

AN ALTERNATE THEORY OF *BURWELL V. HOBBY LOBBY*

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If asked what was the central issue in Burwell v. Hobby Lobby, most informed Americans would likely reply that it was the conflict of reproductive health and religious freedom. This Essay, however, argues for an alternate reading of that now infamous case. It proposes that Hobby Lobby is best understood as a demonstration of how the continued reliance on employer-provided benefits renders employers de facto health-care policy makers with the ability to profoundly impact the health-care access of millions of Americans.

INTRODUCTION

In 2014, the Supreme Court decided the controversial case *Burwell v. Hobby Lobby*, holding that, pursuant to the Religious Freedom Restoration Act, private employers could lawfully refuse to comply with the Affordable Care Act's (ACA) contraceptive mandate.² Common rallying cries among opponents of Hobby Lobby's position were "No Bosses in My Bedroom" and "Birth Control is Not My Boss's Business."³

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² 573 U.S. ____ (2014).

³ Several protestors held signs with type of slogans. See, e.g., <http://www.jta.org/wp-content/uploads/2014/04/hobby-lobby.jpg>; <http://thinkprogress.org/wp-content/uploads/2014/03/GW-college-dems-hobby-lobby-scotus.jpg>. For more about activism invoking this theme, see NARAL, Not My Bosses Business, available at <https://secure.prochoiceamerica.org/site/Advocacy?cmd=display&page=UserAction&id=6005>; UltraViolet, No Bosses in My Bedroom, available at

Although the legal issue presented in the case was whether a private corporation is exempt from a law that its owners oppose for religious reasons, many Americans' core objection to the decision was its implication that private employers could dictate our access to reproductive health care.

This Essay offers an alternate theory of *Hobby Lobby*. I propose that instead of a case about religious freedom, *Hobby Lobby* is best understood as a case about the potential perils of the employer-provided benefits system. While other scholars have noted the effect of employment on health insurance and, consequently, health-care access, *Hobby Lobby* reveals that employers dictate even more about the ability to access health care in the United States than simply whether an individual has insurance.

In the past, private employers have offered their employees relatively generous coverage of their own volition. However, following the passage of the Affordable Care Act (ACA) some employers will find themselves facing legal penalties if they do not provide comprehensive, affordable health insurance to their full-time employees. As primary providers of health insurance, private employers regularly make any number of employment- and insurance-related decisions that ultimately shape the contours of health-care access: whom to insure, what policies to offer, which treatments and providers to cover, and more. Consequently, employers are vested with decisions that directly impact the type and amount of health care that is available to millions of Americans.

In reframing the *Hobby Lobby* decision, this Essay exposes an unfortunate reality: Private employers are acting as de facto health-care policy makers. Following the Supreme Court's controversial decision in *Hobby Lobby*, Americans have gotten a glimpse of how an individual employer's decisions can affect the health-care access of its employees. However, this Essay reveals that these restrictions go well beyond the issue of contraception. As employer-provided benefits remain an enduring aspect of the American health-insurance system, at least in the short-term,⁴ it is essential to explore their effect on accessing needed health care.

This Essay proceeds in three parts. Part I outlines the dominant narrative of *Hobby Lobby* as a religious freedom case and the continued reliance on employers to provide health insurance in the United States. Part II explores how employers—many of whom have even stronger incentives to provide health insurance to their employees post-ACA—act

http://act.weareultraviolet.org/sign/scotus_birthctrl_video/#

⁴ See Jessica L. Roberts, *The ACA Double-Bind* (in progress) (on file with author).

as both gatekeepers and regulators of health care. Part III then reframes the issue as a classic agency problem and proposes that the solution might not be further regulation but a move away from the employer-provided system.

I. DOMINANT NARRATIVE OF *BURWELL V. HOBBY LOBBY*

Part I describes the *Hobby Lobby* case and its political and popular framing as a titanic conflict between socially conservative religious rights advocates and socially liberal champions of reproductive health. However, this reading of the case fails to address the issue of why a private company like Hobby Lobby is offering health insurance to its employees. To address this inquiry, Part I then turns to the employer-provided benefits system that made the controversy in *Hobby Lobby* possible and how ACA recently changed that system.

A. THE SUPREME COURT CASE

Given the wide spread media attention it received, many Americans may already be familiar with. Nonetheless, I begin by briefly summarizing the case and the statutory provisions it interprets.

Among the statute's many provisions, the Affordable Care Act (ACA) requires group health-insurance policies—including employer-provided plans—to offer women “preventative care and screenings” without “any cost sharing requirements” absent an applicable exception.⁵ While Congress did not specifically define what constituted “preventative care and screenings,” it authorized the Health Resources and Services Administration (HRSA), a division of the Department of Health and Human Services (HHS), to issue guidance. In response to this charge, HRSA drafted the Women's Preventative Service Guidelines, which states that non-exempt employers must cover “[a]ll Food and Drug Administration [(FDA)] approved contraceptive methods, sterilization procedures, and patient education and counseling” with no cost sharing.⁶ These regulations became known as the contraceptive mandate. HRSA also created certain exemptions for religious non-profit organizations and grandfathered plans.⁷

⁵ 42 U.S.C. § 300u-11 (2010).

⁶ Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (Feb. 15, 2012).

⁷ *Hobby Lobby Stores, Inc.*, No. 13-354, slip op. at 5 (U.S. Jun. 30, 2014).

In *Burwell v. Hobby Lobby*, three closely held organizations challenged their obligations under the contraceptive mandate as violating their sincerely held religious beliefs pursuant to the Religious Freedom Restoration Act (RFRA). RFRA forbids the Federal Government from taking actions that substantially burden religious exercise unless that action is the least restrictive means to serve a compelling government interest. Justice Alito drafted the majority opinion. First, the Court held that RFRA's definition of a person includes corporations and that corporate entities are capable of religious exercise.⁸ Addressing whether for-profit corporations could hold sincere religious beliefs, the Court stated that "[t]he companies in the cases before us are closely held corporations, each owned and controlled by members of a single family, and no one has disputed the sincerity of their religious beliefs."⁹ Turning to the substantial burden inquiry, the Court noted that failing to offer contraception would result in tax penalties of one hundred dollars per day for each affected individual.¹⁰ It also acknowledged that the companies could drop coverage altogether but that they would be subject to the no-offer penalty,¹¹ described in the following Sub-Part.¹² (Amici suggested that stopping coverage and paying the penalty might actually be a cost-efficient decision for employers, a possibility alluded to in Part II of this Essay.¹³) After finding that the contraceptive mandate posed a substantial burden on religious exercise, the Court then turned to the compelling interest and least restrictive means analysis.¹⁴ Assuming—but not holding—that the Government has compelling interests in public health and gender equality, the Court asserted that HHS failed to demonstrate that it could not achieve its objectives through means that would not substantially burden the exercise of religion, especially given the accommodations already built into the regulations.¹⁵ In sum, the Court's 5-4 majority opinion held that the ACA's contraceptive mandate, as applied to closely held corporations with religious objections, violated RFRA.¹⁶

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 7-8.

¹¹ *Id.* at 8.

¹² *Infra* notes 51-53.

¹³ *Infra* note 85.

¹⁴ *Burwell v. Hobby Lobby Stores, Inc.*, No. 13-354, slip op. at 2 (U.S. Jun. 30, 2014).

¹⁵ *Id.* at 2-3.

¹⁶ *Id.* at 3.

Several other justices filed their own opinions in the case. Justice Kennedy's concurrence, responding to Justice Ginsburg's dissent, first stated that both sides agree that the purpose of RFRA is to protect religious freedom.¹⁷ In discussing the Court's application of the substantial burden test, he emphasized that the majority premised its analysis on the assumption that the contraceptive mandate furthers a legitimate and compelling government interest.¹⁸ Justice Kennedy explained that a direct mandate to provide coverage for contraception is not the least restrictive way to achieve those interests because an accommodation is available for religious objections that would allow access to contraception without infringing on religious beliefs.¹⁹

In Justice Ginsburg's fiery dissent, she framed the issue as a matter of women's rights, asserting that the Court held "RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on third parties who do not share the corporation owners' religious beliefs—in these cases thousands of women employed by Hobby Lobby and Conestoga or dependents of persons those corporations employ."²⁰ She first described the constitutional right to reproductive freedom, the existing cost disparities for women's preventive health care, and the ACA's and its accompanying regulations' requirement that insurers cover women's preventive health services with no cost sharing.²¹ Justice Ginsburg then went on to critique the Court's extension of RFRA's protections to for-profit corporations.²² Even if for-profit corporations meet the definition of "person" for RFRA purposes, she maintained that those entities must still demonstrate that following the contraceptive mandate "substantially burdens" the business's exercise of religion,²³ noting that the substantiality of a burden is a separate inquiry from the sincerity of a belief.²⁴ She concluded that "the connection between the families' religious objections and the contraceptive coverage requirement is too attenuated to rank as substantial."²⁵ However, even assuming a substantial burden, Justice Ginsburg believed the Government had compelling interests in both public health and the well-being of

¹⁷ *Id.* at 1 (Kennedy, J., concurring).

¹⁸ *Id.* at 2.

¹⁹ *Id.* at 3.

²⁰ *Id.* at 2 (Ginsburg, J., dissenting).

²¹ *Id.*

²² *Id.*

²³ *Id.* at 10-11.

²⁴ *Id.* at 11.

