8, 2013) (Jordan, J., dissenting).

[183] Gilardi v. U.S. Dep't of Health & Hum. Servs., 733 F.3d 1208, 1221 (D.C. Cir. 2013), *vacated and remanded by* Gilardi v. U.S. Dep't of Health & Hum. Servs., 573 U.S. 956 (2014).

[184] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 733 (2014).

interests (for example, the need to combat the spread of infectious diseases)."[185]

Denial of health promotion is not, however, a necessary component of religious objections. For example, the plaintiffs in *Braidwood* seem to recognize the health benefits of PrEP. As Judge O'Connor noted, they do "not dispute the government's compelling interest in preventing the spread of infectious disease, the severity of HIV, or the effectiveness of PrEP drugs."[186] They acknowledge PrEP's value to public health and its advantage, if not necessity, for individual well-being.

2. Disputing Financial Protection

A second approach — the financial security theory — instead would design coverage to primarily guard against the financial risk of unanticipated medical bills or expensive chronic illnesses.[187] Health care services are prohibitively expensive for most households, and medical debt is a leading cause of bankruptcy.[188] Unlike health promotion, this theory emphasizes shielding households from large financial shocks that might impact their livelihood.[189] Several provisions of the ACA reflect a commitment to financial security, limiting annual out-of-pocket expenditures[190] and prohibiting annual and lifetime caps on coverage.[191]

Coverage of preventive services has been defended as consistent with a financial security model. Congress acted in response to evidence that women pay sixty-eight percent more in out-of-pocket health costs as compared to men, in large part due to the costs of contraception and reproduction.[192] In amicus briefs to the Supreme Court, women's rights

[185] *Id.* (emphasis added).

[186] Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 653 (N.D. Tex. 2022).

[187] *See* Hoffman, *supra* note 27, at 1908-09.

[188] *See* Noam N. Levey, *100 Million People in America Are Saddled with Health Care Debt*, KAISER HEALTH NEWS (June 16, 2022), https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ [https://perma.cc/RDN6-VX4H].

[189] Hoffman, *supra* note 27, at 1908-10.

[190] *See* 42 U.S.C. § 18022(c) (2018).

[191] *See id.* § 300gg-11.

[192] Rachel Benson Gold, *The Need for and Cost of Mandating Private Insurance Coverage of Contraception*, 1 GUTTMACHER REP. ON PUB. POL. 1, 5 (1998). Up to forty-four percent of

groups highlighted the high price of the most reliable, long-acting forms of contraception, barriers "magnified by women's lower incomes."[193]

Religious objectors instead have argued that the contraceptive mandate is unnecessary for financial protection, because "cost is not a prohibitive factor to contraceptive access."[194] The most expensive oral contraceptive pills, for example, cost around $600 per year.[195] Because the need for contraception is relatively low-cost, the plaintiffs question whether it requires insurance at all.

The Supreme Court's opinions in the contraceptive litigation have foregrounded arguments about financial security. The majority in *Hobby Lobby* assumed that the government had an interest in guaranteeing cost-free access to contraception, because "HHS tells us that '[s]tudies have demonstrated that even moderate copayments for preventive services can deter patients from receiving those services.'"[196] Justice Ginsberg's various dissents likewise underscored that cost formed a barrier to access (that is, that financial security and health promotion conceptions of health insurance aligned).[197]

By contrast, financial security arguments are not playing a significant role in suits involving gender-affirming care and PrEP, likely because these services are prohibitively expensive. The costs of gender-affirming care can reach $100,000 or more.[198] And few can afford to pay out-of-

women's out-of-pocket health care spending was estimated to be due to contraceptives prior to the ACA. Michelle Andrews, *Contraception Is Free to Women, Except When It's Not*, NPR (July 21, 2021, 5:06 AM), https://www.npr.org/sections/health-shots/2021/07/21/1018483557/contraception-is-free-to-women-except-when-its-not [https://perma.cc/ZAX9-8RUB].

[193] Brief for the National Women's Law Center and Sixty-Eight Other Organizations as Amici Curiae in Support of the Government at 15-17, 22, Sebelius v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-356), 2014 WL 333895, at *15-17, 22.

[194] Brief of Plaintiffs-Appellants at 54, Korte v. U.S. Dep't of Health & Hum. Servs., 735 F.3d 654 (7th Cir. 2013) (No.12-3841), 2013 WL 431686, at *54.

[195] *See How Do I Get Birth Control Pills?*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-do-i-get-birth-control-pills (last visited Sept. 8, 2023) [https://perma.cc/A3YE-9X86].

[196] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 727 (2014).

[197] *E.g.*, Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657, 712, 716 (2020) (Ginsberg, J., dissenting).

[198] Benji Jones, *The Staggering Costs of Being Transgender in the US, Where Even Patients with Health Insurance Can Face Six-Figure Bills*, BUS. INSIDER (July 10, 2019, 11:38 AM),

pocket for PrEP, which can run more than $21,000 annually.[199] What is less clear is why the government has not defended coverage of PrEP and gender-affirming care as justified by their high costs and impact on patient finances. Perhaps it is concerned that financial security arguments would undermine its emphasis on health promotion. It might also have preferred to sidestep the issue due to worries about stigma, recalling Justice Alito's invocation of "costly sex reassignment surgery" as a likely "battleground" between firms and employees.[200]

3. Embracing Brute Luck Remediation

Finally, the brute luck theory prioritizes insuring against unavoidable health risks over which individuals have no control.[201] Under this theory, insurance should provide collective financing for harms that could befall any community member at random — think of a pedestrian hit by a bus — but should exclude harms that an individual brings upon herself — such as a smoker with lung disease.[202] This emphasis on chance over choice aligns with a particularly harsh form of luck egalitarianism, which legal philosopher Daniel Markovits describes as "responsibility-tracking."[203] Under this view, redistribution of resources should rule out any "compensation for the differential effects of choice."[204] To the

https://www.businessinsider.com/transgender-medical-care-surgery-expensive-2019-6 [https://perma.cc/7D2U-R43W].

[199] *See* Sarah Varney, *HIV Preventive Care Is Supposed to Be Free in the US. So, Why Are Some Patients Still Paying?*, KFF HEALTH NEWS (Mar. 3, 2022), https://khn.org/news/article/prep-hiv-prevention-costs-covered-problems-insurance/ [https://perma.cc/7UB8-GEBV].

[200] Bostock v. Clayton County, 590 U.S. 644, 730 (2020) (Alito, J., dissenting).

[201] *See* Hoffman, *supra* note 27, at 1922-26. For discussions of luck egalitarianism and the notion of "the undeserving poor," see generally Richard J. Arneson, *Egalitarianism and the Undeserving Poor*, 5 J. POL. PHIL. 327 (1997); G.A. Cohen, *On the Currency of Egalitarian Justice*, 99 ETHICS 906 (1989). For a discussion of luck egalitarianism in health policies, see generally SHLOMI SEGALL, HEALTH, LUCK, AND JUSTICE (2009).

[202] Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 42 (2010).

[203] Daniel Markovits, *Luck Egalitarianism and Political Solidarity*, 9 THEORETICAL INQUIRIES LAW 271, 275-76, 281 (2007) (describing the "responsibility tracking" approach as a "pathologi[cal]" alternative to the "kinder, gentler" luck egalitarianism the author defends).

[204] *Id.* at 276.

extent that the collective chooses to support authors of their own misfortune, it should be as a matter of charity, not shared responsibility.[205]

The ACA largely rejected the notion that insurance should be limited to remedying brute luck but included two exceptions that continue to penalize people for health-related behaviors.[206] First, on the individual insurance exchanges, the "tobacco surcharge" permits insurers to charge higher rates to people who use tobacco. Second, insurers may offer rewards — effectively, lower rates — to people who participate in certain wellness programs promoting behavior changes.[207] Touted as preserving a role for "personal responsibility" within a broader shift toward socializing health care costs, these concessions to brute luck may have made the ACA more politically palatable, but they also made its implementation more difficult.[208]

The notion that chosen risks do not merit collective protection comes to the fore in religious challenges targeting HIV and STI prevention. The *Braidwood* plaintiffs repeatedly describe "sexual promiscuity," "homosexual sodomy," "prostitution," and "drug use" as "lifestyle choices."[209] They allege that a plan should not "pay for the screenings, immunizations, counseling, or treatments [an employer deems objectionable] because they are consequences of a patient's choice."[210] Their language reprises the arguments of wellness-program proponents that the ACA should allow insurance plans to impose penalties on what they referred to as "lifestyle diseases" — like type-two diabetes and coronary artery disease.[211] The overarching message is that the

[205] *Id.* at 281 (describing how "humanitarian" considerations, which "require aiding even the most foolhardy, once their state becomes sufficiently bad," may supplement egalitarian obligations that track individual responsibility); *cf.* Shlomi Segall, *In Solidarity with the Imprudent: A Defense of Luck Egalitarianism*, 33 SOC. THEORY & PRAC. 177 (2007) (arguing luck egalitarianism can be just when complemented with moral considerations).

