Opening the Floodgates: The Dangers of Over-Applying the Religious Freedom Restoration Act to Employer-Sponsored Healthcare Mandates

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Introduction

While alternative options exist, most Americans obtain their health insurance through employer-sponsored group health plans.[1] In 2023, 164.7 million Americans—60.4% of Americans under the age of 65—were on employer-sponsored health insurance.[2] While the Affordable Care Act (ACA) and other care mandates limit the amount of control an employer has over the treatments covered by their health plan, employers can choose plans with various levels of coverage for non-mandated care like infertility treatments.[3] As such, an employer's choice of health insurance plan can affect what treatments their employees and their families can afford to access. Despite this control, the tax subsidies offered to employers who provide a health insurance plan allow employees to receive the same coverage for cheaper than if they had purchased the same plan on their own.[4]

The extent of the control an employer has over their employee's healthcare under employer-sponsored plans has expanded due to recent decisions from the Supreme Court and lower courts.[5] These decisions have utilized the Religious Freedom Restoration Act (RFRA) to elevate an employer's religious beliefs over their employees' ability to access

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[1] *See* Gary Claxton et al., *Employer-Sponsored Health Insurance 101*, KFF Health (May 28, 2024), https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction.

[2] *Id.*

[3] *See id.*; *see generally* Tenesha Goldwire Tutt, *Healthcare Policy: Federally Mandated Insurance Coverage for Infertility Treatment*, 19 Col. Social Work Rev. 1, 8 (2021), https://journals.library.columbia.edu/index.php/cswr/article/view/7587.

[4] Claxton et al., *supra* note 1.

[5] *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 736 (2014); *see also* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654–55 (N. D. Tex 2022).

potentially life-saving treatments.[6] In cases dealing with coverage of contraceptives and other "controversial" healthcare measures, the Supreme Court has brought healthcare to the forefront of the clash between religious beliefs and other personal liberties.[7]

This conflict between religious beliefs and personal lifestyle choices has been a consistent source of debate and litigation in the United States. High-profile Supreme Court cases deciding the legality of same-sex marriage, access to abortion and contraceptives, and the rights of transgender individuals show the consistent debate and controversy surrounding the balance between religious beliefs and personal choices.[8] Frequent objections by religious groups and individuals as to lifestyle choices they perceive as wrong or immoral make it highly likely this debate will remain at the forefront of the minds of the communities affected and the country as a whole. While these objections have manifested throughout many different areas of the law, objections to specific healthcare options and treatments have been a focal point. A significant debate in this area has been access to contraceptive care.[9] Many religious individuals and organizations view contraceptives as immoral, with particular attention paid to medications that prevent the implantation of an already-fertilized egg.[10]

Debates have also arisen over access to healthcare deemed immoral due to connections, either real or perceived, to LGBTQ+ individuals.[11] Religious beliefs against the supposed "LGBTQ+ lifestyle" have resulted in objections to transgender healthcare and

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[6] *See Hobby Lobby*, 573 U.S. at 736; *Braidwood Mgmt.*, 627 F. Supp. 3d at 652.

[7] *See, e.g.*, *Hobby Lobby*, 573 U.S. at 734–35.

[8] While cases about such topics do not always explicitly reference religious beliefs as the basis of objections, the context of the time in which they were decided and the make-up of those for and against the issue under consideration reveals the underlying religious conflict. *See, e.g.*, Obergefell v. Hodges, 576 U.S. 644, 679–80 (2015) (legalizing marriage between adults of the same sex).

[9] The most high-profile debate over healthcare access and religious beliefs has inarguably been about abortion. That has been considered, however, in the context of the existence of a constitutional right to privacy. While the debate has always been intertwined with religious beliefs and personal liberties, it has very little connection to healthcare mandated by the Affordable Care Act. *See, e.g.*, *Hobby Lobby*, 573 U.S. at 720.

[10] Pam Belluck & Erik Eckholm, *Religious Groups Equate Some Contraceptives With Abortion*, N.Y. TIMES (Feb. 16, 2012), https://www.nytimes.com/2012/02/17/health/religious-groups-equate-some-contraceptives-with-abortion.html.

[11] *See* Alexis M. Florczak, *Make America Discriminate Again? Why Hobby Lobby's Expansion Of RFRA Is Bad Medicine For Transgender Health Care*, 28 HEALTH MATRIX 431, 432–33 (2018).

HIV prevention and treatment.[12] On top of objections to the existence of such treatments, many religious groups and individuals believe they are personally committing a wrongful act if they are complicit in the funding or perceived assistance of any "immoral" acts.[13] The American healthcare system's reliance on employer-sponsored health insurance creates problems when employer beliefs clash with the health needs of their employees and their families.

The federal government imposes penalties on large employers that do not provide health insurance for their employees[14] while smaller employers are granted generous tax breaks as an incentive to provide health insurance to their employees.[15] These policies are preferential towards employer-sponsored health insurance. The dominance and relative affordability of these plans have made employees dependent upon employer-sponsored plans by leaving them unable to obtain comparable coverage easily or readily on their own. As a result of this system's monopoly on affordable healthcare coverage, employers should not be able to inject their personal religious or political views to narrow the healthcare treatments their plans provide to their employees. Employees and their families should not be punished for requiring care that goes against their employer's beliefs.

This Comment argues that over-applying the RFRA to allow employers to obtain exceptions from ACA coverage mandates is dangerous and could impact a variety of emerging and future treatments. The Background section of this Comment first discusses the RFRA and how it's been applied to employer-sponsored healthcare, specifically the differences between the case-specific precedent set in *Burwell v. Hobby Lobby Stores*[16] and the broader approach discussed by the district court in *Braidwood Management v. Becerra*.[17] It also outlines the American

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[12] *See id.*; Jason Potter Burda, *When Condoms Fail: Making Room Under the ACA Blanket for PrEP HIV Prevention*, 52 SAN DIEGO L. REV. 171, 174–75 (2015).

[13] Douglas Nejame & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L. J. 2516, 2523 (2015).

[14] Employers with more than 50 employees must provide health insurance to their employees. *Employer Responsibility Under the Affordable Care Act*, KFF HEALTH (Feb. 29, 2024), https://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/.

[15] Employers with less than 50 employees can qualify for tax breaks worth up to 50% of the amount they pay towards their employee's premiums. *See generally id.*; *see also The Small Business Health Care Tax Credit*, HEALTHCARE.GOV, https://www.healthcare.gov/small-businesses/provide-shop-coverage/small-business-tax-credits/.

[16] *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 731 (2014).