²⁵ *Id.* at 22.

women.²⁶ With regard to RFRA's least restrictive means test, she opined that no less restrictive yet equally effective policy would simultaneously satisfy the plaintiff's religious objections and accomplish the contraceptive mandate's goal of ensuring that women receive costless preventative care.²⁷ She elaborated that "[i]mpeding women's receipt of benefits 'by requiring them to take steps to learn about, and to sign up for, a new [government-funded and administered] health benefit' was scarcely what Congress contemplated."²⁸ Justice Ginsberg ended her dissent by asserting that when entities with religious beliefs enter commerce they accept that their beliefs will not be imposed on others engaging in that commercial activity.²⁹ She would, therefore, have limited RFRA's religious exemptions to organizations with a religious purpose, primarily engaged in conduct to further that purpose.³⁰

Finally, Justices Breyer and Kagan wrote a mercifully short dissent explaining that, while they agreed with Justice Ginsburg's assessment that the plaintiffs should have failed on the merits, they did not believe that it was necessary to reach the issue whether for-profit corporations or their owners can bring RFRA claims.³¹

Politicians and the media depicted *Hobby Lobby* as an epic clash between two cherished American constitutional rights (and their passionate advocates). The case might as well have been called *Reproductive Choice v. Religious Freedom*. Prior to the decision, Senator Elizabeth Warren commented: "I cannot believe that we live in a world where we would even consider letting some big corporation deny the women who work for it access to the basic medical tests, treatments or prescriptions that they need based on vague moral objections."³² Republican Senators had their own view, explaining in their amicus brief, "[t]his case does not implicate the individual right to access to contraceptives, which this Court's cases have long protected. Instead, it concerns whether the federal government can force employers to violate their good-faith religious belief and pay for the contraceptives of others."³³ The central issue was thus framed in terms of reproductive health and religious freedom.

²⁶ *Id.* at 23-24.

²⁷ *Id.*

²⁸ *Id.* at 28.

²⁹ *Id.* at 31-35.

³⁰ *Id.* at 35.

³¹ *Id.* at 1. (Breyer, J. and Kagan, J., dissenting).

³² Elizabeth Warren, *We Don't Run this Country for Corporations* (Mar. 26, 2014), <http://elizabethwarren.com/blog/we-dont-run-this-country-for-corporations>.

³³ Brief for Senator Ted Cruz et al. as Amici Curiae Supporting Respondent at

After the decision, politicians continued to weigh in on the side of either women's health care or religious rights. House Speaker John Boehner issued this statement:

Today's decision is a victory for religious freedom and another defeat for an administration that has repeatedly crossed constitutional lines in pursuit of its Big Government objectives. The mandate overturned today would have required for-profit companies to choose between violating their constitutionally-protected faith or paying crippling fines, which would have forced them to lay off employees or close their doors.³⁴

On the other side of the debate, Minority Leader Representative Nancy Pelosi weighed in:

Today, the Supreme Court took an outrageous step against the rights of America's women, setting a dangerous precedent that could permit for-profit corporations to pick and choose which laws to obey. This deeply misguided and destructive decision is a serious blow to Americans' ability to make their own health decisions.³⁵

The media echoed this framing. One article described the case as a "victory at the court [sic] for the religious right."³⁶ Another, discussing the aftermath of the case, queried what would be the "next fronts in the contraception fight."³⁷

In his insightful article, *Regulating Employment-Based Anything*, Brendan S. Maher interrogates the popular construction of the *Hobby*

3, *Burwell v. Hobby Lobby Stores, Inc.*, No. 13-354, slip op. 6 (2015).

³⁴ *Speaker Boehner on the Supreme Court's HHS Mandate Ruling* (June 30, 2014) <http://www.speaker.gov/press-release/speaker-boehner-supreme-court-s-hhs-mandate-ruling#sthash.b56Pq4wH.dpuf>.

³⁵ Press Release, *Pelosi Statement on Supreme Court Hobby Lobby Decision*, (June 30, 2014), <http://pelosi.house.gov/news/press-releases/pelosi-statement-on-supreme-court-hobby-lobby-decision>.

³⁶ Richard Wolf, *Justices Rule for Hobby Lobby on Contraception Mandate*, USA TODAY, Jun. 30, 2014, <http://www.usatoday.com/story/news/politics/2014/06/30/supreme-court-hobby-lobby-religion-contraception-obama/11473189/>.

³⁷ Jaime Fuller, *After Hobby Lobby: The Next Fronts in the Contraception Fight*, WASH. POST, Jul. 1, 2014, <https://www.washingtonpost.com/news/the-fix/wp/2014/07/01/after-hobby-lobby-the-next-fronts-in-the-contraception-fight/>.

Lobby case.³⁸ He notes that many commentators stated the issue in the case was whether private employers should “pay” for their employees’ contraception.³⁹ Maher proposes that this framing misses key nuances of the employer-provided system.⁴⁰ Mainly, as he explains, “[e]mployers are not paying for contraception in the sense that many of the accounts assumed; they are administering a plan that passes employee money along to an insurer who provides coverage that includes contraception.”⁴¹ Maher asserts that to be compelled to be an administrator is a very different obligation than being compelled to spend money that would otherwise belong to the employer.⁴²

But regardless of one’s beliefs regarding contraceptive access or religion, these conflicts and commentaries raise a bigger question: Why are employers making decisions about health-insurance coverage in the first place?

B. EMPLOYER-PROVIDED BENEFITS & THE AFFORDABLE CARE ACT

The central conflict in *Hobby Lobby* would not have occurred absent the American reliance on employer-provided benefits. Of primary interest to this Essay is the crucial role employers occupy by providing private health insurance to millions of individuals in the United States.⁴³ Despite the varied ways of obtaining coverage, a majority of non-elderly Americans are insured through their employers.⁴⁴ When the ACA passed,

³⁸ Brendan Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257 (2016).

³⁹ *Id.* Cf. James D. Nelson, *Conscience, Incorporated*, 2013 MICH. ST. L. REV. 1565 (framing *Hobby Lobby* in terms of which organizations should be able to assert rights of conscience).

⁴⁰ Maher, *supra* note 38.

⁴¹ *Id.*

⁴² *Id.*

⁴³ The U.S. is the only country that relies heavily on employers to provide health insurance. Jacob S. Hacker, *Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform*, 34 BRIT. J. POL. SCI. 693, 697 (2004).

⁴⁴ *Key Facts About the Uninsured Population*, KAISER FAMILY FOUND. (Oct. 5, 2015), <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>; Melissa Majerol et al., *The Uninsured: A Primer – Key Facts About Health Insurance and the Uninsured in America* [hereinafter *The Uninsured: A Primer*], KAISER FAMILY FOUND. (Jan. 13, 2015); Diane Rowland & Adele Shartzter, *America’s Uninsured: The Statistics and Back Story*, 36 J. L. MED. &

one-hundred fifty-seven million Americans had employer-provided health insurance.⁴⁵ At the time, approximately fifty-six percent of individuals under the age of sixty-five hold such policies,⁴⁶ which made employers the primary source of health insurance for individuals who are not covered by Medicare.⁴⁷ The proportion of individuals insured through their employers has led one author to refer to employer-provided benefits as “the primary source of Americans’ health insurance for most of the past century”⁴⁸ and others to call employer-provided coverage “the bedrock of the health insurance system.”⁴⁹ Thus, employers are a primary source of health insurance in the United States.

While employers voluntarily began offering health insurance to their employees as the result of World War II wage controls and favorable tax status,⁵⁰ the ACA further entrenched our dependence on employer-provided benefits. Among the ACA’s most controversial provisions was the law’s so-called “employer mandate.” That provision requires large employers—defined in the law those that employ more than fifty workers—to offer affordable coverage of minimum value to ninety-five percent of their “full-time” employees, employees who work thirty or more hours per week.⁵¹ Lower-wage workers—individuals whose income is

ETHICS 618, (2008).

⁴⁵ Mark Merlis, *The Affordable Care Act and Employer-Sponsored Insurance for Working Americans*, ACAD. HEALTH 1 (2011), http://www.academyhealth.org/files/nhpc/2011/AH_2011AffordableCareReportFINAL3.pdf.

⁴⁶ The Uninsured: A Primer, *supra* note 44. Medicare covers almost all Americans over age sixty-five.

⁴⁷ Rowland & Shartzter, *supra* note 44, at 621.

⁴⁸ Christine Eibner, *Employer-Provided Health Insurance: Why Does It Persist, and Will It Continue after 2014?*, NEW ENG. J. MED. SUPP. (2003), available at <http://images.nejm.org/editorial/supplementary/2013/hbr18-eibner.pdf>.

⁴⁹ See Rowland & Shartzter, *supra* note 44, at 619. Employer-provided benefits have also been referred to as the “cornerstone” of the American health-care system. See John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2298-99 (2008).

⁵⁰ Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 888 (2011) [hereinafter *Employment-Based*]. Unions and the return of the military were also arguably contributing factors. For a thorough discussion of the history of the development of the employer-provided benefits system, see *id.* at 886-92.