[206] *See* Hoffman, *supra* note 27, at 1873.

[207] *See id.* at 1934-36.

[208] *See id.* at 1881-83.

[209] *Braidwood Mgmt.* Complaint, *supra* note 10, at 11, 28, 29, 31.

[210] *Id.* at 29.

[211] For an overview of workplace wellness programs addressing "lifestyle" factors, see Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? An*

government should only mandate insurance coverage to redress harms that fall on community members at random. Just below the surface of the claims is the notion that sex should carry consequences — disease, infection, or pregnancy.

Brute luck also underlies religious objectors' arguments that the services they challenge are a matter of individual preference, not medical necessity. For example, challengers typically distinguish between hysterectomies, hormone treatments, and reconstructive surgeries performed "for medical reasons" (which they are willing to cover) and the services "desired" by transgender patients (which they are not).[212] Objectors similarly differentiate between the use of contraceptives to treat chronic medical conditions and from their use to prevent pregnancy.[213] Justice Kennedy's concurrence in *Hobby Lobby* took this view. Writing to confirm that "the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees," Kennedy noted that "there are many medical conditions for which pregnancy is contraindicated."[214] The language indicates that contraception *can* be health care for women for whom pregnancy would aggravate preexisting medical conditions. In other words, insurance should cover contraception for individuals who need it due to factors outside their control.

This differentiation between preferred and medically necessary services mirrors the separation of therapeutic abortions from nontherapeutic abortions — on the theory that the former result from

Assessment of the Affordable Care Act's Personal Responsibility for Wellness Reforms, 11 IND. HEALTH L. REV. 635, 656-64 (2014).

[212] *See* First Amended Complaint at 15, Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (No. 21-11174).

[213] Irin Carmon, *This Is the Next Hobby Lobby*, MSNBC (July 30, 2014, 8:19 AM PDT), http://www.msnbc.com/msnbc/the-next-hobby-lobby [https://perma.cc/88F4-78X2] (reporting Notre Dame's coverage of contraceptives for medical reasons). A number of state mandates require contraceptive coverage for non-contraceptive purposes even by religious objectors. MICHELLE L. OXMAN, WOLTERS KLUWER L. & BUS., STATE MANDATES FOR INSURANCE COVERAGE OF CONTRACEPTION BEFORE AND AFTER HEALTH REFORM 7 (2013), http://hr.cch.com/hld/LB_Briefing_Contraception-Coverage_10-01_final.pdf [https://perma.cc/6JFY-RSN2P].

[214] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 737 (2014) (Kennedy, J., concurring).

brute luck while the latter are chosen.[215] Now prominent in debates over criminalization of abortion, this distinction also appeared in restrictions on federal funding for abortion[216] and in state laws prohibiting private insurance plans from covering abortion except in cases of rape, incest, or risk of the pregnant person's death.[217] Consistent with a brute luck approach, these purportedly chosen services (and risky behaviors) are properly a matter of personal responsibility.[218]

Health care sharing ministries stand at the pinnacle of brute luck. As bioethicist Charlene Galarneau describes, "HCSMs understand themselves to share expenses primarily for unforeseen and acute illness or injury, or as [one HCSM] describes it, 'those unexpected medical bills'" for broken bones or cancer.[219] Out of four large HCSMs studied by researchers affiliated with the Commonwealth Foundation, only one covers preventive and routine care for adults.[220] Ministries typically require their members to "adhere to healthy, biblical lifestyles."[221] Activities viewed as reflecting moral error are penalized. For example, sexually transmitted infections may only merit collective support if contracted by "innocent transmission" like a work-related needle stick or "verified rape."[222]

Brute luck extends beyond sexual activity. Two examples illuminate. First, HCSMs may impose higher membership fees or cancellation if

[215] *See* B. Jessie Hill, *Abortion as Health Care*, 10 AM. J. BIOETHICS 48, 48-49 (2010); *see also* Edward L. Rubin, *Sex, Politics, and Morality*, 47 WM. & MARY L. REV. 1, 23-24 (2005) ("The reason people who assert that abortion is the murder of a human being are often willing to countenance abortion when the pregnancy results from a rape is that a woman who was raped, unlike other women who seek abortions, did not choose to engage in sex unrelated to the higher purpose of reproduction.").

[216] *See* 42 U.S.C. § 18023(b)(1)(B)(i)–(ii).

[217] *Regulating Insurance Coverage of Abortion*, GUTTMACHER INST., https://web.achive.org/web/20230606132757/https://www.guttmacher.org/node/26267/printable/print (last updated Mar. 1, 2023) [https://perma.cc/BNK5-SD3A].

[218] *See* Jessica A. Clarke, *Against Immutability*, 125 YALE L.J. 2, 65 (2015) ("[T]he thinking may be the unstated assumption that women who choose to engage in nonprocreative sex should not ask the workplace to fund that pursuit.").

[219] Galarneau, *supra* note 115, at 273.

[220] *See* VOLK ET AL., *supra* note 26 at 11.

[221] Sachs, *supra* note 114, at 145.

[222] Galarneau, *supra* note 115, at 274.

members gain significant weight.[223] Second and more broadly, the behavioral rules imposed by many HCSMs that mean, as one HCSM medical director explained, "you need to agree to living a Christian lifestyle, including no smoking, including not abusing alcohol or drugs."[224]

Of course, "brute luck" involves complex questions of which factors are within an individual's control. For example, under one interpretation of brute luck, insurance should exclude contraceptive coverage even for individuals with medical conditions that make pregnancy dangerous, because the choice to have sex remains within their control.[225] Alternatively, one could see the inclusion of contraception under the preventive services mandate as remedying the brute luck of being capable of reproduction, which comes at significant economic and physical costs. Another framing still — reflected in the government's discussion of the benefits of contraceptive use for infant health — addresses the brute luck of being born as a result of a pregnancy for which one's parents were unprepared. As we explore further in Part III, the indeterminacy of distinctions between chosen and unchosen risks grants a prominent role to moralized judgments — often shaped by classism, racism, misogyny, homophobia, transphobia, and ableism.[226]

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In their original form, religious exemptions to the ACA might have seemed relatively marginal. But the evolution of religious challenges reveals their potential to destabilize the social insurance system of the ACA. As Hoffman argued, the ACA's conceptual pluralism may have been a source of strength in the political process,[227] but its lack of a

[223] *Id.*; *see also* VOLK ET AL., *supra* note 26 at 3.

[224] *The Religious Alternative to Obamacare's Individual Mandate*, NPR (Sept. 28, 2013, 6:40 PM), https://www.npr.org/2013/09/28/227238887/the-religious-alternative-to-obamacares-individual-mandate [https://perma.cc/H4FV-RYL6PERMA] [hereinafter NPR, *Religious Alternative*].

[225] *E.g.*, Shari Motro, *The Price of Pleasure*, 104 NW. U. L. REV. 917, 933 (2010) ("Many people believe that sexual freedom comes with responsibility for the consequences. A woman who engages in sexual relations assumes the risk that she might conceive.").

[226] *See infra* Part III.B.

[227] *See* Hoffman, *supra* note 27, at 1953-54.

unified theory of health insurance has made its benefit-design requirements more vulnerable in the courts. In particular, reformers' concessions to brute luck have given religious objectors a foothold for "personal responsibility" narratives.

III. FROM SOCIAL SOLIDARITY TO TRADITIONAL COMMUNITARIANISM

Unlike the libertarian challengers to the individual mandate and exchange subsidies, religious objectors do not repudiate solidarity. Rather, they resist the "social" of our contemporary insurance system and propose to organize aid around collectives of purportedly like-minded religious believers. As Section A shows, their arguments adopt not the pure individualism of "take care of yourself" but the traditionalist solidarity of "take care of your own" — whether family, employees, or fellow religious adherents.[228] These groups are typically hierarchical, countermanding the democratic egalitarianism to which social solidarity aspires. As Section B contends, within these traditionalist groups, objectors employ the logic of actuarial fairness to bolster solidarity within a homogenous group and, consequently, diminish commitment to a "we" that cuts across society.