[17] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654 (N. D. Tex. 2022).

healthcare system's extreme reliance on employer-sponsored healthcare coverage and the other areas where religious objections have clashed with healthcare availability. Next, Part I of the Analysis section outlines the issues with the latest decision and highlights how it has moved away from the original intention and application of the RFRA. Part II highlights dangers that may result from moving away from requiring existing and robust systems of alternative coverage for an objection to succeed by focusing on the new and emerging treatments most likely to be affected by such decisions. Finally, Part III offers a short-term solution to this problem by encouraging the courts to provide an alternative solution for employees without healthcare access while also arguing for a greater shift back toward the RFRA's original intention. While this Comment explains the background and significance of this issue, it does not cover every aspect of this problem.

BACKGROUND

I. THE AMERICAN HEALTHCARE SYSTEM'S RELIANCE ON EMPLOYER-SPONSORED HEALTH INSURANCE

To understand the dangers raised by the recent expansion of religious objections to employer-sponsored healthcare, one must first understand the realities of the American healthcare system. Healthcare coverage in the United States is provided through a combination of government-provided Medicare and Medicaid programs and private healthcare obtained either through an employer or purchased on the federal government-administered health insurance Marketplace.[18] The government provides Medicare and Medicaid to seniors, low-income individuals and families, and those with disabilities; all others must obtain health insurance coverage through private insurance providers.[19] While insurance can be purchased on the healthcare marketplace or

[18] The Marketplace is the online portal run by HHS that allows individuals and families to purchase private insurance outside of the employer-sponsored system. Katherine Keisler-Starkey et al., *Health Insurance Coverage in the United States: 2022*, U.S. CENSUS (Sept. 12, 2023), https://www.census.gov/library/publications/2023/demo/p60-281.html.

[19] *See What's the Difference between Medicare and Medicaid?*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (Dec. 8, 2022), https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html.

through a broker, most private health insurance plans in the United States are connected to employment.[20]

A. Basics of the American Health Insurance System

Prior to the passage of the ACA in 2010, the available employer-sponsored plans had extensive coverage exclusions for preexisting conditions, imposed yearly and lifetime caps on the amount paid out by a specific insurance provider, and were subjected to little regulation on what types of care must be covered.[21] These issues led Congress to pass the ACA.[22]

The ACA had two general purposes: (1) incentivize more Americans to purchase health insurance coverage; and (2) make the available insurance plans more affordable and comprehensive.[23] The second purpose was achieved by forbidding insurance companies from denying coverage for preexisting conditions, eliminating yearly and lifetime caps, and creating a system for mandating the coverage of certain treatment options.[24] To offset the burden such mandates place on the insurance system, the ACA also incentivized the purchase of insurance coverage for healthy individuals.[25] When the law came into effect, this was achieved by enforcing a tax penalty against those who did not have health insurance and creating greater access to coverage through an insurance Marketplace.[26]

Even with the Healthcare.gov Marketplace providing an alternate method of obtaining coverage, employer-sponsored health insurance maintains a tight grip on the American health insurance system.[27] In

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[20] *See* Claxton et al., *supra* note 1.

[21] Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L. J. 261, 276 (2020).

[22] *See id.* at 274–75.

[23] J. B. Silvers, *The Affordable Care Act: Objectives and Likely Results in an Imperfect World*, 11 ANN. FAM. MED. 402, 402 (2013) (referring to the objective of Medicaid Expansion).

[24] *Id.* at 403.

[25] *See id.*

[26] While the individual mandate is technically still in place, the intended incentive effect has been neutralized because the tax penalty for failing to comply is now $0. Francine J. Lipman & James Owens, *Irresponsibly Taxing Irresponsibility: The Individual Tax Penalty Under The Affordable Care Act*, 23 GEO. J. POVERTY LAW & POL'Y 423, 433 (2016); Carmin Chappell, *Trump Administration Makes it Easier to Avoid Obamacare Tax Penalty*, CNBC (Sept. 12, 2018, 3:46 PM), https://www.cnbc.com/2018/09/12/cms-launches-new-process-to-claim-individual-mandate-penalty-exemption.html.

[27] *See* Claxton et al., *supra* note 1.

2023, 164.7 million Americans received their health insurance through a plan provided by their employer or a family member's employer.[28] Around 60% of employers offer some form of health insurance to their employees.[29] The reason for this dominance is the benefits associated with the group health insurance plans offered by most employers. By pooling costs, employers can offer better coverage than an individual employee could obtain on the Marketplace for the same price.[30] As a result, many employees have little choice in whether to opt into the plan offered by their employer because receiving adequate insurance coverage through alternative means is not an affordable option.[31]

This reliance allows employers to have some control over what coverage is offered to employees and their dependents.[32] While this control is normally limited to selecting plans that fit within the confines of the ACA, recent cases have revealed the threat that employers' religious objections to treatment options can pose to their employees' access to coverage.[33]

A. The Affordable Care Act's Coverage Mandates

The ACA mandates coverage for certain treatment types and care categories. The most controversial ACA mandate is the contraceptive care mandate, which requires that all private insurers cover at least one treatment from each category of FDA-approved contraceptives.[34] There are also ten categories of mandated coverage known as Essential Health Benefits (EHBs).[35] Within these categories, federal and state

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[28] *Id.*

[29] *Id.*

[30] Costs are often even higher when purchasing individual plans outside of the Marketplace. Lauren R. Roth, *Overvaluing Employer-Sponsored Health Insurance*, 63 U. KAN. L. REV. 633, 634 (2015).

[31] *Id.*

[32] *See generally id.*

[33] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654 (N. D. Tex. 2022).

[34] Laurie Sobel et al., *State and Federal Contraceptive Coverage Requirements: Implications for Women and Employers*, KFF HEALTH (Mar. 29, 2018), https://www.kff.org/womens-health-policy/issue-brief/state-and-federal-contraceptive-coverage-requirements-implications-for-women-and-employers/.

[35] *Information on Essential Health Benefits (EHB) Benchmark Plans*, CTRS. FOR MEDICAID & MEDICARE SERVS. (2020), https://www.cms.gov/marketplace/resources/data/essential-health-benefits (identifying the 10 essential health benefits as (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs;

government-designated entities regularly determine what treatment or care options are mandated.[36] While there is an EHB covering preventive care, the ACA also includes a separate preventive care mandate.[37] If coverage of a treatment is mandated, it must be covered by both employer-sponsored and Marketplace plans.[38]

1. The Contraceptive Care Mandate

While not included in the EHBs, the contraceptive care mandate similarly requires that all private insurers cover at least one form of birth control within each of the methods that the FDA has identified in its current birth control guide.[39] This coverage must be provided with no cost-sharing placed on the consumer.[40] Studies have shown that the ACA's contraceptive care mandate has succeeded in its goal of expanding and protecting contraceptive access, with overall contraceptive usage increasing and the average out-of-pocket cost of contraceptives to the consumer decreasing.[41]

Despite this success, the contraceptive care mandate has faced significant public and legal pushback from religious groups that are opposed to the use of contraceptives.[42] A variety of religious groups are strongly opposed to the use of contraceptives, with that opposition extending to paying for the use of birth control in any way.[43] In response

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(7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care).