⁵¹ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); see also The Uninsured: A Primer, *supra* note 44. However, not all scholars agree the mandate truly operates as such. See, e.g., Kathryn Moore, *The Pay or Play Penalty Under the Affordable Care Act*:

lower than four-hundred percent of the federal poverty level—may qualify for a refundable tax credit to purchase insurance for themselves and their dependents.⁵² If an employer fails to offer a health plan and just one of its employees purchases subsidized coverage on an exchange, the employer will face a tax of up to two-thousand dollars for *each full-time employee*, not counting the first thirty employees.⁵³ Likewise, if an employer offers a health plan but the plan is not affordable—either the required contribution exceeds 9.5 percent of an employee’s income or the plan pays for less than sixty percent of the covered services—and a qualifying employee obtains tax-subsidized coverage on an exchange, then the employer must pay a three thousand dollar penalty for *each subsidized employee who purchases coverage*.⁵⁴ Thus, the “pay-or-play penalty” actually encompasses two related tax penalties: the “no offer penalty” and the “unaffordable coverage penalty.”⁵⁵

However, the employer mandate is not the only way in which the ACA creates incentives for employers to provide health insurance. Because of the limitations of the small-group system, small employers have historically been far less likely to offer insurance to their employees.⁵⁶ Hence, a substantial portion of the uninsured who are part of working families work (or have a family member who works) for a small employer.⁵⁷ Although the mandate does not apply to small employers, the

Emerging Issues (in progress) [hereinafter *Pay or Play*].

⁵² ACA, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213-20 (codified as amended at 26 U.S.C. § 36B); Merlis, *supra* note 45, at 45.

⁵³ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); Merlis, *supra* note 45, at 2; *see also* The Uninsured: A Primer, *supra* note 44. Some employers have thus assumed that eighty employees is the true threshold for compliance as there will not be a financial impact for employees fifty to seventy-nine. James N. Nelson, *The Patient Protection and Affordable Care Act, ERISA § 510 and the Next Generation of Benefits Litigation Concerns*, ABA Employee Benefits Committee Newsletter.

⁵⁴ ACA, Pub. L. No. 111-148, § 1513, 124 Stat. 119, 253-56 (codified as amended at 26 U.S.C. § 4980H); Merlis, *supra* note 45, at 2.

⁵⁵ I have borrowed the terms “pay-or-play penalty,” “no offer penalty,” and “unaffordable coverage penalty” from Kathy Moore. *See generally* Moore, *Pay or Play*, *supra* note 51. Moore includes a very useful diagram in her Essay, mapping how the pay-or-play penalty operates. *Id.*

⁵⁶ Amy B. Monahan & Daniel Schwarcz, *Saving Small Employer Health Insurance*, 98 IOWA L. REV. 1935, 1942-44 (2013) [hereinafter *Saving*].

⁵⁷ The mandate applies only to employers with fifty or more full-time employees. ACA § 1513, I.R.C. § 4980(H). By failing to cover smaller employers, the mandate could leave a number of individuals uninsured. *See* The

law addresses this issue via tax credits designed to help smaller entities—employers with less than twenty-five employees and annual wages under fifty thousand dollars—cover the costs of providing health insurance to their workers.⁵⁸ These credits became available the year the law passed;⁵⁹ however, no credits are available after the start of this year.⁶⁰ Given the modest nature of the credits and the short lifespan of the program, there is speculation that this incentive will do little to encourage small employers to offer coverage when they haven't in the past.⁶¹ Yet regardless of their impact they provide another example of how the ACA not only perpetuates but attempts to strengthen the American reliance on employer-provided benefits.

In sum, while a vast majority of employers were already offering health insurance to their employees prior to health-care reform,⁶² the ACA further codified our dependence on employers as health-insurance providers through the employer mandate and other provisions designed to encourage employers to provide insurance. Without the employer-provided benefits system there would be no *Burwell v. Hobby Lobby*. As a result, this Essay advocates understanding *Hobby Lobby* as primarily a case about the continued reliance on employers to provide health insurance and the shortcomings of the employer-provided system.

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Commentators framed *Burwell v. Hobby Lobby* as the religious right and the socially liberal left locking horns on the issue of women's

Uninsured: A Primer, *supra* note 44 (explaining that “the employer requirements may help many uninsured individuals with a worker in their family, a majority of uninsured workers work in small firms that are not required to provide insurance coverage”).

⁵⁸ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); I.R.C. § 45R(d); Merlis, *supra* note 45, at 3; The Uninsured: A Primer, *supra* note 44; *see also* Moore, *Employment-Based*, *supra* note 50, 912-17 (describing the tax credit and assessing its probable effect).

⁵⁹ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); The Uninsured: A Primer, *supra* note 44.

⁶⁰ ACA, Pub. L. No. 111-148, § 1421, 124 Stat. 119, 237-42 (codified as amended at 26 U.S.C. § 45R); Merlis, *supra* note 45, at 3.

⁶¹ Merlis, *supra* note 45, at 3.

⁶² Rowland & Shartzter, *supra* note 44, at 621; *see also* Merlis, *supra* note 45, at 3 (“In 2010, 95 percent of firms with 50 to 199 workers and 99 percent of firms with 200 or more workers offered coverage to at least some of their employees.”).

reproductive health. Yet this construction only tells part of the story. If read as an employer-provided benefits case, *Hobby Lobby* is about much more than just access to contraception. Employers make numerous choices that impact how a substantial number of Americans access health care. Hence, Part II argues that the employer-provided system renders employers de facto health-care policy makers.

II. EMPLOYERS AS HEALTH-CARE POLICY MAKERS

Employers make all kinds of decisions that impact how a substantial number of Americans access health care. In other words, they are making health-care policy. Employers act as health-care policy makers in two related ways: as gatekeepers and as regulators. As gatekeepers, employers affect *whether* people have access to health care. Their decisions to offer benefits or to dump potentially costly employees may determine whether certain people can access the health-care system at all. As regulators, employers affect *how* people access health care. The structure of their plans, the kind of coverage they offer, and whether they include cost-sharing mechanisms can all impact how an individual obtains health care.

A. EMPLOYERS AS GATEKEEPERS

Health care in the United States is expensive. America spends approximately eight thousand dollars per person each year on health care⁶³ and that number continues to rise.⁶⁴ This amount is more than two and a half times as much as other developed countries.⁶⁵ Because rising costs render health care unaffordable, many people in the United States must depend on health insurance to finance their medical treatment. Thus, having insurance may in many circumstances be a prerequisite for

⁶³ Jason Kane, *Health Costs: How the U.S. Compares with Other Countries*, PBS Newshour, Oct. 22, 2012, available at <http://www.pbs.org/newshour/rundown/health-costs-how-the-us-compares-with-other-countries/> (stating that the United States pays \$8,233 per person each year); *see also id.* (explaining that the next highest spenders all spent at least \$3,000 and the average annual spending for developed countries was \$3,268 per person (quoting Mark Pearson)).

⁶⁴ Annie Lowery, *Health Care Spending's Recent Surge Stirs Unease*, N.Y. TIMES, April 19, 2014.

⁶⁵ *Id.*; Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES, June 1, 2013.

accessing needed health care. To be sure, *having* health insurance does not alone promise access to good health care, but *lacking* insurance certainly impedes it.⁶⁶ In short, being uninsured affects whether, when, and where individuals access the health-care system.⁶⁷ Employers act as gatekeepers to health care in their decisions to offer benefits and to engage in employee dumping.

1. Whether to Offer Benefits

While employer-provided benefits are a crucial component of the American health insurance system, not all workers receive health insurance from their employers. Some employees, such as part-time workers, may not be offered health insurance, and, even of the ones that are, not all can afford to pay their portion of the premiums.⁶⁸ While some uninsured workers may be employed part-time or as independent contractors, the majority are either self-employed or work for small employers who do not offer benefits.⁶⁹ Employers in certain industries are less likely to offer their employees coverage.⁷⁰ Significantly, over eighty percent of uninsured workers have blue-collar jobs.⁷¹ Hence, not all workers have historically been eligible for coverage and even if they qualify, the policies themselves may be prohibitively expensive. Perhaps surprisingly given the reliance on employers to provide health insurance, three-quarters of the uninsured are actually part of working families.⁷² Employers, therefore, have rarely insured all of their employees. On average, they have covered seventy-

⁶⁶ Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 25 (2010)..

⁶⁷ Rowland & Shartzter, *supra* note 44, at 618.

⁶⁸ *Id.* at 621; *see also* Key Facts, *supra* note 44; The Uninsured: A Primer, *supra* note 44.

⁶⁹ Key Facts, *supra* note 44.

⁷⁰ *Id.* Individuals who work in manufacturing, professional services, and the public sector are more likely to receive employer-provided benefits. *Id.*

⁷¹ *Id.*

⁷² The Uninsured: A Primer, *supra* note 44. Approximately 60% of the uninsured have at least one full-time worker in the family and 16% have at least one part-time worker. *Id.*; Key Facts, *supra* note 44; *see also* The Uninsured: A Primer, *supra* note 44 (reporting the numbers as 66.7% and 20.2%, respectively); Rowland & Shartzter, *supra* note 44, at 620 (reporting the numbers at 70% and 11%, respectively).

seven percent of their workers.⁷³ Yet when employers do offer health insurance, their employees are highly likely to take them up on it.⁷⁴

Several employer-provided plans have historically excluded some of their full-time employees, usually those individuals who make less money.⁷⁵ As a group, low-income workers are less likely to be covered through their employers than their high-income counterparts.⁷⁶ Of course, the ACA will change the way in which employers can limit the coverage they provide to some extent. As mentioned, the employer mandate requires large employers to provide insurance to all of their full-time employees or face a penalty.