A. Shrinking the Collective

Religious objectors defend a traditionalist form of communitarianism. Whereas the ACA's obligations are owed by virtue of social citizenship — to people who may be coworkers or complete strangers — religious objectors to the ACA aim to aid discrete

[228] Because objections from individuals often claim to reject a collective in favor of personal tailoring of insurance, this Section focuses on religious exemptions at an enterprise level – whether an employer or a HCSM — which accept mutual aid but propose a smaller and more homogenous collective. Even individual claims, however, necessarily construct community. *See, e.g.*, Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, *in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 27-33 (Tom Baker & Jonathan Simon eds., 2002) (explaining that whether one buys insurance to protect self or others, the enterprise necessarily involves the social — the many contribute to the few); Brian J. Glenn, *Risk, Insurance, and the Changing Nature of Mutual Obligation*, 28 L. & SOC. INQUIRY 295, 303-04 (2003) ("The ideas of an individual policyholder somehow being disconnected from others in the community no longer makes sense. . . . Insurance builds communities of interest, whether we realize it or not.").

collectives united by moral values. They construct communities that defy the egalitarian aspirations of the ACA in favor of hierarchical relationships of parents over children, bosses over workers.

Across claims from families, firms, and health care sharing ministries, the image is of people with uniform values and needs. In exempting one university from the contraceptive mandate, one court insisted that the employer "employs individuals who share its religious views regarding emergency contraception."[229] In another case, employer Liberty University argued that it was defending "the type and level of health care services that are desirable to its employees."[230] In this, litigants and courts mirror the public relations language of HCSMs. Consider, for example, an administrator of one large HCSM who described it as "a group of people, in this case Christians, who band together and agree that they want to share one another's burdens."[231] In the rhetoric of their proponents, these groups draw together individuals with identical religious beliefs to engage in solidaristic mutual aid.

On this view, aid is owed only to concrete others who share moral values, are familiar, and can be counted on to conform to community norms. The family is often the organizing frame. Individual objectors insist on an insurance plan organized around the private family rather than a wider group in the insurance market or society.[232] Even large employers use this rhetoric.[233] The workplace is described "as an extension of the domestic life of the family," a group that can be relied on to support one another.[234] As feminist political theorist Joan Tronto

[229] La. Coll. v. Sebelius, 38 F. Supp. 3d 766, 787 (W.D. La. 2014).

[230] First Amended Complaint at 8, Liberty Univ. v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010) (No. 6:10-CV-00015-nkm), 2010 WL 5867473.

[231] NPR, *Religious Alternative*, *supra* note 224.

[232] *E.g.*, Real Alternatives, Inc. v. Sec'y Dep't of Health & Hum. Servs., 867 F.3d 338, 346 (3d Cir. 2017) (the three employees and managers of non-religious employer objected to a plan that covers contraceptives for "their wives and total of seven minor children, three of whom are female").

[233] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 702 (2014) (stressing that the parents and their children "run the businesses in accordance with the family's religious beliefs").

[234] Elizabeth Sepper & James D. Nelson, *The Religious Conversion of Corporate Social Responsibility*, 71 EMORY L.J. 217, 259-60 (2021) (analyzing the firm-family analogy in employer claims for religious exemption).

cautions, "when we care, we do not think of society; we think of our intimates and their concrete and particular needs."[235]

Surprisingly, HCSMs — whose members are typically scattered and strangers to one another — also pretend to solidarity with concrete others. For example, Solidarity HealthShare, a leading health care sharing ministry, invites applicants to "join our community and live out your faith."[236] Ministries encourage people to send checks and messages of support to other members in times of illness.[237] By doing away with the privacy and anonymity of insurance in favor of the sharing of names and diagnoses, HCSMs create "the feeling[s] of knowing" other members.[238] Participants can view themselves as actually helping and being helped by community members they know on a personal level.[239]

The traditionalist collectives of family, firm, or ministry move away from the ACA's ideals of equality and mutuality and its reciprocal obligations among individuals and institutions. In particular, employment-based collectives, which objectors defend, are rife with authority relations. Employees stand in subordinate positions to employers and are subject to considerable authority.[240] Managers set rules that are oligarchic, and they rarely invite employee input into their

[235] Joan Tronto, *The Value of Care*, BOSTON REV. (Feb. 1, 2002), https://www.bostonreview.net/forum_response/joan-tronto-value-care/ [https://perma.cc/B4YM-YW33].

[236] SOLIDARITY HEALTHSHARE, https://solidarityhealthshare.org/ (last visited Apr. 30, 2023) [https://perma.cc/VLJ6-6KKB].

[237] Galarneau, *supra* note 115, at 270.

[238] Carolyn Schwarz, *Paying for Something Bigger*: *The Sentiment of Sociality and Health Care Sharing Ministries in the United States,* 93 ANTHROPOLOGICAL Q. 625, 628, 634 (2020) [hereinafter Schwarz, *Paying for Something Bigger*].

[239] *See* Andrew Verstein, *Enterprise Without Entities*, 116 MICH. L. REV. 247, 293 (2017) (noting the more direct and relational role of HCSM members). For analysis of how framing health insurance in terms of community solidarity promotes enrollment, see Wendy Netter Epstein, Hansoo Ko, Christopher Robertson, Kevin H. Wilson & David Yokum, *Moral Framing and Affirmative Outreach as Drivers of Health Insurance Enrollment in Medicaid and a State Exchange: A Randomized Field Experiment* (July 12, 2023), https://ssrn.com/abstract=4592912 [https://perma.cc/MR3T-S5Z3].

[240] *See* ANDERSON, *supra* note 29, at 39-40.

decisions.[241] The few command the many, not as their delegates as democratically chosen representatives do, but as their bosses — in a way that is "incompatible with relations of equality between them and us."[242]

Individual objections and HCSMs can give rise to analogous concerns. For example, in several cases, individual objectors assert patriarchal control over the family, usually in the form of a purported parental right to withhold coverage from daughters.[243] Likewise, while HCSMs are often analogized to fraternal organizations, they, like firms, lack characteristics of equality and reciprocity.[244] At least some HCSMs rely on consumer confusion or misleading marketing.[245]

Objectors' vision of community reflects a nostalgia for a time when individuals were dependent on relations of family, church, and charity for support.[246] Through exemptions, they would return mutual aid to

[241] *See* Niko Kolodny, *Help Wanted: Subordinates*, *in* ELIZABETH ANDERSON, PRIVATE GOVERNMENT: HOW EMPLOYERS RULE OUR LIVES (AND WHY WE DON'T TALK ABOUT IT) 102 (2017).

[242] *Id.* at 105-06 (whereas the democratic state wields authority as delegate of the people such that "if the state is realizing the democratic aspiration, then you're not, simply in virtue of being subject to its decisions, subordinated to any other individual").

[243] For a description of such a claim, see Wieland v. U.S. Dep't of Health & Hum. Servs., 793 F.3d 949, 952-53 (8th Cir. 2015).

[244] *See* Molly Worthen, *Onward, Christian Health Care?*, N.Y. TIMES (Jan. 31, 2015), https://www.nytimes.com/2015/02/01/opinion/sunday/onward-christian-health-care.html (arguing that ministries have commonalities with mutual aid societies of the early twentieth century).

[245] *E.g.*, Thomas Brewster, *A Christian Ministry Promised an Obamacare Alternative. The FBI Says Its Leaders Pocketed $4 Million and Left Members with Thousands in Unpaid Medical Bills*, FORBES (Feb. 20, 2023), https://www.forbes.com/sites/thomasbrewster/2023/02/20/fbi-says-christian-obamacare-nonprofit-was-a-4-million-fraud/?sh=ccdf697454fc; VOLK ET AL., *supra* note 26, at 4, 10 (noting that some have marketed plans in the bronze, silver, and gold designations that the ACA requires for exchange plans and that regulators often report consumer confusion).

[246] Richard B. Saltman, *Health Sector Solidarity: A Core European Value But With Broadly Varying Content*, 4 ISR. J. HEALTH POL'Y RES. 5, 5 (2015) (noting solidarity "grew out from personal (family) to communal (churches) to occupational (guilds, unions) and finally to national . . . when the state stepped in as the financial regulator and guarantor"); *see also* TER MEULEN, *supra* note 18, at 173 (observing that European states' welfare cuts are legitimized by "the idea that the reduction of involvement of the state may create 'real solidarity' within families and small communities").

these lower-level collectives and away from society.[247] Like libertarian critics of the ACA, they would cultivate a minimal state that neither structures the insurance collective nor interferes in private arrangements in the market.[248] As legal scholar Mary Ann Case explains, an individual's health insurance coverage would increasingly become "a function of his or her hierarchical attachments, such as those to a state, employer, church, or family."[249]

B. Reviving Actuarial Fairness with a Moralized Twist

The collectives of families, firms, and HCSMs generate in-group solidarity in part through narratives of actuarial fairness. Instead of contrasting actuarial fairness with solidarity — as Stone does[250] — religious challengers harmonize the two principles to create a vision of a homogenous collective. They introduce a moralized twist to actuarial fairness, seeking to pool people based on a combination of moral desert and health risk.

Consider, for example, arguments from individual religious challengers that they and their wives "do not want or need" coverage that includes the objectionable preventive care because they "are in monogamous relationships" or "past child-bearing years."[251] They describe their behavior as conforming to religious rules that negate their individual need for mutual aid. In this sense, objectors insist on a return to a risk-based vision of insurance where benefits reflect individual behaviors and demographics, at least for certain types of care.