[36] *See id.*

[37] Sobel et al., *supra* note 34.

[38] *See generally* CMS, *supra* note 35.

[39] The categories of birth control approved by the FDA are updated regularly. There are currently twenty methods identified within the birth control guide. Jennifer Hickey, *Insuring Contraceptive Equity*, 17 NW. J. L. & SOC. POL'Y 61, 67–68 (2022); *Birth Control Guide*, U.S. FOOD & DRUG ADMIN. (May 2024), https://www.fda.gov/media/150299/download.

[40] *Id.*

[41] *Id.* at 69 ("Data on prescription drug use in 2013, after the birth control benefit went into effect, indicate a five percent uptick in filled birth control pill prescriptions. Express Scripts, one of the nation's largest pharmacy benefit management companies, attributed this increase to the birth control benefit fulfilling a previously unmet need.").

[42] Laurie Sobel & Alina Salganicoff, *Round 3: Legal Challenges to Contraceptive Coverage at SCOTUS*, KFF HEALTH (May 4, 2020), https://www.kff.org/womens-health-policy/issue-brief/round-3-legal-challenges-to-contraceptive-coverage-at-scotus/.

[43] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 697–98 (2014); *see* Pam Belluck & Erik Eckholm, *Religious Groups Equate Some Contraceptives With Abortion*, N.Y. TIMES (Feb. 16, 2012),

to these objections, the ACA explicitly exempts churches and houses of worship from the contraceptive care mandate, while the Department of Health and Human Services (HHS) maintains a regulatory exemption for non-profit religious organizations.[44] This workaround system allows affected employees to access contraceptives with no cost-sharing while also bypassing any form of participation by the non-profit religious employer.[45] This system of exemptions was later applied to for-profit religious organizations as well.[46]

2. The Preventive Services Mandate and the Essential Health Benefits

While the contraceptive care mandate has frequently been discussed, mandated preventive care has recently come under fire as well.[47] The ACA and subsequent HHS regulations designate the independent United States Preventive Services Task Force (USPSTF) as the division in charge of identifying what preventative care treatments are necessary under the preventive care mandate and the preventive health services EHB.[48] The USPSTF meets regularly to consider emerging treatments and existing treatments that have gained greater importance.[49] Under the ACA, any preventative treatment of particular importance receives an "A" or "B" grade from the PSTF and must be covered by employer-sponsored insurance plans.[50] Recommended treatments include HIV Preexposure Prophylaxis (PrEP) medications, screening for various sexually transmitted infections, and screening for mental health conditions such as depression and anxiety.[51]

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https://www.nytimes.com/2012/02/17/health/religious-groups-equate-some-contraceptives-with-abortion.html.

[44] *Fact Sheet: Women's Preventive Services Coverage and Non-Profit Religious Organizations*, CTRS. FOR MEDICAID & MEDICARE SERVS. (May 28, 2013), https://www.hhs.gov/guidance/document/fact-sheet-womens-preventive-services-coverage-and-non-profit-religeous-organizations.

[45] *Id.*

[46] *Hobby Lobby*, 573 U.S. at 736.

[47] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 631 (N. D. Tex. 2022).

[48] *See* 29 C.F.R. § 2590.715-2713(a)(1)(i) (2024).

[49] *See About the USPSTF*, U.S. PSTF, https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf.

[50] 29 C.F.R. § 2590.715-2713(a)(1)(i) (2024).

[51] *A & B Recommendations*, U.S. PREVENTATIVE SERVS. TASK FORCE (Sept. 2023) https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations?SORT=D.

The coverage mandates within the ACA apply to all private insurance plans except those designated as "grandfathered plans."[52] What constitutes a grandfathered plan differs depending on whether a plan is provided by an employer or purchased individually.[53] For employer-sponsored health insurance plans, a grandfathered plan is any plan that existed prior to March 23, 2010, and has not undergone significant changes in coverage or cost to the consumer since that date.[54] The addition of new employees or dependents does not impact the grandfathered status of employer-sponsored group health plans, so employers may maintain relatively the same group health plan for years.[55] A plan must also explicitly state that it is grandfathered to be considered grandfathered as such under the ACA.[56] While grandfathered plans are subject to some ACA regulations, they are not required to provide coverage for preventive care services or the EHBs.[57] As of 2019, 13% of workers on employer-sponsored health insurance plans were on a grandfathered plan.[58] While the number of grandfathered plans is limited, they continue to exist without providing coverage for the treatments that plans purchased after the ACA are required to cover.[59] Grandfathered plans, though dwindling in number, have emerged as a successful tool in court for religious objections to controversial treatment.[60]

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[52] *Grandfathered Health Insurance Plans*, HEALTHCARE.GOV, https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

[53] *Id.*

[54] *Id.* (stating that for individual plans, any plan purchased before March 23, 2010, is considered grandfathered, regardless of if the terms existed prior to that date– the same rules regarding significant changes to coverage and cost apply).

[55] 45 C.F.R. Sec. 147.140(b)(1).

[56] 45 C.F.R. Sec. 147.140(a)(2)(i) ("While identification is required to be a grandfathered plan, a plan is not automatically grandfathered simply for identifying as such. All other requirements must still be met to be treated as a grandfathered plan under the Affordable Care Act.").

[57] 45 C.F.R. Sec. 147.140(a)(2)(ii).

[58] *2019 Employer Health Benefits Survey*, KFF HEALTH (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/.

[59] *See id.*

[60] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654 (N. D. Tex. 2022).

II. THE EVOLUTION OF THE RFRA AND ITS APPLICATION TO EMPLOYER-SPONSORED HEALTHCARE

The Supreme Court's jurisprudence of cases where a neutral law burdens the free exercise of religion has evolved significantly. Strict scrutiny, the highest level of scrutiny adopted by the Supreme Court, applies in cases where a fundamental constitutional right is alleged to have been infringed upon or when a government action applies to a suspect classification such as race or national origin.[61] Strict scrutiny originally emerged during the early Warren Court years in response to the need to protect certain "preferred" or "fundamental" rights whose importance exceeded the protection offered by the rational basis test, but that did not rise to the level of categorical protection.[62] With that came a higher standard for laws that burdened religious exercise, including those neutral to religion on their face: the strict scrutiny test.[63]

Strict scrutiny, as is clear from its name, places strict limitations on the government's ability to infringe upon constitutionally guaranteed rights.[64] The Supreme Court determined that laws burdening the free exercise of religion, as a right enshrined in the First Amendment, were subject to strict scrutiny review.[65] First, strict scrutiny review requires the plaintiff alleging infringement to show they hold a sincere religious belief burdened by the law.[66] Once such a showing has been made, the government must prove that: (1) it has a compelling government interest in the specific burdening provision; (2) the law is narrowly tailored to serve that interest; and (3) the law is the least restrictive means of achieving that interest.[67] Courts have applied this test broadly with the existence of higher-cost or more difficult to achieve alternatives being enough to make a law unconstitutional.[68]

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[61] Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VAND. L. REV. 793, 800 (2006).