Recently, employers have had a potentially restrictive effect on health-care access by reducing the benefits available to individuals who are not the employee. In particular, employers have begun cutting coverage for working spouses who have access to health insurance through their own jobs, following the passing of the ACA.⁷⁷ These cuts have taken different forms. Whereas some employers have added a surcharge or increased the employee's share of the premium for spousal coverage, others have simply eliminated it.⁷⁸ Employers have reduced coverage for working spouses for explicitly cost-related reasons.⁷⁹ For example, UPS maintained it would save a whopping sixty million dollars per year by cutting benefits for spouses who are eligible for health insurance through their own employers.⁸⁰

Even after the ACA, employers will not necessarily uniformly offer coverage to their employees. Recall that the mandate does not apply to smaller employers and the tax credits designed to facilitate their entrance into the market ended in 2015. Consequently, employers of fewer than fifty that have not previously offered health insurance to their employees have little added incentive to start now. Indeed, they could arguably have less incentive, given that employees can now purchase often heavily subsidized policies on the exchanges. Additionally, larger employers could still decide not to offer their employees coverage and nominally comply with the law. One way that employers could avoid the requirements of the

⁷³ The Uninsured: A Primer, *supra* note 44.

⁷⁴ *Id.*

⁷⁵ Merlis, *supra* note 45, at 4.

⁷⁶ Moore, *Employment-Based*, *supra* note 50, at 896.

⁷⁷ Moore, *Pay or Play*, *supra* note 51.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.* (citing Jay Hancock, *UPS Won't Insure Spouses of Many Employees*, USA TODAY (Aug. 20, 2013)).

ACA would be to keep their number of full-time employees below the employer mandate's fifty full-time workers threshold. Employers right at the cusp of the mandate could opt not to hire new workers⁸¹ or to hire new workers exclusively on a part-time or contract basis.⁸² Employers whose workforce already exceeds fifty employees could either fire enough employees to put them below the cut-off⁸³ or could switch certain employees to part-time or contract work.⁸⁴ Alternatively, employers might opt to drop coverage altogether and instead pay the relatively modest tax penalties.⁸⁵

How an employer's decision about offering benefits will affect the health-care access of its employees depends on the individual employee's income and the scope of the coverage the employer would have offered. As explained in Part I, thanks to the ACA, lower-income workers have access to highly subsidized health insurance on the exchanges.⁸⁶ On one hand, if an employee can get cheaper and/or more generous coverage than she would have received from her employer via the exchanges the employer's decision not to offer benefits will not have a harmful impact. Paradoxically, the employee might actually end up better off in the long run. (She will of course have to deal with administrative hassle of having to switch insurance carriers, which could disrupt her access to health care, particularly if it occurs mid-treatment.) On the other hand, if an individual does not qualify for the tax credit or other government benefits and/or the coverage available to her on the exchanges is less comprehensive, the absence of employer-provided benefits might deny her access to health care. For example, a person without employer-provided benefits who finds herself in the Medicaid gap could end up without meaningful access to health care.⁸⁷ Of course, another factor to consider is that policies

⁸¹ Moore, *Pay or Play*, *supra* note 51.

⁸² However, a recent article in Health Affairs only found marginal evidence in favor of an increased reliance on part-time workers. See Asako S. Moriya, Thomas M. Selden, & Kosali I. Simon, *Little Change Seen In Part-Time Employment As A Result Of The Affordable Care Act*, 35 HEALTH AFFAIRS 119 (2016).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ Merlis, *supra* note 45, at 1. That said, the tax penalties are not themselves tax deductible, while the premiums are, which means that the penalties could be substantially larger than they first appear.

⁸⁶ *Supra* note 52 and accompanying text.

⁸⁷ Medicaid may also be an option for some but with the piecemeal enactment of the Medicaid expansion and the gap it creates between public benefits and the availability of subsidies in some states, people may find themselves in a

purchased on the exchanges are not tax-deductible, while employer-provided benefits are (at least to a point), which may also affect the relative desirability of an exchange policy versus an employer-provided one.

2. Targeted Employee Dumping

An employer could also act as a gatekeeper by excluding certain employees. But why would employers want to offer health insurance to some employees but not others? The answer is simple: cost. By denying benefits to potentially expensive employees, employers can theoretically save on health insurance costs. Moreover, employers can make themselves more competitive by passing on some of the savings to workers in the form of higher pay. Amy Monahan and Dan Schwarcz refer to this practice as “targeted dumping.”⁸⁸ Employers can engage in both explicit and in structural employee dumping behaviors.

Explicit dumping practices are relatively straightforward. An employer who does not wish to offer insurance to a potentially expensive employee could fire her, switch her to part-time or contract work to avoid the employer mandate, or not hire her to begin with. A handful of cases indicate that at least a few employers have engaged in this type of conduct.⁸⁹ Encouraging a potentially expensive employee to voluntarily leave a health plan is a less dramatic explicit dumping strategy. For example, one woman reported that after she had prophylactic surgeries due to a heightened genetic risk of breast cancer, her boss yelled at her at work for increasing the yearly cost of the health policy by \$13,000, asked her to switch to her husband’s insurance, and offered her additional compensation to leave the employer-provided plan.⁹⁰

In addition to explicit employee dumping, employers may also adopt subtler strategies specifically geared to shunt potentially costly individuals off their health plans. I call this phenomenon “structural

Goldilocks dilemma. They could be too poor to afford health insurance yet too wealthy to qualify for Medicaid or the low-income subsidy.

⁸⁸ Amy B. Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 128 (2011) [hereinafter *Dumping*].

⁸⁹ See JESSICA L. ROBERTS & ELIZABETH WEEKS LEONARD, *HEALTHISM: HEALTH-STATUS DISCRIMINATION & THE LAW* (forthcoming Cambridge University Press 2018).

⁹⁰ SEC’Y’S ADVISORY COMM. ON GENETICS, HEALTH, & SOC’Y, U.S. DEP’T OF HEALTH & HUMAN SERVS PUBLIC PERSPECTIVES ON GENETIC DISCRIMINATION: SEC’Y’S ADVISORY COMM. ON GENETICS, HEALTH, & SOC’Y 14-15 (2004).

employee dumping.” This variety of targeted dumping operates through “subtle, informal pressure” not outright coercion.⁹¹ Monahan and Schwarcz explain that employers can dump potentially expensive employees from their health plans using “indirect risk classification.” Indirect risk classification does not rely upon the employer’s differentiating between high and low-risk employees but rather creates situations in which the individuals themselves will self-classify based on risk through their decisions related to health insurance.⁹²

Employers can achieve this goal through both positive and negative signals. On one hand, they could adopt plans that offer significant benefits related to wellness, such as joining a gym or maintaining a healthy blood pressure or weight, thereby encouraging low-risk employees to accept coverage.⁹³ On the other, the plans could include high deductibles and exclude drugs and treatments associated with chronic conditions, thus creating incentives for high-risk employees to seek health insurance elsewhere.⁹⁴

Employers could also go as far as advising their high-risk employees that those individuals may have better coverage going through the exchanges.⁹⁵ Thus, after adopting policies with elements designed to attract low-risk employees and discourage high-risk ones, employers can explain to the high-risk employees why it is in their self-interest not to accept the employer-provided plan because outside health insurance would better meet their medical needs. Remarkably, the ACA does very little to combat targeted dumping, especially by self-insured employers.⁹⁶ Despite the polarized reaction to health-care reform, Monahan and Schwarcz argue that people of all political and ideological stripes should agree that gaming the system through targeted dumping is an undesirable outcome.⁹⁷

Like the impact of the decision whether to offer benefits, the effect of targeted employee dumping also depends on the individual employee’s income (i.e., access to subsidies) and the relative desirability of the policies available on the exchanges as compared to the policies provided by the employer. If a dumped individual can access more affordable and/or expansive coverage on the exchanges, the effect could be neutral, even

⁹¹ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 171.

⁹² *Id.* at 134-35.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.* at 171.

⁹⁶ *Id.* at 146.

⁹⁷ *Id.* at 132.

preferable. If she cannot, it is problematic. Moreover, it is worth noting that dumping that affects employment, such as failing to hire, firing, or switching to part-time or contract work, will have the added negative impact of reducing the wages available to purchase health care out-of-pocket.

B. EMPLOYERS AS REGULATORS

Employers' gatekeeping function is all-or-nothing: Either the employee has access to meaningful employer-provided coverage, or she does not. If an individual without employer-provided benefits also cannot obtain coverage on the exchanges or afford to purchase health care on her own, she may find herself effectively shut out of the health-care system. Yet as regulators, employers make decisions that have a more subtle impact on health-care access by shaping the conditions under which their employees obtain care.⁹⁸ In other words, they can affect *how* their employees access health care. The affected individuals could end up under-insured—that is they nominally hold health insurance but are still unable to access needed health care—or they might choose one treatment option or medical professional over another, not for health related reasons but because of their coverage. This Sub-Part explores three ways in which employers regulate health-care access: plan structure; scope of coverage; and cost-sharing.⁹⁹

1. Plan Structure

The types of plans employers choose to offer their employees shape how those covered individuals access the health-care system. Employers may choose from a variety of benefits structures when offering

⁹⁸ See Abigail R. Moncrieff, *The Individual Mandate as Healthcare Regulation: What the Obama Administration Should Have Said in NFIB v. Sebelius*, 39 AMER. J. L. & MED. 539, 541 (2013) (explaining that health insurance “imposes regulatory constraints on individual consumption decisions, steering beneficiaries toward particular goods and services”).