Through the rhetoric of actuarial fairness, employers may enhance solidarity within the more narrowly defined communities they claim to

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[247] PRAINSACK & BUYX, *supra* note 86, at 54 (identifying solidaristic practices at three levels – interpersonal, group, and "legally enforceable norms").

[248] TER MEULEN, *supra* note 18, at 16 ("In the neoliberal view, the 'minimal state' is the best way to generate social solidarity and the flourishing of personal virtues and good character.").

[249] Mary Anne Case, *"A Patchwork Array of Theocratic Fiefdoms?" RFRA Claims Against the ACA's Contraception Mandate as Examples of the New Feudalism*, *in* LAW, RELIGION, AND HEALTH IN THE UNITED STATES 230, 230 (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017).

[250] Stone, *Struggle*, *supra* note 15, at 289.

[251] *Braidwood Mgmt.* Complaint, *supra* note 10, at 4-6.

defend. The firms in *Braidwood*, for example, cast themselves as shielding employees from the "costs of lifestyle choices" of others who might seek prevention or treatment of HIV or other STIs.[252] Because reproductive and sexual health care are only needed by some, requiring other insureds to assume their costs is described as unfair. "Subsidy" becomes a pejorative, "forced" upon coworkers and business owners by an individual who does not belong.[253] Indeed, challengers often frame employment benefits as "largesse" from "generous" businessowners to workers.[254] They harness "the widely credited fiction that the money involved is the employer's rather than the employees'"[255] — contrary to the economic fact that benefits, like wages, are earned by and belong to workers.[256]

Others argue that if employees desire contraceptives and STI prevention, they should pay for those services with their wages instead of benefits.[257] This too is an endorsement of actuarial fairness whereby each individual bears the costs of their own needs. By excluding benefits only some will want or need, coverage can convey that certain "people

[252] *Id.* at 29.

[253] Stone, *Struggle*, *supra* note 15, at 293 (noting this rhetoric from commercial insurance). For examples of the subsidy language, see Brief for Respondents at 10, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354), 2014 WL 546899; Brief for Petitioners at 5, Conestoga Wood Specialties Corp. v. Sebelius, 573 U.S. 682 (2014) (No. 13-356), 2014 WL 173487.

[254] JENNIFER KLEIN, FOR ALL THESE RIGHTS: BUSINESS, LABOR, AND THE SHAPING OF AMERICA'S PUBLIC-PRIVATE WELFARE STATE 37, 222 (2003) (noting how employers framed benefits as employer "generosity" and "gratuity").

[255] William M. Sage, *Solidarity: Unfashionable, but Still American*, *in* CONNECTING AMERICAN VALUES WITH HEALTH REFORM 10, 11 (Mary Crowley ed., 2009).

[256] *See* Sepper, *supra* note 106, at 320-24 (discussing health benefits as compensation); *see also* Liberty Univ., Inc. v. Lew, 733 F.3d 72, 91 (4th Cir. 2013) (noting that the employer's share of health insurance premiums is "part of an employee's compensation package"); Sepper, *supra* note 106, at 320-24 (discussing health benefits as compensation). For bioethical accounts sharply contrasting social solidarity with charity, see PRAINSACK & BUYX, *supra* note 86, at 67; Ben Davies & Julian Savulescu, *Solidarity and Responsibility in Health Care*, 12 PUB. HEALTH ETHICS 133, 134-35 (2019).

[257] *E.g.*, Hobby Lobby Stores, Inc. v. Sebelius, 723 F.3d 1114, 1144 (10th Cir. 2013) (observing that exemption would "not prevent employees from using their own money to purchase the contraceptives at issue").

are different [from us] and we should not be responsible for those different [from] us."[258]

Courts occasionally have embraced the logic of actuarial fairness. Most notably, in *March for Life v. Burwell*, a district court endorsed what it called "a simple solution" to religious objections — let insurers offer individual objectors "plans consistent with their sincerely held religious beliefs." [259] The court was unpersuaded by the government's parade of horribles whereby insurers would have "to tailor each health plan to the specific needs and desires of each individual."[260] In the court's view, insurers would play a disciplining function, individualizing plans only when actuarial fairness and administrative convenience aligned. And so, "one particular religious accommodation may make actuarial sense, while another may not."[261] The remedy, the court concluded, was to leave the decision to the market.[262] Of course, we know what private insurers did in a market characterized by actuarial fairness — they failed to cover reproductive health care and excluded, or imposed barriers to, preventive services.[263]

Although litigation has thus far centered on reproductive and sexual health, the logic of actuarial fairness has no such limits. Political opposition to social insurance has long asserted that the healthy and virtuous should not bear costs associated with the bad choices of their fellow citizens.[264] As the government has pointed out, "it is always the

[258] Mariner, *supra* note 24, at 207; Stone, *Struggle*, *supra* note 15, at 290 (noting that pre-ACA actuarial model would "foster[] in people a sense of their differences, rather than their commonalities").

[259] March for Life v. Burwell, 128 F. Supp. 3d 116, 132 (D.D.C. 2015). In litigation seeking a state exchange plan that did not cover abortion, another district court similarly allowed an individual plaintiff's claim to proceed due to his absence of medical need — his lack of "dependents and thus no possibility of ever using insurance coverage for abortion services." Howe v. Burwell, No. 2:15-CV-6, 2015 WL 4479757, at *1 (D. Vt. 2015).

[260] *March for Life,* 128 F. Supp. 3d at 131-32.

[261] *Id.* at 132.

[262] *Id.*

[263] *See* Deborah Dinner, *The Costs of Reproduction: History and the Legal Construction of Sex Equality*, 46 HARV. C.R.-C.L. L. REV. 415, 444, 456 (2011) (discussing maternity benefits exclusion); Sylvia A. Law, *Sex Discrimination and Insurance for Contraception*, 73 WASH. L. REV. 363, 369-70 (1998) (explaining that few plans covered women's contraceptives).

[264] Stone, *supra* note 15, at 287, 293.

case that employees deprived of coverage could spend 'their own' money instead" of relying on insurance.[265]

The mix of morality and actuarial fairness in HCSMs gives a preview of the logical end (and in some cases political ambition) of the claims proceeding through the courts. For example, maternity services may be eligible for sharing only if the woman is married and has been a member for ten months prior to conception.[266] This requirement simultaneously condemns premarital sex and attempts to avoid adverse selection, whereby people who know they are pregnant or likely to become pregnant join. HCSM members also say they do not want their insurance premiums "paying for abortions and alcoholism and drugs and everything else,"[267] or "spent to take care of someone who wasn't taking of themself, physically or spiritually, either one."[268] Actuarial fairness takes on religious significance for a wide range of behavioral risks.

Common moral values support "the unity and coherence of the group."[269] "Christians are just healthier people," another member says by way of explaining his decision to join a ministry.[270] As ethnographer Carolyn Schwarz concludes, members' feelings of inclusion "also rest on forms of exclusion that may involve divisions of race, religion, and political affiliation."[271] Under this insider-outsider dynamic, solidarity may increase within the more narrowly defined community of the "virtuous," even as members become more opposed to solidarity on a society-wide basis.[272]

Across claims from individuals, ministries, and employers, objectors would sever obligations to a diverse society in favor of collectives fragmented by religion. Recall that as an inherently collective enterprise, insurance sends a message about how Americans "should

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[265] Brief for the Petitioners at 15, 46-51, Sebelius v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (Nos. 13-354, 13-356), 2014 WL 173486.

[266] VOLK ET AL., *supra* note 26, at 11.

[267] Schwarz, *Freed from Insurance*, *supra* note 119, at 6.

[268] NPR, *Religious Alternative*, *supra* note 224 (quoting a HCSM member).

[269] TER MEULEN, *supra* note 18, at 27.

[270] Paquette, *supra* note 123.

[271] Schwarz, *Paying for Something Bigger*, *supra* note 238, at 669.

[272] *See* TER MEULEN, *supra* note 18, at 106 ("When citizens are distancing themselves from a shared communal life, they are less inclined to support the welfare arrangements [of social insurance].").

think about what ties them together and to whom they have ties."[273] Religious objectors recognize this fact — after all, it is their complicity (or relationship) with others who use contraception or engage in non-marital sex that is at the root of their objection to the ACA. The remedy they seek is to disconnect from others with conflicting values and needs. The out-groups here are likely to be non-Christians, progressive Christians, women of reproductive age, and LGBTQ+ people.[274] The collective fragments and shrinks.