[62] Richard H. Fallon Jr., *Strict Judicial Scrutiny*, 54 UCLA L. REV. 1267, 1270 (2007); *see also* Sherbert v. Verner, 374 U.S. 398, 403 (1963). While this case did not explicitly reference a "strict scrutiny" standard, it was the first Supreme Court opinion to apply the "compelling state interest" standard to a law burdening the free exercise of religion. *See id.*

[63] Fallon, *supra* note 62, at 1269.

[64] Winkler, *supra* note 61.

[65] *Sherbert*, 374 U.S. at 403.

[66] Nathan S. Chapman, *Adjudicating Religious Sincerity*, 92 WASH. L. REV. 1185, 1190 (2017).

[67] *Strict Scrutiny Review (First Amendment)*, WESTLAW, https://next.westlaw.com/Glossary/PracticalLaw/.

[68] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 728 (2014).

In 1990, the Supreme Court put forth a new, more forgiving standard applicable only to religious exercise cases that involved neutral laws of general application.[69] In *Employment Division v. Smith*, a group of employees at a drug rehabilitation center were fired for ingesting peyote, a hallucinogenic substance.[70] They were then denied unemployment benefits because the firing was deemed "work-related misconduct" and thus disqualifying.[71] The employees were members of the Native American Church and argued that they had taken the peyote for sacramental purposes; therefore, the members of the church argued that the law that prevented them from receiving unemployment compensation violated their rights under the Free Exercise Clause of the First Amendment.[72] The Supreme Court upheld the law despite strong strict scrutiny precedent, stating that the Free Exercise Clause only pertains to laws that ban the performance or abstention from physical acts such as assembling for a worship service or taking sacramental bread or wine solely because they are motivated by religion [73] The Court upheld the Oregon law because it did not discriminate between sacramental peyote users and those who use it for non-religious purposes.[74]

The Court saw no reason for the compelling government interest standard to apply here, fearing that its application would open the door for "constitutionally required religious exemptions from civic obligations of almost every conceivable kind."[75] This set a new precedent, holding laws that burden the free exercise of religion constitutional so long as they were neutral towards religion and generally applicable.[76] All other laws that burdened religious beliefs and exercise remained subject to the strict scrutiny standard.[77]

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[69] Emp't Div. v. Smith, 494 U.S. 872, 881–82 (1990).

[70] *Id.* at 874.

[71] *Id.*

[72] *Id.*

[73] *Id.* at 877–78.

[74] *Emp't Div.*, 494 U.S. at 890.

[75] *Id.* at 888.

[76] Fallon, *supra* note 62, at 1269, 1307.

[77] *Id.* at 1269.

A. *The RFRA*

The *Employment Division* decision outraged a wide variety of religious groups across the political spectrum.[78] Within three years of the Supreme Court's decision, Congress responded by passing the Religious Freedom Restoration Act of 1993 (RFRA).[79] The RFRA circumvented the Supreme Court's decision and statutorily reimposed the strict scrutiny standard for facially neutral laws that burden religious exercise.[80] This legislative action specifically reinstated the requirement that the government "justify burdens on religious exercise imposed by laws neutral toward religion."[81] The RFRA states that the test utilized prior to *Employment Division* is a "workable test for striking sensible balances between religious liberty and competing prior governmental interests."[82] Moreover, the government may not "substantially burden a person's exercise of religion," even if the burden results from a rule of general applicability, unless they demonstrate that the rule is "in furtherance of a compelling governmental interest" and is the "least restrictive means" of furthering that interest.[83]

Under this standard, a plaintiff must first show they hold a sincere religious belief that has been substantially burdened by a law or regulation before the consideration moves to whether the government has a compelling interest.[84] What constitutes a "sincere religious belief" is somewhat of a low bar under current precedent.[85] In making such a determination, the court must not delve into the validity or believability of an individual or group's beliefs; instead, it must only determine that the belief is sincere.[86] This standard has focused more on ideology than sincerity, with groups looking to obtain exemptions for actions

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[78] *E.g.*, *In an Era of Religious Refusals, the Do No Harm Act Is an Essential Safeguard*, ACLU (Feb. 28, 2019), https://www.aclu.org/news/religious-liberty/era-religious-refusals-do-no-harm-act-essential; *see also Religious Freedom for All: Passing the Religious Freedom Restoration Act of 1993*, NAT'L ASS'N OF EVANGELICALS (Sept. 22, 2015), https://www.nae.org/religious-freedom-for-all/.

[79] 42 U.S.C.S. § 2000bb(a)(4)–(b)(1).

[80] *See* 42 U.S.C.S. § 2000bb(b)(1).

[81] 42 U.S.C.S. § 2000bb(a)(4).

[82] 42 U.S.C.S. § 2000bb(a)(5).

[83] 42 U.S.C.S. § 2000bb-1(a)–(b).

[84] Chapman, *supra* note 66.

[85] Gregory M. Lipper, *The Contraceptive-Coverage Cases and Politicized Free-Exercise Lawsuits*, 2016 U. ILL. L. REV. 1331, 1332 (2016).

[86] *Id.* ("The government has largely taken the plaintiffs' sincerity for granted, failing to invoke (or even investigate) significant evidence that many of the asserted claims are insincere.").

that branch farther and farther away from what had previously been considered a sincerely held religious belief.[87] Courts almost universally take a claimed religious belief to be sincere.[88]

While the burden placed on a plaintiff under the RFRA has been minimal, the Supreme Court has done the exact opposite with what it requires from the government. Under the RFRA, the Court has reasoned that the "compelling government interest" standard is particularly demanding.[89] The phrase "shall not substantially burden a person's exercise of religion" requires the government to establish that allowing the particular individuals involved in a particular case to freely exercise their religion in violation of the law would prevent the furtherance of the government's interest.[90] As such, the government must show that its interest is frustrated to a sufficient level if the individual parties to this case are allowed to violate the law; the court does not take into account the likelihood or impact of others similarly violating the law.[91]

The requirement that a restriction on the free exercise of religion be the "least restrictive means" of furthering a compelling government interest further tightens what actions the government can take.[92] This can manifest in a variety of ways. For example, the Supreme Court has previously refused to accept arguments based on the financial cost to the government of implementing alternative, less restrictive means.[93] The Court has, at times, been reluctant to hold a greater cost to the government as proof that a regulation is the least restrictive means, often refusing to accept the excuse of higher cost unless the exact cost breakdown can be provided.[94] While not all issues of the least restrictive means come down to a matter of cost, the government can use such a defense when defending its legislation or regulation against

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[87] *Id.* ("The government has offered increasingly generous accommodations, despite any reason to believe that they would be accepted; plaintiffs and courts have, in turn, presented these accommodations as evidence that the previous requirement violated the plaintiffs' free-exercise rights.").