⁹⁹ Matthew identified a similar list of strategies. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Markets, Courts and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1045-49 (1996) (identifying four major approaches that employers have taken to manage health insurance costs). Matthew cites adopting plans with cost-sharing provisions, limiting coverage for costly individuals, self-insuring, and opting not to offer coverage. *Id.*

health-insurance coverage to their employees. Typical health plan structures include indemnity plans, preferred provider organizations (PPOs), point-of-service plans (POSs), health maintenance organizations (HMOs), and finally accountable care organizations (ACOs). Yet while employers enjoy significant choice in selecting which health plans to offer they tend to provide only one or two options to their employees.¹⁰⁰

Indemnity plans are the simplest. They indemnify the insured from the costs of health care.¹⁰¹ Few cost-limiting mechanisms existed under such plans and the insurance company typically paid on the billed amount, leaving the provider to recoup any additional costs from the insured.¹⁰² While these kinds of plans were common before the managed-care revolution of the 1980s and early 1990s, they now make up only one percent of the current health-insurance market.¹⁰³

Common plan structures include PPOs, HMOs, POSs, and ACOs. PPOs are currently the most popular variety of managed-care plans.¹⁰⁴ PPOs contract with a network of “preferred” health-care providers who agree to the plan’s payment structure.¹⁰⁵ The PPO pays the providers directly for their services.¹⁰⁶ HMOs not only handle benefits coverage but also create and maintain the very health-care delivery system itself.¹⁰⁷ The vast majority of HMOs contract with health systems and hospitals directly.¹⁰⁸ Because they are licensed by the states, HMOs must comply with more rules and regulations than other types of plans, such as providing adequate access to health-care providers and permitting direct access to PCPs.¹⁰⁹ Importantly, HMOs typically share some degree of risk with their physician network.¹¹⁰ POSs combine characteristics of managed-care and indemnity plans by allowing insureds to choose which type of benefits they want to use when they access health care, or at the “point of service.”¹¹¹ These plans allow employers to capitalize on the cost-savings of an HMO-

¹⁰⁰ Margaux J. Hall, *A Fiduciary Theory of Health Entitlements*, 35 *CARDOZO L. REV.* 1729, 1741 (2014); Robertson, *Cost-Sharing*, *supra* note 145.

¹⁰¹ PETER R. KONGSTVEDT, *ESSENTIALS OF MANAGED HEALTH CARE* (2012).

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

style plan while still allowing some coverage for out-of-network health-care services.¹¹² Finally, because of the backlash against traditional managed care organizations, the ACA ushered in a new variety of managed care: ACOs.¹¹³ As with HMOs, in ACOs, participating providers agree to share the responsibility for a group of patients in terms of both financial risk and health-care delivery.¹¹⁴ However, ACOs differ from HMOs because they are provider-led and are designed to guarantee both efficient and effective care. While the primary payment incentives with respect to HMOs are financial, ACOs also introduce a quality standard. ACOs adopt an alternate payment structure designed not only to reward economic efficiency but also quality of care.¹¹⁵

The type of plan an employer selects can have a direct effect on how its employees access health care. For example, in a PPO, insureds who seek care in network receive certain benefits,¹¹⁶ thereby pushing them toward the providers who have agreed to the terms of the PPO. If a person's top choice of health-care provider has not agreed to the terms of the PPO, that individual may be inclined to instead seek care in-network. PPOs therefore limit individual choice and shape where insureds ultimately access health care. Similarly, the indemnity-style coverage of POSs tends to incorporate steep cost-sharing mechanisms to encourage individuals to seek care in network.¹¹⁷ Further, to access the highest degree of coverage for non-emergency treatment, individuals in POSs must first go through their primary-care physician (PCP).¹¹⁸ Hence, like PPOs, POSs push individuals toward certain providers. Additionally, requiring a PCP visit prior to specialty care structures the way in which insureds access health care by restricting their ability to independently seek care from specialists.

HMOs, like the other kinds of managed-care plans, also restrict where insureds can access health care. Even post-ACA, employers—self-insured and otherwise—are more or less able to craft their provider networks however they choose.¹¹⁹ Those choices can have far-reaching implications for patient access. Frequently, participants must access care in network and must go through a designated PCP before obtaining

¹¹² *Id.*

¹¹³ See generally Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393 (2012)

¹¹⁴ *Id.* at 1410-12.

¹¹⁵ *Id.* at 1410.

¹¹⁶ KONGSTVEDT, *supra* note 101.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 149.

specialized care.¹²⁰ Seeing out-of-network specialists may prove particularly challenging. For example, the plan might require PCP pre-approval or a referral from an in network provider or might cap the number of times that a participant can see an out-of-network specialist.¹²¹ Thus, insureds face two types of limitations. First, to fully enjoy the benefit of their health-insurance coverage they must seek care from a predetermined group of health-care providers, regardless of whether a physician outside the network could better meet their needs. Second, they cannot simply see a particular doctor—in network or not—when they please. They must go through the steps of acquiring referrals or pre-approvals to be covered in many circumstances. These restrictions significantly limit patients in their choices of which provider they see and when they see them. And that is no accident. Managed care plans are designed to funnel patients to particular clinics and physicians and through particular treatment channels to keep costs low. However, increasingly narrow networks can have a negative effect on health-care access, especially for the very sick.¹²²

Moreover, given the payment structure and risk-sharing aspects of HMOs, physicians have incentives to favor lower cost treatment options for the patients.¹²³ Capitation, a common mechanism for encouraging health-care providers to cut costs, can have a restrictive effect on health-care access.¹²⁴ Pursuant to a capitation regime, the insurer gives the physician a predetermined amount of money for treating a plan participant over a particular time span.¹²⁵ If the treatment costs are less than the payment, the physician keeps the overage.¹²⁶ If they are more, the physician receives no additional compensation.¹²⁷ Clearly, the incentive is to provide health care at as little cost as possible to retain the maximum share of the capitation payment. Therefore, a doctor may not recommend a particular procedure or course of treatment—even if it has therapeutic benefit—thereby restricting the patient’s choice of covered treatment options. Moreover, a patient may not even *know* a treatment alternative exists if she depends on

¹²⁰ *Id.* at 168.

¹²¹ *Id.*

¹²² See generally Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63 (2015).

¹²³ Bronsteen et al., *supra* note 49, at 2318.

¹²⁴ KONGSTVEDT, *supra* note 101.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

her physician to inform her.¹²⁸ This scenario is particularly problematic because the patient, being unaware of the full panoply of possible treatments, does not even have the choice to pay out-of-pocket for a more expensive option. As a result, the use of financial incentives to encourage health-care providers to factor cost into their treatment recommendations has been cited as an example of the agency problems described in Part III.¹²⁹ ACOs may also encourage health-care providers to offer less expensive treatment options, thereby restricting choice in health care and, as a result, potentially denying patients access to medically beneficial care.¹³⁰

In sum, the types of plans employers choose to offer their employees can have a significant impact on the conditions under which those individuals access health care. In particular, the plan structure can dictate which kinds of medical professionals a person can consult, when, and for what price.¹³¹ These constraints are designed primarily to reduce costs, including wasteful medical spending, but not necessarily to ensure access or improve health-care delivery.

2. Scope of Coverage

Employers have discretion with respect to the scope of the benefits they offer. Small-group insurers, like those on the individual market, must offer federally determined essential health benefits.¹³² Although large employer-provided and self-insured plans need not provide all ten of the essential benefits like their individual and small-group compatriots, they are subject to certain requirements in terms of both coverage and affordability.¹³³ However, because coverage and affordability are both

¹²⁸ *Id.*

¹²⁹ *Id.*; Bronsteen et al., *supra* note 49, at 2317 (asserting that such systems could “incentivize physicians to underprovide care”).

¹³⁰ Mantel, *supra* note 113, at 1427. Of course, more expensive treatment is not necessarily better.

¹³¹ Moncrieff, *supra* note 98, at 552-53 (describing ways in which insurance coverage shapes health-care decisions through its pricing structure and administrative requirements).

¹³² Specifically, the ACA imposes coverage requirements on plans in the individual and small-group markets. See Monahan & Schwarcz, *Saving*, *supra* note 56, at 1945-46.

¹³³ See Allison Hoffman, *Health Care Spending and Financial Security After the Affordable Care Act*, 92 N.C. L. REV. 101 (2014) [*hereinafter Health Care Spending*] (describing the relatively loose regulation of employer-provided health

described in terms of the cost of the plan, those requirements do not mandate particular substantive benefits.¹³⁴ Thus, large-group and self-insured employer-provided plans maintain significant freedom regarding what they choose to cover.¹³⁵ As Amy Monahan and Dan Schwarcz point out, a self-insured employer could lawfully implement a health plan that covers *only* preventive services, the four types of coverage mandated by ERISA, and the routine costs of individuals in clinical trials.¹³⁶ Nothing more. It is also worth noting that because of the notorious promise that “if you like the plan you have, you can keep it,”¹³⁷ plans that do not comply with the ACA’s requirements but were in effect before March 23, 2010 have grandfathered status.¹³⁸ Hence, while the ACA does impose some substantive requirements on certain types of policies, it leaves a fair amount of discretion for certain kinds of employers.¹³⁹

Given the leeway described above, employers with self-insured or large-group plans that wish to limit coverage—either for financial or, as in *Hobby Lobby*, ideological reasons—could do so in a variety of ways. For example, many health insurance policies both limit their coverage to medically necessary treatment (the determination of which may be left to the insurer’s discretion) and exclude experimental options.¹⁴⁰ Employers can also select plans that do not cover the treatment of certain conditions.

insurance under the ACA). Hoffman proposes that by banning caps, the ACA could actually discourage employers from adopting plans that cover essential benefits. *Id.*

¹³⁴ Monahan & Schwarcz, *Dumping*, *supra* note 88, at 158 (explaining that neither “affordable” or “minimum value” apply to the scope of the benefits provided).