One might reply that the solidaristic collective that religious employers imagine is broader than this account suggests. After all, plaintiffs have advanced, and several courts endorsed, public funding as an alternative that would spread costs across society, rather than impose them on the workplace.[275] In *Hobby Lobby*, the Supreme Court suggested the "most straightforward" approach "would be for the Government to assume the cost of providing [] contraceptives [] to any women who are unable to obtain them under their health-insurance policies."[276] Litigants say the government could mandate that all non-objecting health care providers deliver PrEP drugs, the HPV vaccine, and STI and drug-use screenings and counseling free of charge and then reimburse them.[277] Similarly, to secure access to gender-affirming care,

[273] Stone, *Struggle*, *supra* note 18, at 289.

[274] Studies show religiosity is associated both with prosocial behaviors and with in-group bias and out-group prejudice. *See* Jesse Lee Prestonm Erika Salomon & Ryan S. Ritter, *Religious Prosociality: Personal, Cognitive, and Social Factors*, *in* RELIGION, PERSONALITY, AND SOCIAL BEHAVIOR 149, 149 (Vassilis Saroglou ed., 2013); Wade C. Rowatt, Tom Carpenter & Megan Haggard, *Religion, Prejudice, and Intergroup Relations*, *in* RELIGION, PERSONALITY, AND SOCIAL BEHAVIOR, 170, 170 (Vassilis Saroglou ed., 2013).

[275] *See* Brief for Respondents at 58, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354), 2014 WL 546899 ("The most obvious less-restrictive alternative is for the government to pay for its favored contraceptive methods itself."); *see also* Korte v. Sebelius, 735 F.3d 654, 686 (7th Cir. 2013); Newland v. Sebelius, 881 F.Supp.2d 1287, 1298-99 (D. Colo. 2012).

[276] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 728 (2014). *Cf.* Frederick Mark Gedicks, *One Cheer for* Hobby Lobby*: Improbable Alternatives, Truly Strict Scrutiny, and Third-Party Employee Burdens*, 38 HARV. J.L. & GENDER 153, 157-63 (2015) (criticizing these alternatives as "improbable").

[277] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654 (N.D. Tex. 2022) (agreeing that the government had not shown that it would "be unable to assume the cost of providing PrEP drugs").

the government could "provide subsidies, reimbursements, tax credits or deductions."[278]

While superficially compelling, these alternatives subvert the social insurance system of the ACA and its delicate balance between public and private. First, as a matter of political reality, Congress will not create a single-payer insurance plan for contraception or STI prevention alone. Nor does it seem likely to expand public health funding.[279] Second, these piecemeal approaches disregard the basic structure of insurance, which functions by pooling and spreading different risks across populations. A comprehensive insurance plan expends money toward preventive care (including contraception) and reaps savings from reduced risks (like unintended pregnancies).[280] But a contraceptive-only or STI-prevention-only plan does not benefit from reduced risks because it does not cover the costs of pregnancy and STI treatment. It also suffers from adverse selection, whereby only people likely to need such services join. Third and fundamentally, these purported alternatives to benefit mandates revive gendered tiers of social provision, with a welfarist state for women and earned insurance for most men.[281]

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[278] Christian Emps. All. v. U.S. Equal Opportunity Comm'n, No. 1:21-CV-195, 2022 WL 1573689, at *8 (D.N.D. May 16, 2022).

[279] *See Title X: Budget & Appropriations*, NAT'L FAM. PLAN. & REPROD. HEALTH ASS'N, http://www.nationalfamilyplanning.org/title-x_budget-appropriations (last visited Sept. 30, 2023) [https://perma.cc/MWS4-GPBV] ("Current funding levels are less than 40% of what is needed to meet the need for publicly funded family planning . . . [.] Title X funding dropped by $31 million from 2010 to 2018.").

[280] While most preventive care is not cost-saving over the long term because people live longer and eventually use more care, contraceptive coverage produces short- to medium-term savings. *See* John Bertko, Sherry Glied, Erin Miller, Adelle Simmons & Lee Wilson, *The Cost of Covering Contraceptives Through Health Insurance*, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION (Feb. 9, 2012), https://aspe.hhs.gov/reports/cost-covering-contraceptives-through-health-insurance [https://perma.cc/644B-WW3T].

[281] *See, e.g.*, SUZANNE METTLER, DIVIDING CITIZENS: GENDER AND FEDERALISM IN NEW DEAL PUBLIC POLICY 73 (1998) (in establishing social security, Congress excluded teachers, religious workers, and social workers, the vast majority of whom were women); Sonya Michel, *A Tale of Two States: Race, Gender, and Public/Private Welfare Provision in Postwar America*, 9 YALE J.L. & FEMINISM 123, 123 (1997) (noting that U.S. social citizenship is "highly inflected by gender" whereby "citizens usually gain entitlements and benefits based on sex or on types of status that are gender-related, such as employment, military service, and motherhood").

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Allowing religious objectors to opt out of certain benefits reopens questions about belonging, rights, and obligations in the health insurance system.[282] Through religious exemptions, individuals, employers, and HCSMs create traditionalist collectives separate from the broader society. They destabilize the socializing function of insurance, reviving the principle of actuarial fairness with a moralized twist.[283] Social insurance, in turn, may face a "legitimation crisis" as citizens become unwilling to make sacrifices for generalized others — who might be non-Christian, gay, or pregnant and unmarried.[284]

IV. POWER AT WORK

Despite their rhetoric, the insurance community of religious objectors' court filings is elusive (or invented) — especially when it comes to employers. The modern workplace is characterized by a labor force with plural beliefs. As a result, Section A argues, religious exemptions from benefit-design requirements work to discriminate against religious, gender, and sexual minorities in hiring decisions as well as insurance benefits. Employers, moreover, are poorly positioned to defend solidarity within the firm, because the employer-employee relationship is hierarchical, rather than egalitarian. As Section B explains, religious exemptions exacerbate this imbalance and arrogate power to employers over not only the terms of employer-based insurance but the private lives of workers as well.

This Part illuminates that the remedy for an employer's complicity in its employees' health choices is either discrimination or control. As constitutional law scholars Doug NeJaime and Reva Siegel have explained, complicity-based claims necessarily concern the objector's relationship to "others who do not share the claimant's beliefs, and whose lawful conduct the person of faith believes to be sinful."[285] For

[282] *See* Glenn, *supra* note 14, at 306 (noting that the definition of an insurance community and its justification for helping members is a "dynamic" process).

[283] *See* Graetz & Mashaw, *supra* note 46, at 353.

[284] TER MEULEN, *supra* note 18, at 106.

[285] Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2519 (2015).

employers, avoidance of complicity entails either ending the relationship (by expelling certain classes of people) or deterring that conduct (whether use of contraception, promiscuous sex, or same-sex relationships).

A. Discrimination in Insurance and Hiring

Employers' objections are unlikely to reflect employees' values. In large workplaces, workers rarely hold religious beliefs identical to owners, management, or other workers.[286] Even large religious non-profits typically employ individuals of plural religious beliefs (and, of course, co-religionists can diverge dramatically in their understanding of the good).[287] What workers have in common is the firm, and what they share is a commitment to laboring to achieve their employer's economic goals. Indeed, large employers have long been considered a desirable way to pool people for health insurance, because they draw together a

[286] *See* Katharine Jackson, *Disaggregating* Corpus Christi*: Illiberal Implications of* Hobby Lobby*'s Right to Free Exercise*, 14 FIRST AMENDMENT L. REV. 376, 421 (2016) ("It is not unreasonable to assume that because employees usually agree to work so that they can earn a wage, and not so they can practice religion, they had no role in forming this particular corporate will."); Noah D. Zatz, *Does Work Law Have a Future if the Labor Market Does Not?*, 91 CHI.-KENT L. REV. 1081, 1100 (2016) (observing that *Hobby Lobby* allowed a for-profit corporation to unilaterally "define the relationship in religious terms, even if for the workers this was 'just a job'").

[287] *See, e.g.*, Carmon, *supra* note 213 (reporting on disagreement and competing lawsuits involving students and employees at Notre Dame). Although HCSMs nominally unite people with "a common set of ethical or religious beliefs," they sometimes a reflect a similar dynamic. Members join for reasons ranging from cost to conservative politics to religiosity. The religious nature of some HCSMs may be hard to detect. *E.g.*, ALTRUA HEALTH SHARE, https://altruahealthshare.org/ (last visited Oct. 16, 2023) [https://perma.cc/Y5ZP-TTVS] (displaying "What if I could save $600 on health care?" and "Join Like-minded People to Discover Possibilities and Savings Today"); Laura Santhanam, *1 Million Americans Pool Money in Religious Ministries to Pay for Health Care*, PBS NEWS (Jan. 16, 2018, 5:46 PM), https://www.pbs.org/newshour/health/1-million-americans-pool-money-in-religious-ministries-to-pay-for-health-care [https://perma.cc/H2N2-A57K] (discussing Sedera, which adopts a relatively secular frame).

relatively heterogenous group of people with varying health needs.[288] In this, they have been a microcosm of society.[289]

From the perspective of plaintiffs and their supporters, a natural and desirable result of securing religious exemptions from benefits requirements is to move away from pluralistic workplaces. One sees this argument, for example, from the Christian Employers Alliance, which links the design of insurance consistent with Christian values to the construction of faith-infused workplaces.[290] From this point of view, employee benefits help determine the composition of the labor force.