[88] *Id.*

[89] Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 653 (N. D. Tex. 2022) (quoting Gonzales v. O Centro Espírita Beneficente União do Vegetal, 546 U.S. 418, 430–31 (2006)).

[90] *Id.*

[91] *Id.*

[92] Noah Marks, *"Least Restrictive Means":* Burwell v. Hobby Lobby, 9 HARV. L. & POLICY REV. 19, 21 (2015).

[93] Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 738–39 (2014).

[94] *Id.*

accusations of undue burden.[95] This step of strict scrutiny review boils down to the requirement that if the government can achieve its interests in a way that does not burden religion, it must do so, even if it requires more money or work.[96]

The issue of what constitutes a "substantial burden" on religious exercise seems to be the least settled element of the RFRA determination.[97] Many scholars and judges disagree over what this term includes, with much of the discussion centering around the viability of the complicity argument.[98] According to some, claims for protection under the RFRA for complicity in the actions of others must fail because being complicit in another's action is not a *substantial* burden.[99] In such cases, a plaintiff argues that being forced to register or identify as a religious group to obtain an exemption may automatically trigger an alternative means of providing services or incentivizing conduct the group disagrees with.[100] Doing so makes them equally complicit in such actions and still burdens their religious exercise.[101] Allowing such an argument to successfully overturn a statute could allow the Court to grant recourse for a variety of burdens placed upon religious exercise, regardless of severity or substantiality.[102] By contrast, other scholars argue that assessing how substantial a burden needs to be would cross over into an impermissible assessment of the reasonability of a plaintiff's beliefs and would thus violate the Free Exercise Clause.[103] While this discussion has not been definitively settled, the Supreme Court has yet to accept that complicity alone constitutes a substantial burden.[104]

B. Hobby Lobby: *The Religious Freedom Restoration Act and the Contraceptive Care Mandate*

In *Hobby Lobby*, several for-profit corporations whose owners had sincerely held religious beliefs against the use of contraceptives

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[95] *Id.*

[96] *Id.*

[97] Michael A. Helfand, *Identifying Substantial Burdens*, 2016 U. ILL. L. REV. 1771, 1772 (2016).

[98] *Id.* at 1774.

[99] *Id.* at 1771.

[100] R. George Wright, *Substantial Burdens in the Law*, 46 S.W. L. REV. 1, 23 (2016).

[101] *Id.*

[102] *Id.* at 24–25.

[103] Helfand, *supra* note 97, at 1791.

[104] *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 726 (2014).

challenged mandated contraceptive coverage.[105] The owners of the corporations held "sincere Christian beliefs" directing that "life begins at conception."[106] In accord with those beliefs, the owners asserted that their religion was violated by being forced to "facilitate access to contraceptive drugs or devices" that operate after the point of conception.[107] By refusing to provide contraceptive coverage to their employees as a result of those beliefs, they faced fines of up to $1.3 million a day and $475 million per year.[108] Thus, the owners argued that the mandate and associated fines substantially burdened the free exercise of their religion, a violation of the RFRA.[109]

When considering the "substantial burden" step of the RFRA standard, the Supreme Court agreed with the owners.[110] Despite widespread disagreement over the term's meaning, the Court reasoned that if the multi-million-dollar fines did not amount to a substantial burden, "it is hard to see what would."[111]

The Court then continued to its RFRA analysis of the "least restrictive means of achieving a compelling government interest."[112] It found it "unnecessary to adjudicate the issue" of whether the government had a compelling interest, instead assuming that HHS had an "interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA."[113]

Next, the Court considered whether the mandate was the least restrictive means of fulfilling that interest.[114] The Court held that the mandate "plainly fail[ed]" the least restrictive means prong because "[t]here are other ways in which Congress or [HHS] could equally ensure that every woman has cost-free access to the particular contraceptives at issue here and, indeed, to all Food and Drug Administration (FDA)-approved contraceptives."[115] Within this consideration, the Court took issue with there being an exemption already facilitated for non-profit

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105 *Id.* at 682–85.

106 *Id.* at 702.

107 *Id.*

108 *Id.* at 691.

109 *Id.* at 682–85.

110 *Hobby Lobby*, 573 U.S. at 723–26.

111 *Id.* at 691.

112 *Id.* at 692.

113 *Id.* at 728.

114 *Id.* at 728–32.

115 *Id.* at 692.

religious organizations.[116] HHS had already "devised and implemented a system that seeks to respect the religious liberty of religious nonprofit corporations" while still ensuring their employees received "precisely the same access to all FDA-approved contraceptives" as employees of companies whose ownership did not possess religious objections to providing contraceptives.[117] The existing system facilitated for non-profit religious organizations allowed affected employees to obtain contraceptives directly from their insurance company, carving out contraceptive coverage from the remaining portion paid for separately by their employer.[118] Additionally, HHS failed to provide the Court with any reason why the same system could not be utilized with for-profit corporations.[119] The combination of a viable and existing alternative system and the lack of argument against its usage with for-profit corporations indicated to the Court that the mandate was not the least restrictive means of fulfilling the government's interest in ensuring access to contraceptive care.[120]

The Supreme Court presumably realized the potential implications of allowing employers to refuse to cover any healthcare that violated their religious beliefs. As such, the *Hobby Lobby* opinion was specifically limited to mandated contraceptive care and should not be expanded beyond that application.[121] The circumstances of *Hobby Lobby* were unique and specific in that a robust framework already existed as an alternative means of providing employees with contraceptive care.[122] These particular circumstances created by the existing exemption showed there was a less restrictive means of achieving the same result as was already in effect.[123] The Court asserted that all other care mandated by the ACA and HHS regulations remained unaffected.[124]

Despite the Supreme Court's assertions that the decision's impact was limited due to the case's unique circumstances, the decision dismayed groups in favor of contraceptive access and worried the LGBTQ+ community and other groups that regularly faced similar

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116 *Hobby Lobby*, 573 U.S. at 698–99.

117 *Id.* at 692.

118 *Id.*

119 *Id.*

120 *Id.* at 727–30.

121 *Id.* at 693.

122 *Hobby Lobby*, 573 U.S. at 693.