¹³⁵ *Id.* at 147

¹³⁶ *Id.* at 148.

¹³⁷ See Administration of Barack Obama, Statement on the Third Anniversary of the Signing of the Patient Protection and Affordable Care Act, (Mar. 23, 2013).

¹³⁸ ACA, Pub. L. No. 111-148, § 1251, 124 Stat. 119, 161-62 (codified as amended at 42 U.S.C. § 18011). Grandfathered plans can continue to impose restrictions on coverage such as preexisting condition exclusions and annual and lifetime caps. Yet plans can very easily lose their grandfathered status by adopting any number of changes. Merlis, *supra* note 45, at 3.

¹³⁹ Yet where the ACA falls short in terms of benefits regulation, state law may do some work. Although ERISA prevents states from regulating self-insured plans, it specifically allows them to impose substantive requirements on health insurers who provide insurance to employers and states have availed themselves of the opportunity by requiring insurers to cover a significant range of benefits. Monahan & Schwarcz, *Dumping*, *supra* note 88, at 144.

¹⁴⁰ Bronsteen et al., *supra* note 49, at 2316

They could, therefore, select or design plans that exclude drugs and care for stigmatized or especially costly health problems, such as AIDS and hemophilia.¹⁴¹ Yet even when they provide coverage for a particular condition, employers and health insurers may only cover certain options for treating that condition. Likewise, a policy may cover only one course of treatment or one aspect of the treatment process. A policy could, therefore, cover tests for autism while excluding the behavioral therapy needed for long-term management and care, or simply cap coverage for a given condition at a particular amount.¹⁴² Given the discretionary and patchwork nature of certain health plans, it is not terribly surprising that many individuals with cancer report that their employer-provided plans fail to comprehensively cover their treatment.¹⁴³ Because employees have little choice with respect to the content of their employer-provided plans, which in turn leads to little incentive to actually read coverage details carefully, they frequently are unaware of these gaps in benefits. Sadly, many times, it is not until an individual or her family falls ill that she discovers she lacks coverage for a needed treatment.¹⁴⁴

The scope of coverage an employer offers can affect access. First, individuals may forgo potentially beneficial treatments or services because they are not covered and the employees cannot afford to pay out-of-pocket. Treatments or services with therapeutic value may not be “medically necessary.” Thus, even if an individual could benefit from health-care services, if the insurer deems the services unnecessary or experimental, that person may not be able to access them. Second, individuals may be uninsured for certain conditions. When an employer chooses a plan that does not cover a particular health condition, a covered employee may not seek any treatment because she cannot afford it without the help of insurance. The absence of any meaningful treatment options raises gatekeeping concerns. Finally, individuals may make treatment decisions based on coverage instead of medical opinion. For example, a person

¹⁴¹ See Monahan & Schwarcz, *Dumping*, *supra* note 88, at 147.

¹⁴² See *id.* at 166. Such caps could lead employees to begin treatment that they must eventually abandon once they reach the cap. Hoffman, *Health Care Spending*, *supra* note 133.

¹⁴³ S. Yousuf Zafar et al., *The Financial Toxicity of Cancer Treatment: A Pilot Study Assessing Out-of-Pocket Expenses and the Insured Cancer Patient's Experience*, THE ONCOLOGIST (2013); see also Henry J. Kaiser Foundation, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System*, Jan. 30, 2009, available at <http://kff.org/health-costs/event/spending-to-survive-cancer-patients-confront-holes/>.

¹⁴⁴ Matthew, *supra* note 99, at 1048.

might choose drug therapy over surgery even when surgery is the most desirable treatment option. While they may not be as harmful as outright exclusion, such limitations on substantive health-insurance benefits provide yet another example of how employers' decisions ultimately dictate health-care access.

3. Cost-Sharing

Cost-sharing mechanisms can also affect health-care access. Cost-sharing provisions, such as including deductibles, co-payments, and co-insurance, require individuals to pay some amount out-of-pocket to access the covered health care.¹⁴⁵ The major aim of these kinds of measures is to reduce wasteful spending by ensuring that people have skin in the game. However, the same mechanisms could also discourage obtaining needed medical treatments because of cost.

The ACA also creates some restrictions on cost-sharing. For instance, the law requires coverage with no cost-sharing for certain preventive services, such as immunizations depending upon age and population, as well as screenings (and sometimes counseling) for various conditions, including alcohol misuse, diabetes, HIV, and depression.¹⁴⁶ Thus, employer-provided plans can theoretically no longer cut costs by passing a portion of those particular kinds of expenses down to the employees. However, they may pass costs down to employees by making them pay more for coverage or by skimping in other areas. The ACA also limits the maximum amount an individual can contribute in cost-sharing obligations for essential benefits in individual and small group plans on the exchanges, as well as employer-provided group plans,¹⁴⁷ and caps cost-

¹⁴⁵ Because individuals must pay up to a certain threshold before accessing their benefits, Christopher Robertson has aptly described cost-sharing mechanisms as “just the absence of insurance for certain costs.” Christopher T. Robertson, *Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security*, 14 *YALE J. HEALTH POL’Y, L., & ETHICS* 239 (2014) [hereinafter *Cost-Sharing*]; see also Moore, *Pay or Play*, *supra* note 51; Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, *YALE J. HEALTH POL’Y, L., & ETHICS* 453, 457 (2009).

¹⁴⁶ ACA, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 131-32 (codified at 42 U.S.C. § 300gg-13); Dep’t of Health and Human Servs., Preventative Services Covered Under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>.

¹⁴⁷ ACA, Pub. L. No. 111-148, § 1302(c), 124 Stat. 119, 165-167 (codified as amended 42 U.S.C. § 18022).

sharing for individual and small-group plans.¹⁴⁸ Despite those restrictions, it seems that health-care reform has actually encouraged many employer-provided health plans to increase their adoption of cost-sharing devices. Following the ACA, employers may start to move away from managed-care plans, which carry with them lower out-of-pocket costs, to higher deductible and co-pay plans.¹⁴⁹

Cost-sharing mechanisms can shape how individuals access health care because high deductibles and co-pays may discourage them from seeking medical treatment when they actually need it.¹⁵⁰ Importantly, cost-sharing mechanisms affect workers differently. For example, a \$5000 annual deductible is of a higher relative cost to an employee that makes \$20,000 per year as compared to an employee who makes \$100,000. Thus, while deceptively facially neutral, a co-pay or deductible that fits comfortably within the price range of one employee might be too expensive for another. As a result, some individuals may nominally hold health insurance from their employers but still be unable to meaningfully access the health-care system, leaving them under-insured.¹⁵¹ To cope with this under-insurance, they may allocate money away from other necessities¹⁵² or forgo needed care altogether.¹⁵³ Hence, from a practical perspective,

¹⁴⁸ ACA, Pub. L. No. 111-148, § 1302(c)(1), 124 Stat. 119 (codified as amended at 26 U.S.C. § 18022(c)(1)) (citing 26 U.S.C. § 223(c)(2)(A)(ii)); *see also* Monahan & Schwarcz, *Saving*, *supra* note 56, at 1946. Interestingly, the ACA also originally included a provision that would have applied only to small-group plans, forbidding deductibles that exceed two and four thousand dollars for individual and family coverage, respectively, but it was repealed. *See* ACA, Pub. L. No. 111-148, § 1302(c)(2)(A), 124 Stat. 119, 166 (repealed 2014); *see also* Monahan & Schwarcz, *Saving*, *supra* note 56, at 1946.

¹⁴⁹ John Ydstie, *More U.S. Companies Switch to High Deductible Health Plans*, NPR (Feb. 18, 2014) <http://www.npr.org/2014/02/18/278952305/there-s-hope-health-care-costs-can-be-brought-under-control> (citing Tom Mangan).

¹⁵⁰ Proponents of these plans contend that the benefits of discouraging insureds from seeking care that significantly exceeds their benefits outweighs these potential detriments.

¹⁵¹ The differing impacts of cost-sharing also create distortions on the other side. Affluent people end up over-insured because the cost-sharing mechanisms are not set high enough to deter them from spending and all of the care over the threshold amount is fully covered. Robertson has proposed a straightforward, elegant solution to this problem: scaled cost-sharing. Under such a system, cost-sharing obligations would vary depending on an individual's ability to pay. Robertson, *Cost-Sharing*, *supra* note 145.

¹⁵² *Id.* at 250-51.

¹⁵³ *Id.* at 252.

being under-insured can be just as harmful as being uninsured.¹⁵⁴ Not surprisingly, cost-sharing mechanisms, therefore, have a disproportionately negative effect on the chronically ill¹⁵⁵ and the disabled.¹⁵⁶

* * *

Viewed through the lens of employer-provided benefits, the real problem of *Burwell v. Hobby Lobby* is not that employers' religious freedom may conflict with employees' reproductive rights, but rather that private employers play a dominant role in many Americans' access to health care. After having outlined the ways in which employers shape health-care access, Part III proposes that less reliance on employers to provide health insurance could help end their reign as de facto health-care policy makers.

III. GOING FORWARD

Hobby Lobby can be understood as being about much more than just access to contraception. Employers act as both gatekeepers and regulators of the health-care system. So if a woman's job should not have anything to do with her decisions about her reproductive health, then arguably her job should not have any bearing on which doctors she sees or which treatment she chooses. Likewise, it is unclear why private employers should offer health insurance to their employees that conflicts with their financial or ideological interests. Thus, the real solution to the *Hobby Lobby* problem might be a move away from the employer-provided benefits system. Part III begins with a brief defense of employers and then turns to the uncertain future of employer-provided benefits in the wake of health-care reform.