Discrimination results on two levels. First and most obviously, exemptions segregate insurance risk pools and discriminate against people whose risks lose collective support.[291] The expectation is that dissenting workers whose values or medical needs differ from their employers' commitments will exit. For example, Hobby Lobby offered one unrealistic option: workers who wanted contraceptive coverage

[288] Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILBANK Q. 5, 9 (2003).

[289] *See generally* Cynthia L. Estlund, *Working Together: The Workplace, Civil Society, and the Law*, 89 GEO. L.J. 1 (2000) (describing how workplaces unite diverse people who communicate and cooperate across difference).

[290] Christian Emps. All. v. United States Equal Opportunity Comm'n, No. 1:21-CV-195, 2022 WL 1573689, at *1 (D.N.D. May 16, 2022) (noting its goal to aid "Christian nonprofit and for-profit employers" to "provide health or other employment related benefits to their respective employees and engage in other employment practices in a manner that is consistent with Christian values").

[291] Because bias influences perceptions of risk-taking, this may result in discrimination based on race, sexual orientation, gender identity, and other traits. *See, e.g.*, Sarah K. Calabrese, Valerie A. Earnshaw, Manya Magnus, Nathan B. Hansen, Douglas S. Krakower, Kristen Underhill, Kenneth H. Mayer, Trace S. Kershaw, Joseph R. Betancourt & John F. Dovidio, *Sexual Stereotypes Ascribed to Black Men Who Have Sex with Men: An Intersectional Analysis*, 47 ARCHIVES SEXUAL BEHAV. 143, 153-54 (2018) (empirical study of sexual stereotypes associated with Black men who have sex with men); Christine Reyna, P.J. Henry, William Korfmacher & Amanda Tucker, *Examining the Principles in Principled Conservatism: The Role of Responsibility Stereotypes as Cues for Deservingness in Racial Policy Decisions*, 90 J. PERSONALITY & SOC. PSYCH. 109, 110 (2005) (empirical study of the effect of stereotypes relating to irresponsible behavior associated with Black people on policy preferences); Lisa Rosenthal & Marci Lobel, *Stereotypes of Black American Women Related to Sexuality and Motherhood*, 40 PSYCH. WOMEN Q. 414, 414 (2016) (empirical study of sexual and mothering stereotypes associated with Black women).

"could simply purchase their own policy on the exchanges."[292] Among employees who stay, certain groups — women, young families, people with HIV, and transgender people — receive less comprehensive coverage of their health needs and are worse-compensated for their labor than their peers.[293]

Second, religious exemptions from benefit-design requirements can work to eliminate dissenters from the workplace altogether — discriminating against religious, gender, and sexual minorities in hiring as well as insurance. As courts and regulators have long recognized, decisions about benefits can keep certain individuals or categories of people out of the insurance pool.[294] An insurer can equally discriminate by charging A more than B because of her sex, by denying coverage to A based on her sex, or by withholding sex-linked benefits from its plan.[295] The discriminatory effect is the same, and the result is a risk pool with few women.

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[292] Brief for Respondents at 58, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354), 2014 WL 546899, at *58 n.29; *see also* Religious Sisters of Mercy v. Azar, 513 F. Supp. 3d 1113, 1149 (D.N.D. 2021) (claiming ACA exchanges offer the government an alternative to ensure access to gender-affirming care). Because employees are not eligible for subsidies to purchase exchange plans if their employer offers insurance, such plans are a poor economic bargain or entirely inaccessible. *See* Joseph Fishkin, Hobby Lobby*: Federal Agent*, BALKINIZATION (Nov. 30, 3013), https://balkin.blogspot.com/2013/11/hobby-lobby-federal-agent.html [https://perma.cc/2RKT-AW92].

[293] *Cf.* Alaska Civ. Liberties Union v. State, 122 P.3d 781 (Alaska 2005) (denying spousal benefits for same-sex domestic partners was tantamount to paying one group of workers less than their similarly situated co-workers).

[294] *See, e.g.*, Newport News Shipbuilding & Dry Dock Co. v. EEOC, 462 U.S. 669, 684 (1983) (holding that an employer's health benefit plan that excluded comprehensive pregnancy benefits for spouses of employees discriminated on the basis of sex because it "unlawfully gives married male employees a benefit package for their dependents that is less inclusive than the dependency coverage provided to married female employees"); *see also* Valarie K. Blake, *Civil Rights as Treatment for Health Insurance Discrimination*, 2016 WIS. L. REV. FORWARD 37, 42-43 (compiling cases and complaints). *See generally* Elizabeth Guo, Douglas B. Jacobs & Aaron S. Kesselheim, *Eliminating Coverage Discrimination Through the Essential Health Benefit's Anti-Discrimination Provisions*, 107 AM. J. PUB. HEALTH 253 (2017) (describing several ACA provisions that protect against benefit designs with discriminatory effect or intent).

[295] Crossley, *supra* note 65, at 82.

Although religious challenges target *what* must be covered by plans, they thus would shape *who* is within the collective. Exemptions can be expected to constructively exclude workers particularly likely to need reproductive or sexual health care. As empirical research shows, the modal job seeker usually focuses on whether an employer offers a health plan at all and may overlook less noticeable features like which services are covered.[296] By contrast, exclusion of certain services will be highly salient for those applicants who know they are likely to need them and may end up dictating their choice of workplace.[297]

Braidwood showcases the connection between benefit design and employment discrimination.[298] There, in an odd turn, it was the government that described the for-profit corporation as uniting co-religionists, instead of employing diverse collectives of individuals.[299] It stated that "it is difficult to imagine that individuals eligible to be prescribed PrEP medications would choose to work for Braidwood, given that the 'principles and teaching' on which the business is 'operate[d]' are openly opposed to their various lifestyles."[300] Ironically, this argument seemed to indicate that the company was violating prohibitions against religious and sex discrimination under Title VII of the Civil Rights Act. And Braidwood's filings in a subsequent case admitted as much: as a "Christian business," it discriminates against all "individuals who are engaged in homosexual behavior or gender non-conforming conduct of any sort," including people who refuse to comply with its highly gendered dress code.[301]

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[296] Amy B. Monahan, *Employers as Risks*, 89 CHI.-KENT L. REV. 751, 772 (2014) (summarizing this research).

[297] *E.g.*, Valarie K. Blake & Elizabeth Y. McCuskey, *The Infertility Shift*, BILL OF HEALTH (May 12, 2023), https://blog.petrieflom.law.harvard.edu/2023/05/12/the-infertility-shift/ [https://perma.cc/XT2A-DGDB] (exploring how non-coverage of fertility services within employer-based plans results in some individuals taking jobs in order to obtain coverage).

[298] *See* Defendants' Reply in Support of Cross-Motion for Summary Judgment at 8, Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-CV-00283-O).

[299] *See id.*

[300] *Id.*

[301] Bear Creek Bible Church v. Equal Emp. Opportunity Comm'n, 571 F. Supp. 3d 571, 588-89 (N.D. Tex. 2021).

The idea of discrimination in hiring is evident in several arguments from objectors. For example, when they claim their employees do not need certain services because of their adherence to religious codes of conduct, for-profit businesses are admitting to discrimination based on religion (and perhaps other traits). More subtle are claims that employer exemptions are harmless, because no employees use the benefits to which the owners object.[302] Implicit is the idea that people who take PrEP — assumed to be gay men — or require gender transition services — transgender people — simply will not be hired or retained by objecting employers. Or consider the idea that dissenting employees can quit and find another employer.[303] Such arguments overlook that exit is unlikely to be a meaningful option for many employees in the absence of guaranteed benefits and income.[304] Each of these defenses rejects the explicitly race-, color-, age-, disability-, national-origin-, and sex-inclusive "we" of social citizenship in favor of a gendered and sectarian vision of insurance and employment.[305]

[302] *E.g.*, Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 633-34 (N.D. Tex. 2022) (assuming that employees would never need STI-related services); Beckwith Elec. Co., Inc. v. Sebelius, 960 F. Supp. 2d 1328, 1349 (M.D. Fla. 2013) (emphasizing that "no plan participant has used the coverage" for emergency contraceptives).

[303] *See* Michael A. Helfand, *Religious Institutionalism, Implied Consent, and the Value of Voluntarism*, 88 S. CAL. L. REV. 539, 570 n.168 (2015) (developing theory of implied consent to employment contracts).