123 *Id.*

124 *Id.* at 733.

opposition from religious groups.[125] The chief concern among such groups was that the decision displayed that the Supreme Court had moved towards favoring claims of religious freedom over statutes put in place to protect healthcare access and prevent gender and sexual orientation discrimination.[126] Despite these concerns, scholars largely did not believe that the *Hobby Lobby* decision presented a significant threat of legitimized discrimination by the RFRA.[127] Instead, many believed that "entrenched precedent concerning the compelling interest of the state in eradicating discrimination" would succeed in the end.[128] The most common response from progressive groups and scholars to the *Hobby Lobby* decision was both worry and cautious confidence in the continued stability of the balance of religious freedoms with healthcare access and anti-discrimination protections.[129]

In contrast, proponents of religious liberty viewed the *Hobby Lobby* decision as a marked shift towards elevating and protecting religious beliefs.[130] The decision was described as the "new, powerful arrow in the[] quiver of the Religious Right" and was celebrated as a monumental success for pro-life arguments against contraceptive care before the Supreme Court.[131] It was viewed by religious groups as a step towards shoring up religious liberties because these groups were faced with a rising tide of state and federal laws mandating the coverage of controversial healthcare treatments and prohibiting discrimination based on gender or sexual orientation.[132] Such laws protect both healthcare treatments and "lifestyle choices" opposed by a variety of religious denominations.[133] It is likely that proponents of the *Hobby Lobby* decision hoped to expand the RFRA's application beyond the parameters set by the Supreme Court in that case.

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125 Kyle C. Velte, *All Fall Down: A Comprehensive Approach to Defeating the Religious Right's Challenges to Antidiscrimination Statutes*, 49 CONN. L. REV. 1, 6 (2016).

126 *Id.*

127 *Id.* at 7.

128 *Id.*

129 *See id.*; *see also* William P. Marshall, *Bad Statutes Make Bad Law:* Burwell v. Hobby Lobby, 2014 SUP. CT. REV. 71, 73–74 (2014).

130 *See* Velte, *supra* note 125, at 6.

131 *Id.*

132 Léa Brière-Godbout & Marie-Andrée Plante, *Religious Challenges to Anti-Discrimination Law: The Mobilization of the "Minority Label"*, 66 MCGILL L. J. 377, 380–81 (2020).

133 *Id.* at 379.

C. Braidwood: *Challenges to the HIV PrEP Mandate*

Hobby Lobby appeared to be a one-off case where the Supreme Court was willing to allow an employer's religious objections to dictate the insurance coverage their employees receive.[134] A 2023 decision from the Northern District of Texas, Fort Worth Division, however, reopened the issue.[135] In *Braidwood*, several business owners and individual plaintiffs challenged mandated coverage of preventative HIV preexposure prophylaxis treatments (HIV PrEP).[136] Similar to the contraceptive care mandate overseen by HHS, the ACA authorizes the USPSTF to determine which preventive treatments must be provided without cost-sharing measures by employer-sponsored plans.[137] In 2019, the USPSTF issued a recommendation that mandated the coverage of HIV PrEP medications.[138] This mandate, along with the contraceptive care mandate, became the case's central issue.[139]

The plaintiffs were a mixed group of individuals and business owners who objected to certain mandated preventive care treatments.[140] They opposed being forced to pay for coverage under their personal insurance plans for mandated preventive treatments they had religious objections to.[141] Like the plaintiffs in *Hobby Lobby*, the business owner plaintiffs here objected to paying for the mandated treatments as part of their employees' health insurance.[142]

Unlike the challenge to contraceptives, the sincerely held religious objections at issue in this case are less clear or well-known. HIV PrEP medication is a fairly recent medical development, with the first medication of this type approved by the FDA in 2012.[143] Taken by HIV-negative biological males at risk of exposure to HIV, PrEP

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

135 Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 633–34 (N. D. Tex. 2022).

136 *Id.*

137 *Enhancing Coverage of Preventive Services Under the Affordable Care Act Proposed Rules*, CTRS. FOR MEDICAID AND MEDICARE SERVS. NEWSROOM (Oct. 21, 2024), https://www.cms.gov/newsroom/fact-sheets/enhancing-coverage-preventive-services-under-affordable-care-act-proposed-rules.

138 *Braidwood Mgmt.*, 627 F. Supp. 3d at 632.

139 *Id.* at 632–33.

140 *Id.* at 633.

141 *Id.* at 633–34.

142 *Id.* at 634–35; *see* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 701 (2014).

143 *Morbidity and Mortality Weekly Report, Preexposure Prophylaxis for Prevention of HIV Acquisition Among Adolescents: Clinical Considerations, 2020*, CTR. FOR DISEASE CONTROL (Apr. 24, 2020), https://www.cdc.gov/mmwr/volumes/69/rr/rr6903a1.htm.

medications significantly decrease the risk of HIV transmission.[144] HIV PrEP medications, along with retroviral treatments for HIV-positive individuals, are an important tool in preventing the spread of HIV.[145] The plaintiffs objected to the medication's well-known usage by men who have relations with other men.[146] According to the business owners, they believed that funding HIV PrEP medications made them "complicit in facilitating homosexual behavior, drug use, and sexual activity outside of marriage between one man and one woman."[147] In articulating this argument, the plaintiffs stated that,

> (1) the Bible is 'the authoritative and inerrant word of God,' (2) the 'Bible condemns sexual activity outside marriage between one man and one woman, including homosexual conduct,' (3) providing coverage of PrEP drugs 'facilitates and encourages homosexual behavior, intravenous drug use, and sexual activity outside of marriage between one man and one woman,' and (4) purchasing coverage of PrEP drugs by purchasing such coverage for personal or business use makes them complicit in those behaviors.[148]

Additionally, the individual plaintiffs argued they "d[id] not want or need" the coverage and thus should not be required to pay for it.[149]

The connection between the plaintiffs' religious beliefs and HIV PrEP treatments is more tenuous than the opposition to contraceptive coverage litigated in previous cases.[150] With HIV PrEP medication, the plaintiffs' objections assume that individuals of certain lifestyles are the only ones taking the medication.[151] The religious objections are not tied to the actual drug and its effects but to potential scenarios, the plaintiffs believe are occurring.[152] Supreme Court precedent, however, held that it is not the correctness of a religious belief that is at issue,

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144 *HIV Prevention: Pre-Exposure Prophylaxis (PrEP)*, U.S. NAT'L INST. OF HEALTH (Dec. 11, 2023), https://hivinfo.nih.gov/understanding-hiv/fact-sheets/pre-exposure-prophylaxis-prep.

145 Burda, *supra* note 12, at 184.

146 *Braidwood Mgmt.*, 627 F. Supp. 3d at 633–34.

147 *Id.*

148 *Id.* at 652.

149 *Id.* at 634.

150 Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 701, 703 (2014).

151 *Braidwood Mgmt.*, 627 F. Supp. 3d at 633–34.