A. A BRIEF DEFENSE OF EMPLOYERS

If viewed as an employer-provided benefits case, the issue in *Hobby Lobby* becomes a classic agency problem. When administering

¹⁵⁴ *Id.* at 251-52 (asserting that “being severely underinsured is the same as being uninsured, as the empirical evidence about the consumption behavior of these two groups demonstrates”).

¹⁵⁵ Pendo, *supra* note 145, at 457-58.

¹⁵⁶ Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 1972 (2013).

health plans, employers act as their employees' agents. But employer and employee interests may not align, either economically or ideologically. As predominantly private entities, employers tend to be more interested in their business operations than the promotion of public health.¹⁵⁷ Because it is frequently in employers' best interests to keep costs low,¹⁵⁸ employers have strong financial incentives to construct their benefits to avoid legal penalties, such as those in the ACA's pay-or-play provisions, while reaping potential benefits, tax or otherwise, whenever possible. Moreover, employers may have certain ideologies. While this claim is most clear in the case of sole proprietorships—where the person and the business are one in the same—*Hobby Lobby* illustrated that corporate persons are made up of actual persons, whose beliefs may also affect how they want to run their business. These efficiency- and ideology-driven interests can impact the kinds of health-insurance benefits that employers offer their workers.

¹⁵⁷ Long before the ACA, Dayna Matthew explained: “[L]egislators, and to a lesser degree the courts interpreting these statutes, have essentially appointed employers their agents to serve a broad social ideal: to provide health insurance coverage and, therefore, health care access to all working Americans, on a non-discriminatory, virtually non-contributory basis.” Matthew, *supra* note 99, at 1066. However, employers often act with self-interest. See Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance under the ACA*, 31 YALE L. & POL’Y REV. 275, 283 (2013) (explaining that “the employer-sponsored insurance regime involves voluntary promises undertaken by actors motivated by self interest”). While Matthew published her Essay in 1996, almost twenty years later her observations still ring true:

Current regulatory controls miss the mark by not reckoning with the fact that employers are increasingly unable to satisfy both the weighty social goal that has been imposed upon them—ensuring that all working Americans are guaranteed minimal access to health care—and their obligation to serve their own business interests. Thus, it is not only employees that incur significant agency costs under the employment-based health insurance system, but to the extent that we collectively depend upon employers to serve health policy objectives through this system, these costs are borne by the rest of society as well.

Matthew, *supra* note 99, at 1040-41.

¹⁵⁸ Matthew, *supra* note 99, at 1038 (“Assuming employers are . . . rational utility maximizers, their objective is to minimize the cost of obtaining the level and quality of health insurance that the labor market, relevant to the employer’s enterprise, demands.”).

Employers are not villains here: An employer's primary function is not providing health insurance. Their cost-reducing strategies may be economically rational and their ideological beliefs may be sincerely held. Thus, employers find themselves in a sticky situation. On one hand, the health plans they provide are a key instrument of health-care reform's effort to expand access. Yet on the other, they have businesses to run and are composed of people with personal lives and beliefs. These competing loyalties have not gone unnoticed. Early in the history of employer-provided benefits, the Supreme Court acknowledged that, when administering an insurance plan, employers rightly serve the interests of both themselves and their employees.¹⁵⁹ The question then becomes how to properly balance these competing concerns.

One way to think of this possible conflict of interest is in agency terms.¹⁶⁰ To invoke the agency model, one party must be entrusted with serving the interests of another. Commentators have traced an employer's duty to act on behalf of its employees when administering health insurance to its obligations under ERISA¹⁶¹ and the ACA¹⁶² and to the common

¹⁵⁹ See *Boseman v. Conn. Gen. Life. Ins.*, 301 U.S. 196, 204 (1937) ("When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums and generally in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer but for their employees and for themselves.").

¹⁶⁰ See, e.g., Bronsteen et al., *supra* note 49; Hall, *supra* note 99; Matthew, *supra* note 98, at 1038 (asserting that "the agency model best explains the nature of, and problems presented by, the employment-based health insurance system"). However, the agency model is not the only way to understand the relationship between employers and employees with respect to health insurance. See Matthew, *supra* note 98, at 1039 ("One might conclude the employment-based insurance system is not an agency problem at all, but rather a contract relationship in which one party undertakes to resolve a classic collective action problem incident to the terms of the contract.").

¹⁶¹ Bronsteen et al. explain that an ERISA plan is effectively a quasi-trust, thereby giving rise to all of the associated obligations. Bronsteen et al., *supra* note 49, at 2304 ("Indeed, an ERISA benefit plan is, in design and practice, a form of statutory quasi trust administered by the employer (or its designees) as a fiduciary for the employee. Whatever the extent of ERISA's overlap with trust law, it is undeniable that an ERISA benefit plan creates (in economic terms) an agency relationship: the principal (i.e., the plan participant) relies on the agent (i.e., the plan fiduciary) to protect and advance the principal's interest.").

¹⁶² Hall identifies both pre- and post-ACA health entitlements. Hall, *supra* note 100, at 1745-54.

law.¹⁶³ If employers act as fiduciaries, they would then owe their employees the duties of loyalty and care.¹⁶⁴ Yet, with any agency relationship comes the potential for agency problems: Will the agent truly prioritize the interests of the principal?¹⁶⁵ Given the importance of health insurance in ensuring health-care access¹⁶⁶ and the fact that employer-provided benefits are often determined pre-employment, effectively making them contracts of adhesion,¹⁶⁷ employees are particularly vulnerable principals. Employees must rely on their employers to select the very benefits that will determine whether and how they obtain health care. Specifically, the relationship generates agency costs because at times the interests of employer-agent and the employee-principal will diverge.¹⁶⁸

It is worth pausing to note that agency costs are not inevitable. They only occur when the agent's and the principal's priorities do not align. Sometimes, however, employer and employee health-insurance interests converge. For example, a large employer acting on behalf of its employees has more bargaining clout and can therefore negotiate better rates and terms—as well as advocate more zealously in the event of a

¹⁶³ Matthew, however, asserts that the agency relationship “arises between employer and employee when, upon accepting a job in which health insurance benefits represent a portion of the compensation package, an employee engages his employer to perform the service of purchasing and administering a health insurance plan on his behalf.” Matthew, *supra* note 99, at 1038. As a result, according to Matthew, “courts impose a general responsibility, akin to a fiduciary duty, upon employers administering health insurance plans for their employees.” *Id.* at 1054; *see also* Dawes Mining Co. v. Callahan, 272 S.E.2d 267, 269 (Ga. 1980) (holding that “in procuring the group policy and obtaining employee applications, the employer acts as an agent of the employees where the employees will be contributing toward payment of the premium”).

¹⁶⁴ Bronsteen et al., *supra* note 49, at 2304; Hall, *supra* note 99, at 1763-65 (discussing the duties of loyalty and care). However, it is worth noting that while scholars and courts may view employers as fiduciaries with respect to their health-insurance plans, the employers themselves may not share that perspective. *See* Matthew, *supra* note 98, at 1041 (“Employers do not perceive themselves or behave as their employees’ agents in the insurance market.”).

¹⁶⁵ Bronsteen et al., *supra* note 49, at 2304.

¹⁶⁶ *See* Part I.B., *supra*.

¹⁶⁷ Bronsteen et al., *supra* note 49, at 2320.

¹⁶⁸ *See id.* at 2299 (defining “agency cost” as “the cost arising from a system that gives an agent the incentive to act contrary to the interests of its principal”). Likewise Matthew explains, “Costs are generated by this agency relationship, like all others, because employers’ objectives will diverge from the objectives of their employee-principals.” Matthew, *supra* note 99, at 1038.

dispute—than most employees acting on their own.¹⁶⁹ Also the employer-provided benefits system saves individuals a fair amount of time and hassle. Employees do not have to seek out health insurance or pay brokers; instead, upon employment, they receive a plan—or choice of plan from a heavily restricted menu of options—that has already been negotiated, purchased, and administered on their behalf.¹⁷⁰ Allowing an employer to act as an employee’s health-insurance agent thereby delivers some measure of administrative ease and convenience. From this perspective, a limited number of plans could actually be a benefit of the employer-provided health-insurance system because it simplifies the decision-making process.¹⁷¹ Admittedly, many of the historically cited benefits of the employer-provided system, such as collective negotiation and a limited number of possible choices for insureds, are likewise present when purchasing policies on the exchanges. Regardless, even when serving their own interests, under some circumstances, employers may act as excellent agents for their employees.¹⁷²

Despite the lower cost and administrative advantages of employer-provided health insurance, evidence indicates that employers do not select the insurance that employees would choose for themselves.¹⁷³ Put differently, employers and employees have different views regarding what health insurance is “optimal.”¹⁷⁴ Further complicating matters is that the employer acts as the agent of multiple principals, each who may have

¹⁶⁹ Matthew, *supra* note 99, at 1043; Moore, *Employment-Based*, *supra* note 50, at 897.

¹⁷⁰ Matthew, *supra* note 99, at 1043; *see also* Moore, *Employment-Based*, *supra* note 50, at 896-97 (explaining how the employer-provided benefits system saves employees transaction costs).

¹⁷¹ *See* Moore, *Employment-Based*, *supra* note 50, at 897 (asserting that “[e]mployers assist employees by offering employees a limited choice among plans”).