[304] *See* Kathryn Anne Edwards, *Worker Mobility in Practice: Is Quitting a Right, or a Luxury?*, 3 J.L. & POL. ECON. 104, 104-05 (2022) (explaining labor market conditions mean exit is not a viable counterweight to employer power); Jayne S. Ressler, *Workplace Anonymity*, 70 BUFF. L. REV. 1495, 1501-02 (2022) (noting economic research that shows workers face significant burdens of acquiring new health insurance even after the ACA). See generally ROBERT S. TAYLOR, EXIT LEFT: MARKETS AND MOBILITY IN REPUBLICAN THOUGHT (2017), for an account that emphasizes exit as antidote to employer domination but only where redistributive support allows meaningful and easy exit.

[305] *See* TER MEULEN, *supra* note 18, at 102 (describing social citizenship this way); *see also* Martha T. McCluskey, *Efficiency and Social Citizenship: Challenging the Neoliberal Attack on the Welfare State*, 78 IND. L.J. 783, 785, 843 (2003) (describing attacks on welfare reform at the turn of the twenty-first century as preferring a "racialized, genderized, and class-based vision of" mutual aid).

B. Coercion and Invasion of Privacy

Employee benefits have long served as an important avenue for wielding power over employees. In the company towns of a century ago, benefits ensured "control was pervasive. Companies regulated drinking, smoking, gambling, cleanliness, speech, association rights, and also, more generally, morals."[306] As one historian describes it, "[g]enerosity brought intrusiveness."[307] Modern-day workplace wellness programs continue this tradition, penalizing tobacco use, obesity, and other so-called "lifestyle" risks.[308] Religious objectors seek to expand on the model.[309]

Like the more modest health reforms that preceded it, the ACA sought to limit employers' subordination of employees through insurance.[310] Its reforms were expected to loosen firms' stranglehold over health benefits and thus reduce their authority over employees.[311] No longer

[306] M. Todd Henderson, *The Nanny Corporation*, 76 U. CHI. L. REV. 1517, 1536 (2009); *see also* ANDERSON, *supra* note 29, at 49 ("Workers were eligible for Ford's famous $5 daily wage only if they kept their homes clean, ate diets deemed healthy, abstained from drinking.").

[307] Margaret Crawford, *Earle S. Draper and the Company Town in the American South*, *in* THE COMPANY TOWN: ARCHITECTURE AND SOCIETY IN THE EARLY INDUSTRIAL AGE 139, 146 (John S. Garner ed., 1992) (noting efforts to police and regulate workers' sexual activities).

[308] *See* ANDERSON, *supra* note 29, at 49; *see also* Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 589 (2014) (identifying employer paternalism in "deterring unhealthy behavior and promoting wellness" for moral reasons); Stephen D. Sugarman, *"Lifestyle" Discrimination in Employment*, 24 BERKELEY J. EMP. & LAB. L. 377, 398-401 (2003) (noting employers surveil off-duty activities including through "blood, urine, saliva, breath and other tests").

[309] *See* Lynch & Curfman, *supra* note 106, at 154 (arguing that exemption claims indicate the benefit of ending employers' role in health insurance).

[310] HIPAA freed employees to transition from one employer to another by prohibiting employer plans from excluding coverage for preexisting conditions, which tends to lock employees into a job where they can maintain continuous coverage. Before the ACA's reforms, contract work, early retirement, or job loss would usually lead to loss of insurance because plans available for individuals to purchase were often unaffordable or undependable. *See supra* Part I.B. The ACA did preserve considerable discretion for employers with regard to the health benefits they provide. Valarie K. Blake & Elizabeth Y. McCuskey, *Employer-Sponsored Reproduction*, 124 COLUM. L. REV. 273, 283-316 (2024).

[311] Involving employers in insurance need not inevitably lead to unjustified power over workers. In a number of countries, employers play a substantial role in health

would workers be trapped in firms by their inability to access health benefits elsewhere.[312] The individual exchanges would offer viable and freedom-enhancing alternatives. Employers would become less central to the insurance system.[313]

Religious exemptions for businesses instead have exacerbated the problem of employer control over the private lives of workers, well beyond the time and place of work. As part of escalating demands, religious objectors do not merely wish to be left alone. They seek to deter certain behaviors and spur others among workers who may or may not share their beliefs.

In the contraceptive challenges, it was plausible to maintain, as some did, that objectors had no intention of interfering with employees' use

insurance. *E.g.*, Shinya Matsuda, *Health Policy in Japan — Current Situation and Future Challenges*, 2 JAPAN MED. ASS'N J. 1, 3-4 (2019) (explaining the employer-based insurance system in Japan that covers the majority of the population); Monika Steffen, *Social Health Insurance Systems: What Makes the Difference? The Bismarckian Case in France and Germany*, 12 J. COMPAR. POL'Y ANALYSIS 141, 146-48 (2010) (discussing employer role in France and Germany). In the United States, social insurance programs related to workers' compensation and unemployment run through the workplace without outsized employer control.

[312] *E.g.*, Jeanne M. Lambrew, *The Tortuous Journey of the Health Insurance Marketplace*, 46 J.L., MED. & ETHICS 862, 866 (2018) (explaining that the ACA "reduced 'job lock'" with an estimated 1.5 million more people choosing to become self-employed); Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFFS. 124, 127 (1999) (explaining that health insurance through employment "can induce employees to remain indentured in a detested job simply because it is the sole source of affordable health coverage").

[313] Thomas Buchmueller, Colleen Carey & Helen G. Levy, *Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act?*, 32 HEALTH AFFS. 1522, 1529 (2013) (relying on firms as a mechanism for pooling insurance risk generates efficiency costs because of labor market distortions). It was anticipated that many employers would drop employer-based plans in favor of the exchanges. *E.g.*, Arthur L. Kellermann, *Will More Employers Drop Coverage Under the ACA? Don't Bet on It*, RAND BLOG (July 27, 2012), https://www.rand.org/blog/2012/07/will-more-employers-drop-coverage-under-the-aca-dont.html [https://perma.cc/TP9H-47PC] (summarizing employer surveys that predicted between ten and thirty percent of employers would drop coverage). These predictions were not borne out. Reed Abelson, *Despite Fears, Affordable Care Act Has Not Uprooted Employer Coverage*, N.Y. TIMES (Apr. 4, 2016), https://www.nytimes.com/2016/04/05/business/employers-keep-health-insurance-despite-affordable-care-act.html.

of contraceptives.[314] It was their own behavior — paying for the service through insurance — that concerned them.[315] The connection between their objection (to the pill) and their act (covering it) was tighter, notwithstanding the numerous intervening acts by beneficiaries seeking care and the clinicians providing it.

In the PrEP case, it has become clear that the objection to benefit mandates is really (and perhaps always has been) about how other people behave. Plaintiffs do not see PrEP itself as morally objectionable. Instead, they object to the sexual activity and "homosexual behavior" that they believe STI prevention "encourages and facilitates."[316] Eliding this distinction between an objection to a medication and an objection to a behavior that the medication allegedly facilitates, the *Braidwood* trial court concluded that *Hobby Lobby* squarely required exemption.[317]

Some contraceptive-mandate challengers also seek to discourage nonprocreative sex — arguing "that human sexuality serves two purposes: to unite husband and wife and to generate new life"[318] and that access to contraception would "open wide the way for marital infidelity

[314] *See, e.g.*, Brief for Respondents at 41, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354), 2014 WL 546899, at *41 ("'[I]t is not the employees' health care decisions that burden [Respondents'] religious beliefs . . . .' Respondents have never filed suit regarding any decisions by their employees."); Reply Brief of Appellants at 11, Korte v. Sebelius 735 F.3d 654, (7th Cir. 2013) (Nos. 13-1077, 12-3841), 2013 WL 1451375, at *11 (saying plaintiffs "are not suing to stop their employees from exercising their rights to purchase and use contraceptives").

[315] *See, e.g.*, Zubik v. Burwell, 578 U.S. 403, 407-08 (2016) ("Petitioners have clarified that their religious exercise is not infringed where they 'need to do nothing more than contract for a plan that does not include coverage for some or all forms of contraception,' even if their employees receive cost-free contraceptive coverage from the same insurance company.").

[316] First Amended Complaint at 7, Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-CV-00283-O), 2020 WL 13558705, at *7. PrEP generally suffers from this stigma. *See generally* Doron Dorfman, *The PrEP Penalty*, 63 B.C. L. REV. 813, 841-51 (2022) (reporting that public opinion on PrEP users varies based on sexual orientation and family form).

[317] Kelley v. Azar, No. 4:20-CV-00283-O, 2021 WL 4025804, at *17 (N.D. Tex. Feb. 25, 2021).