152 *Id.*

but the sincerity of the claimed belief.[153] It is not the judiciary's job to tell plaintiffs that their beliefs are logically or factually flawed, even if the connection between the morally objectionable conduct and their complicity in the conduct "is simply too attenuated."[154]

Regardless of the tenuous connection, the Northern District of Texas found that the plaintiffs objected to the preventive care mandates based on their sincerely held religious beliefs.[155] As a result, the ACA's care mandates forced the plaintiffs to choose between purchasing health insurance that violates their religious beliefs and foregoing conventional health insurance altogether.[156] According to the *Braidwood* Court, it is clear that putting individuals or businesses up to this choice imposes a substantial burden on religious exercise.[157] Unlike the *Hobby Lobby* Court, the judge in *Braidwood* clearly stated that complicity-based arguments fulfill the "substantial burden" test.[158] Accordingly, both the individual choices the businesses were forced to make and their beliefs against being complicit in the use of PrEP were enough to show their religious beliefs had been substantially burdened.[159]

The *Braidwood* court's focus then shifted to the validity of the government's compelling interest and whether the preventive care mandates were the least restrictive means of fulfilling that interest.[160] The plaintiffs there did not dispute that Congress and HHS hold a compelling government interest in inhibiting the spread of HIV.[161] The court clarified, however, that the proper framing of an RFRA challenge in this context is that the government must demonstrate "that the compelling interest test is satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened."[162] In other words, the proper analysis is an individual examination of the government's interest regarding each plaintiff, not a general consideration of the

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153 *Id.* at 653 (quoting *Hobby Lobby*, 573 U.S. at 725–26).

154 *Id.*

155 *Id.*

156 *Id.* at 652.

157 *Braidwood Mgmt.*, 627 F. Supp. 3d at 652–53.

158 *Id.* at 653; *but see Hobby Lobby*, 573 U.S. at 686.

159 *Braidwood Mgmt.*, 627 F. Supp. 3d at 652–53.

160 *Id.* at 653–54.

161 *Id.* at 653.

162 *Id.* (quoting Gonzales v. O Centro Espírita Beneficente União do Vegetal, 546 U.S. 418, 430–31 (2006)).

government's overarching interests. None of the individual plaintiffs in *Braidwood* were participating in behaviors that would qualify them for HIV PrEP usage.[163] None of their employees or their dependents who obtained their insurance coverage through the plaintiffs were currently or had ever been on HIV PrEP medications.[164] As such, the court determined that the government failed to prove that requiring the particular plaintiffs in this specific case to fund coverage of HIV PrEP would have an impact on the government's interest in preventing the spread of HIV.[165]

Additionally, the court found that enforcing the HIV PrEP mandate against the plaintiffs was not the least restrictive way to achieve the government's goal of preventing the spread of HIV.[166] Moreover, the ACA's exemptions for grandfathered plans allowed plans with no coverage for HIV PrEP medications to lawfully exist, even a decade after the ACA was enacted.[167] The court used the existence of such plans as evidence that it must not be necessary for *every* insurance plan to cover HIV PrEP.[168] If the government allowed plans with no HIV PrEP coverage to exist with no intervention, then allowing the plaintiffs to obtain such plans is unlikely to significantly impact the government's interest in preventing the spread of HIV.[169]

Additionally, because HHS did not show that it could not provide alternative access to HIV PrEP care to any affected employees or dependents, they failed to fulfill their RFRA burden to demonstrate that there are no alternative means of achieving their interest that would be less burdensome to the plaintiff's religious beliefs.[170] As a result, the government was unable to establish that they had implemented the least restrictive means of preventing the spread of HIV.[171] While

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163 *Id.* at 634.

164 *Id.* at 637.

165 *Braidwood Mgmt.*, 627 F. Supp. 3d at 654.

166 *Id.* at 653–54.

167 *Id.* at 654. The court also used the existence of small businesses without any mandated care as proof of less restrictive means; however, relying on small business exemptions would allow for essentially any coverage mandate to be thrown out, leaving a large portion of the Affordable Care Act worthless. The massive implications of such a loophole shows it is not actually a serious threat as it would be utilized in far more coverage disputes. As of now, it has only been mentioned in conjunction with other discrepancies in care. *Id.*

168 *Id.*

169 *Id.*

170 *Braidwood Mgmt.*, 627 F. Supp. 3d at 653–54.

171 *Id.* at 654–55.

there is no guarantee that providing such evidence would have swayed the court, the government's failure to provide the court with the cost or impracticality of alternative measures contributed to the court's decision in favor of the plaintiffs.[172]

While the initial opinion requested further briefing, the *Braidwood* court eventually held for the plaintiffs and allowed them to be exempted from the HIV PrEP mandate.[173] Unfortunately, the court provided no alternative method of coverage for any employees or dependents looking for HIV PrEP coverage in the future.[174] No preexisting workarounds to this coverage were available, let alone an alternative solution on par with that relied upon by the Supreme Court when deciding *Hobby Lobby*.[175] Until an employee or dependent seeks to obtain a treatment that falls within the exemption, the full implications of this decision will remain unknown.[176]

Additionally, there are a variety of new and developing treatments that could face religious objections in the future.[177] Allowing employer objections to limit access to health insurance coverage could have real, long-term health consequences for employees and their dependents. As such, courts should avoid granting employer objections if there is no existing alternative for obtaining the affected care. The following section explores a few examples of vulnerable treatments, the intersection this issue has with broader "culture war" politics, and how courts should handle similar cases in the future.

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172 *Id.*

173 *Id.* at 655; Braidwood Mgmt. v. Becerra, 666 F. Supp 3d. 613, 627 (N. D. Tex. 2023).

174 *Braidwood Mgmt.*, 666 F. Supp at 627.

175 *Id.*; Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 692 (2014).

176 *See generally Braidwood Mgmt.*, 666 F. Supp 3d. The plaintiffs also challenged the legality of the USPTSF as an independent board implementing mandates with the force of law. The Fifth Circuit issued an opinion on only that part of the case, leaving the District Court for the Northern District of Texas's decision regarding religious objections intact. *Id.*

177 *Cf. Braidwood Mgmt.*, 627 F. Supp. 3d at 634.

ANALYSIS

I. THE DANGERS OF CONTINUING TO EXPAND RELIGIOUS EXEMPTIONS TO HEALTHCARE COVERAGE MANDATES

The *Braidwood* decision opened a door that had already been unlocked by the *Hobby Lobby* decision.[178] *Braidwood* weakened the precedent that was carefully crafted by the Supreme Court in *Hobby Lobby*, potentially allowing courts to exploit the existence of grandfathered plans and differences between state mandates to allow coverage exemptions for new and emerging treatment options.[179] The *Braidwood* decision was based on an exemption that was significantly less established than the one utilized in *Hobby Lobby*.[180] Instead of utilizing a robust, well-established alternative means of obtaining HIV PrEP as the evidence of less restrictive means, the *Braidwood* court instead relied on the mere existence of grandfathered plans as a dubious mechanism for granting exemptions to religious business owners.[181] The court also failed to provide a valid alternative for employees impacted by the decision, instead making vague references to HHS covering the cost.[182] Deciding to overturn the mandate despite such conditions significantly broadened the standard set in *Hobby Lobby* and potentially opened the door for similar objections to be allowed.[183]

These missteps create several potential avenues to be exploited by religious employers. By relying on grandfathered plans as evidence that a care mandate is not the government's least restrictive means of achieving their public health goals, future courts may be able to exempt any coverage developed or approved since 2010.[184] Differences in state-to-state policies regarding what constitutes EHBs could further expand this loophole.[185] If differences that are inherent to the employer-sponsored healthcare system can be exploited to deny coverage, there may be nothing preventing each new treatment option from being at

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178 *See Braidwood Mgmt.*, 666 F. Supp 3d. at 627; *see also Hobby Lobby*, 573 U.S. at 734.