¹⁷² *See* Matthew, *supra* note 99, at 1040 (“Employers act in their entrepreneurial self-interest, purchasing health insurance under terms which may also benefit and serve the employees’ needs and interests as well.”). Research confirms this outcome. *See* Moore, *Employment-Based*, *supra* note 50, at 897 (citing Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 *MILBANK Q.* 5 (2000)).

¹⁷³ Matthew, *supra* note 99, at 1056 (stating that “employers’ and employees’ demand curves for health insurance are distinctive”); *id.* at 1061 (asserting that “employers, acting as agents for their employees, will make different health insurance choices than employee representatives will make for themselves”).

¹⁷⁴ *Id.* at 1057.

different needs. For instance, it may be in the best interests of one set of employees to have comprehensive coverage with large networks that lack financial incentives to lower spending but another set of employees might prefer lower health-care costs so that they take home more in wages every month. Exacerbating this issue is the zero-sum nature of providing benefits—employers and insurers either grant benefits and pay or deny benefits and save—and the level of discretion left to providers in making those choices.¹⁷⁵

Of course, the agent-principal paradigm reduces the very complex interests at stake in the employer-provided benefits systems to a single vector: employee and employers. Several other parties could have a dog in this fight. Employers' desire to maximize profits could flow from a competing fiduciary relationship, company to shareholders. And the United States government itself has an interest in employer-provided health insurance, as it is a key part of the ACA's move toward universal coverage. Unfortunately, Congress's decision to vest private employers with the responsibility of insuring a significant portion of Americans perpetuates the intractable tension between the employers' interests, whether in efficiency and cost minimization or in practicing religion, and the government's desire to improve health-care access by expanding health-insurance coverage.

There is no need to tether health insurance to employment. Yet, none of the commentators in *Hobby Lobby*—or even the Supreme Court Justices themselves—questioned the link between work and health insurance. This silence reveals the tacit assumption that Americans are entitled to health insurance through their employers. However, this entitlement does not stem from a necessary relationship between health insurance and employment (if anything the agency issues described above undermine the wisdom of such a system) but rather the historical tendency of employers to offer health insurance in the first place. Maher explains that if a substantial number of people receive a particular good in conjunction with employment, they will conflate the practical connection between work and the good with a logical connection between work and the good.¹⁷⁶ In other words, the reality that so many employers *provide* health insurance translates to the belief that employer-provided health insurance is sensible. However, as this Essay has attempted to demonstrate, employers are not necessarily logical health-insurance

¹⁷⁵ Bronsteen at al., *supra* note 49, at 2311 (explaining that in the zero-sum game of benefits distribution “fiduciaries lose by granting benefits”).

¹⁷⁶ Maher, *supra* note 38.

providers. To that end, Maher poses the important question: “Why did the ACA promote, to some degree, the continued existence of [employer-provided] health insurance?”¹⁷⁷ While he notes some possible political and tax-based reasons, he concludes that “the legislation’s pro-[employer-provided benefits] bias was a questionable (although not indefensible) policy choice.”¹⁷⁸ To be sure, Congress could have avoided the kinds of agency problems described above if it had done away with the employer-provided benefits system.¹⁷⁹

B. UNCERTAIN FUTURE OF EMPLOYER-PROVIDED BENEFITS

At least one way to avoid future *Hobby Lobbys* would be to stop the American reliance on the employer-provided benefits. While such a drastic change will not likely come from Congress anytime soon, there is some reason to believe the employer-provided benefits system—at least as conceived by the ACA—is relatively uncertain, including the controversies surrounding the employer mandate and the potential effect other parts of the legislation might have on employers.

Through the employer mandate, as described in Part I, the ACA not only kept the employer-provided benefits system intact, it actually codified the American reliance on employers to provide health insurance. However, the mandate has not gone unchallenged. Originally, the employer mandate was set to take effect in 2014. Consequently, President Obama made headlines when he delayed its implementation until 2015 to allow employers more time to comply with the new law.¹⁸⁰ In a similar move, in February 2014, the White House announced that the employers on the

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ For additional arguments in favor of decoupling health insurance and employment, see Hadley Heath, *Disconnect Insurance from Employment*, REAL CLEAR POLICY BLOG, Feb. 7, 2014, http://www.realclearpolicy.com/articles/2014/02/07/disconnect_insurance_from_employment_828.html and Seth J. Chandler, *The Cons of the ACA*, ACA DEATH SPIRAL BLOG, May 29, 2015 (discussing the employer mandate), available at <http://acadeathspiral.org/2015/05/29/the-cons-of-the-aca/>.

¹⁸⁰ See, e.g., Juliet Eilperin & Amy Goldstein, *White House Delays Health Insurance Mandate for Medium-Sized Employers Until 2016*, WASH. POST, Feb. 10, 2014, available at 2014 WLNR 3711223; Robert Pear, *Further Delays for Employers in Health Law*, N.Y. TIMES, Feb. 11, 2014, available at <http://www.nytimes.com/2014/02/11/us/politics/health-insurance-enforcement-delayed-again-for-some-employers.html?r=0>.

lower end of the spectrum—employers with fifty to ninety-nine employees—would have until 2016 to institute the required changes.¹⁸¹ Similarly, employers of one hundred or more employees can escape the statutory penalties in 2015 by offering affordable policies to seventy—not ninety-five—percent of their full-time workers.¹⁸²

Opponents of the ACA have launched several strategies to attempt to undermine the employer mandate. In November 2014, House Speaker John Boehner, on behalf of the Republican members of the House, sued the secretaries of the Treasury and HHS and their respective departments, alleging that the Obama administration abused its executive power by twice delaying the implementation of the employer mandate.¹⁸³ Most recently, Burwell filed a motion to dismiss, the House responded, and she replied. The litigation is ongoing. Additionally, in early 2015, the House passed a bill that would redefine the full-time workweek from thirty to forty hours.¹⁸⁴ While champions of the legislation assert it is designed to protect workers from potential gaming by employers to avoid the mandate (as described in Part II), opponents view it as a way to undermine the employer mandate's application to some of the nation's more vulnerable workers, people who work under forty hours per week.¹⁸⁵ Economists estimate that if such a bill were to pass, one million Americans would lose their health-insurance coverage.¹⁸⁶ Those individuals would either end up with government-provided benefits or with no health insurance at all.¹⁸⁷ Such a development could balloon federal spending by over fifty billion dollars in the next ten years.¹⁸⁸ However, the bill's success seems highly unlikely. It

¹⁸¹ See 79 Fed. Reg. 8544 (Feb. 12, 2014)(to be codified at 26 C.F.R. pt. 1, 54, 301) (explaining the changes to the ACA's employer mandate provisions); see also Eilperin & Goldstein, *supra* note 180; Pear, *supra* note 180.

¹⁸² *Id.*

¹⁸³ The lawsuit also asserted that funds tied to the ACA's cost-sharing program were not authorized by Congress. Complaint, U.S. House of Rep. v. Burwell, No. 14-cv-01967 (79 F.Supp. 3d 1 (D.C. 2015)), http://pdfserver.amlaw.com/nlj/boehner_burwell_20141121.pdf.

¹⁸⁴ Jonathon Weisman, *House Fires Shot at Health Care Law, Seeking to Alter Critical Coverage Rule*, N.Y. TIMES (Jan. 9, 2015), available at <http://www.nytimes.com/2015/01/09/us/politics/house-fires-shot-at-health-care-law-seeking-to-alter-critical-coverage-rule.html>.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

has not garnered sufficient support in the Senate and President Obama has indicated he would veto it if the legislation made it to his desk.¹⁸⁹

Although ACA adversaries have taken direct shots at the law's reliance on employers to provide health insurance, certain provisions of the statute could also—perhaps inadvertently—move us away from the employer-provided system. Particularly the Cadillac tax, a forty percent excise tax on benefits over a particular threshold, could encourage employers to opt in favor of the no-offer penalty if the cost of providing benefits continues to rise.¹⁹⁰

* * *

When situated in the greater context of employer-provided benefits, instead of being the clash between reproductive freedom and religious rights, the central conflict of *Hobby Lobby* becomes employer interests versus employee interests. Whether ideological or economic, the employers who offer health insurance have different priorities than the employees who use those benefits. But that is not to say employers should be more selfless. After all, the primary function of an employer is not to provide health insurance. Thus, viewed from this perspective, *Hobby Lobby* looks more like a failure of the employer-provided benefits system than a victory for the religious right. Perhaps then the most sensible way to avoid future conflicts of this kind would be to eliminate our reliance on employers to provide health insurance. Yet given all of the difficulties surrounding the ACA, Congress is not likely to revisit this issue for quite a while. But in the meantime, we could see the prevalence of employer-provided benefits winding down, in part because of steadfast Republican challenges and in part because of the ACA's own provisions.

CONCLUSION

This Essay's central assertion is that *Burwell v. Hobby Lobby* is best understood as an employer-provided benefits case. The vast majority of Americans depend on health insurance to access health care. Employers are the primary providers of health insurance for the non-elderly. Tying health insurance to employment renders employers de facto health-care policy makers who unwittingly serve both gatekeeping and regulating functions.

¹⁸⁹ *Id.*

¹⁹⁰ Roberts, *supra* note 4.

While the ACA could have untethered health insurance from employment, instead it entrenched their relationship. Now certain employers must provide their workers with comprehensive, affordable health insurance or face a tax penalty. Yet while employers may offer health insurance to their employees, they are still private entities with interests—both financial and ideological—beyond providing comprehensive, cost-effective coverage. As long as we depend on employers to provide health insurance for millions of Americans, we will continue to see conflicts regarding the kinds of policies employees need and the kinds of policies employers are willing to provide.^w