[318] Mersino Mgmt. Co. v. Sebelius, No. 13-CV-11296, 2013 WL 3546702, at *3 (E.D. Mich. July 11, 2013); *see also* Roman Cath. Archbishop v. Sebelius, 19 F. Supp. 3d 48, 72 (D.D.C. 2013) ("[S]exual union should be reserved to committed marital relationships in which the husband and wife are open to the transmission of life.").

and a general lowering of moral standards."[319] Others contend that contraception and sterilization are "simply devices that enable women who do not wish to become pregnant — but who are unwilling to refrain from sexual intercourse — to engage in sexual intercourse while greatly reducing their risk of pregnancy."[320] Any prevention of sexually transmitted infections could face similar argumentation.

Here, at least implicitly, pregnancy or disease operates as punishment. The objector not only wants to disaffiliate with people who engage in particular sexual behavior — he also wants them to bear the full consequences of that behavior.[321] On this view, PrEP and STI screening, for example, unjustly shield plan members from risks "associated with drug use, prostitution, homosexual conduct, and sexual promiscuity."[322] The arguments echo longstanding campaigns against reproductive health, which justified restrictions on contraceptives as necessary to deter fornication[323] and claimed the HPV vaccine would lead to teen promiscuity.[324] From this perspective, the risk of pregnancy, STIs, and various cancers is necessary to deter immoral behavior.

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[319] Brief of American Freedom Law Center as Amicus Curiae in Support of Hobby Lobby and Conestoga, et al. at 8, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014) (No. 13-354, 13-356), 2014 WL 333888; *see also* DeOtte v. State, 20 F.4th 1055, 1062 (5th Cir. 2021) (noting plaintiffs' beliefs that contraception "encourages illicit sexual activity outside of marriage").

[320] *Braidwood Mgmt.* Complaint, *supra* note 10, at 25.

[321] *See* Brief Amicus Curiae of Eberle Communications Group, Inc., et al. in Support of Petitioners at 8, 33, Conestoga Wood Specialties Corp. v. Sebelius, 573 U.S. 682 (2014) (No. 13-356), 2014 WL 316722 (contending that contraceptive coverage "encourages amoral recreational sex without reproductive consequences" and "the maximization of sexual activity . . . unencumbered by the risk of pregnancy").

[322] *Braidwood Mgmt.* Complaint, *supra* note 10, at 29.

[323] *See* Eisenstadt v. Baird, 405 U.S. 438, 448 (1972) (describing as "plainly unreasonable" to assume the state had any interest in the "pregnancy and the birth of an unwanted child as punishment for fornication"); Julie E. Meyers & Kent A. Sepkowitz, *A Pill for HIV Prevention: Déjà Vu All Over Again?*, 56 CLINICAL INFECTIOUS DISEASES 1604, 1604-10 (2013) (discussing concerns about "potential impact on sexual behavior" from PrEP and contraceptives).

[324] *See* Andrew F. Brouwer, Rachel L. Delinger, Marisa C. Eisenberg, Lora P. Campredon, Heather M. Walline, Thomas E. Carey & Rafael Meza, *HPV Vaccination Has Not Increased Sexual Activity or Accelerated Sexual Debut in a College-Aged Cohort of Men and Women*, 19 BMC PUB. HEALTH 821, 822 (2019) (study dispelling these concerns based on empirical evidence).

Individual privacy also faces more intensive intrusions under a regime of religious exemptions — and the insurance benefit designs structured around morality that result. For example, some employers object to covering contraception for pregnancy prevention but not for treatment of medical conditions. To discern the difference, they must force workers to share sensitive information. Indeed, in *Braidwood*, the plaintiffs seem close to claiming a right to intrude upon employee privacy.[325] For employees who cannot exit, a choice previously left to each individual's conscience "may turn into a duty toward one's employer."[326]

HCSMs manifest a similar dynamic. For example, in excluding treatment for STIs for consensual sex outside of marriage, Samaritan Ministries makes it "the member's responsibility to explain how the disease was contracted."[327] Authorizing these inquiries via religious exemption stands in contrast to social insurance which "is supposed to protect beneficiaries from the intrusive and stigmatizing interventions into private conduct."[328] Even for those who conform to the moral strictures set by an employer or ministry, the price of coverage is the loss of privacy.

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In mandating nondiscrimination and a baseline of preventive services, the ACA constrained employer authority, even as it continued to permit firms to determine other parameters of health insurance coverage.[329] Religious exemptions once again subject workers to unaccountable decisionmakers, "stemming the growth of the social safety net while allowing corporate paternalism to thrive."[330] They authorize discrimination against religious, gender, and sexual minorities in hiring

[325] *See Braidwood Mgmt.* Complaint, *supra* note 10, at 29.

[326] Margo Trappenburg, *Lifestyle Solidarity in the Healthcare System*, 8 HEALTH CARE ANALYSIS 65, 70 (2000).

[327] Last Week Tonight with John Oliver, *Health Care Sharing Ministries*, YOUTUBE (June 27, 2021), https://www.youtube.com/watch?v=oFetFqrVBNc [https://perma.cc/6EZS-X46Y].

[328] HACKER, *supra* note 20, at 37-38.

[329] *See* Blake & McCuskey, *supra* note 310, at 278-79.

[330] Leo E. Strine, Jr., *A Job Is Not a Hobby: The Judicial Revival of Corporate Paternalism and Its Problematic Implications*, 41 J. CORP. L. 71, 100 (2015).

as well as insurance. They coerce the reproductive decisions and intimate relations of workers with varied moral commitments. Employee benefits become contingent on the firm's religion, rather than an entitlement of social citizenship.[331]

CONCLUSION

Viewed through a political economy lens, ongoing and increasing religious objections threaten the ACA's distinctively American approach to social insurance. Religious challengers go further than asserting a right to be left alone. They claim a prerogative to design benefits around their own moral values — undercutting the "shared responsibility" for social insurance under the ACA.

Our analysis offers four key lessons for U.S. social insurance writ large. First, benefit design is integral to social insurance. As Part I explained, the ACA's move toward social insurance was widely discussed with respect to eligibility, rates, and subsidies: questions of who is covered and at what price. The role of benefits had gone largely unexamined. Yet, as our analysis demonstrates, decisions about what is covered and the process by which coverage determinations are made also define the "social" in social insurance. Exclusion of benefits can easily instantiate discrimination in eligibility for social citizenship.

Second, ambiguity about the conditions that trigger solidarity has invited prolonged contestation in the courts. The ACA's conceptual pluralism — alternatively endorsing health promotion, financial protection, and brute luck remediation as priorities for benefit design — has granted a foothold to religious objectors eager to rewrite the insurance social contract. Here, our account offers a novel explanation for the successes of suits against the ACA's benefit-design requirements,

[331] *See* Baker, *supra* note 228, at 27 (arguing that insurance both reflects and influences societal norms of accountability). HCSMs show where this absence of accountability leads. They insist that the relationship between members and ministry creates no contract; there is no enforceable guarantee that the ministry will meet any need that arises. Will Maddox, *Why Healthcare Sharing Ministries Are Growing in Dallas-Fort Worth*, D MAG. (Apr. 5, 2022, 9:00 PM), https://www.dmagazine.com/healthcare-business/2022/04/why-health-care-sharing-ministries-are-growing-in-north-texas/ [https://perma.cc/39HT-LS78] (using the example of OneShare).

which goes beyond the religious doctrinal developments in the Supreme Court.

Third, commitment to the solidarity principle may not suffice to resolve disputes about mutual aid in a pluralistic society. Religious objectors typically embrace the idea of insurance but resist the "social" collective. They want freedom to construct coverage on terms that reflect their own judgments about deservingness. The fact that religious objectors are able to harmonize the rhetoric of solidarity with their moralized claims to actuarial fairness suggests that there is less distance between these principles than insurance scholars tend to think.

Fourth and finally, the campaign for religious exemptions exposes the high costs of relying on private employers, whose goals and values may diverge from those endorsed by democratic majorities. Individuals may be permitted to opt out of a social insurance scheme without causing much harm to others. But when the courts permit employers to impose exclusionary benefit designs on their employees, workers become subject to discrimination both in insurance plans and in hiring. People marginalized by gender, sexual orientation, gender identity, and religion find themselves barred from the workplace or subordinated within it. Employers' authority to control and coerce grows and stretches beyond the workplace into private lives. Questions of insurance coverage are no longer resolved through democratic decision-making; they are transferred to employers in the first instance and to the courts in the second.

To promote solidarity among equal citizens in a democracy, social insurance schemes — for health insurance and beyond — must guard against aggrandizing the power of employers over workers at work and at home. The dynamics of these lawsuits should prompt a deeper examination of how the relevant collective for insurance is formed, of where that community directs its efforts (whether toward promoting health, protecting finances, or remedying brute luck), and of how political and economic power relations within the collective shape these choices. At stake is the survival of health insurance as a collective social enterprise between equal citizens.