179 *Id.*

180 *Braidwood Mgmt.*, 627 F. Supp. 3d at 654; *see also Hobby Lobby*, 573 U.S. at 734–35.

181 *Braidwood Mgmt.*, 627 F. Supp. 3d at 654.

182 *See id.*

183 *See Hobby Lobby*, 573 U.S. at 734–35.

184 *See infra* Section I(A).

185 *See id.*

risk of religious objection. While this is already a significant issue, the *Braidwood* court's shift away from requiring a preexisting, robust framework for alternative access to treatment may leave employees with no other option than to personally fund their care, an outcome that could violate the ACA's prohibition against consumer cost-sharing.[186] The following sections explore some treatment options that may be objected to in the future and discuss the impact successful employer objections could have on the health of those on employer-sponsored health plans.

A. *Allowing Objections Due to the Existence of Grandfathered Plans Disadvantages Employees Utilizing New or Experimental Treatments*

Healthcare has made significant strides in treatment and care options since the 2010 cutoff for grandfathered plans. Allowing employers to object to any treatments that were not covered by plans at that time potentially allows for successful objections to a variety of healthcare improvements that have become available over the last decade. Expanding the *Braidwood* court's flawed reasoning beyond the damage that has already been done opens the door to a myriad of objections that could impact access to life changing and lifesaving care across a wide spectrum of healthcare disciplines.

1. Mandated Sexually Transmitted Infections Screening.

Based on the reasoning cited by the winning plaintiffs in *Braidwood*, other forms of healthcare believed by some religious groups or individuals to be connected to "sex outside of marriage" or LGBTQ+ relationships could eventually be objected to.[187] The legitimacy of such beliefs or concerns is not in question; the beliefs must only be "sincerely held" and related to the employer's free exercise of religion.[188] Objections to STI screenings recommended by the USPSTF may be just as likely to succeed as those in *Braidwood*.[189]

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[186] *See infra* Section I(B).

[187] *See Braidwood Mgmt.*, 627 F. Supp. 3d at 633–34.

[188] *Id.* at 653.

[189] *Id.* at 654.

One duty that the USPSTF is charged with is determining what preventative infectious disease screening measures are of such importance to individual and overall health that they must be covered by both employer-sponsored and Marketplace plans.[190] Within that directive, the PSTF regularly issues mandates regarding preemptive screening for sexually transmitted diseases.[191] As such, the PSTF issued recommendations mandating the coverage of screenings for syphilis, chlamydia, and gonorrhea.[192] These recommendations, issued in 2021 and 2022, expanded upon recommendations issued prior to the March 23, 2010, cutoff for grandfathered plans.[193] That expansion offered new insights and adjusted the demographics included under each mandate.[194] As a result, grandfathered plans are not required to cover screenings for individuals newly included in the recommendation.[195]

Sexually transmitted infection screenings can allow for the treatment of life-altering or ending infections at an earlier stage than waiting for symptoms to appear.[196] Such coverage also guarantees that individuals already suffering from symptoms cannot be denied testing that can be a prerequisite for receiving adequate care.[197] Under the reasoning used by the court in *Braidwood,* however, an employer's religious objections to such screenings be able to bar employees from obtaining screenings when indicated.[198] Sexually transmitted infections like syphilis and gonorrhea, while not as life-threatening as HIV, can have life-long complications if not treated in a timely manner.[199]

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190 *Preventive Services Covered by Private Health Plans under the Affordable Care Act*, KFF HEALTH (May 15, 2023), https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.

191 *Id.*

192 *A & B Recommendations*, U.S. PREVENTATIVE SERVS. TASK FORCE (Sept. 2023), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

193 *Chlamydia and Gonorrhea: Screening*, U.S. PREVENTATIVE SERVS. TASK FORCE (Sept. 12, 2021), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening; *Syphilis Infection in Nonpregnant Adolescents and Adults: Screening*, U.S. PREVENTATIVE SERVS. TASK FORCE (Sept. 27, 2022), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-nonpregnant-adults-adolescents-screening.

194 *Id.*

195 KFF HEALTH, *supra* note 190.

196 Troy Grennan & Darrell H.S. Tan, *Benefits of Opportunistic Screening for Sexually Transmitted Infections in Primary Care*, CAN. MED. ASS'N J. (Apr. 19, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8084552/.

197 *See id.*

198 *See* Braidwood Mgmt. v. Becerra, 666 F. Supp 3d. 613, 654 (N. D. Tex. 2023).

199 *See* Grennan & Tan, *supra* note 196.

Employees should not be forced to endure serious health consequences because of their employer's personal beliefs.

This is just one example of the potential loophole created by using grandfathered plans as a general exception. Even widely accepted forms of healthcare like sexually transmitted infection screenings are at risk of falling victim to a religious employer's objections over what coverage employers are required to provide to their employees. Continuing upon the reasoning of the *Braidwood* decision, the existence of plans without coverage for sexually transmitted infection screenings shows that the government's interest must not be compelling because if the government truly had a compelling interest in the coverage of sexually transmitted infections, there would be no exceptions.[200] The reasoning utilized by the Texas court could be easily applied to a wide variety of treatments, screenings, and other forms of healthcare.[201]

A closely related aspect of the *Braidwood* decision was the court's consideration of the government's compelling interest concerning each individual plaintiff or business.[202] Deciding whether coverage should be mandated based on the current or past needs of a business's employees or their dependents leaves no recourse for changes within the needs of the existing pool of employees or for the needs of any employee hired in the future. While this issue is already impactful when considering the limited usage of HIV PrEP medications, it becomes a much larger concern when considering the common behaviors associated with greater exposure to sexually transmitted infections.[203] In 2020, over 123.1 million sexually transmitted infection tests were administered in the United States.[204]

Like the HIV PrEP treatments at issue in *Braidwood*, sexually transmitted infection screenings have connections to actions seen by some religious groups as immoral.[205] The USPSTF's recommendations for sexually transmitted infections screenings apply largely to drug users

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200 *See Braidwood Mgmt.*, 627 F. Supp. 3d at 654.

201 *See id.*

202 *Id.* at 653.

203 *See* Grennan & Tan, *supra* note 196.

204 Amina R. Zeidan et al., *Sexually transmitted infection laboratory testing and education trends in US outpatient physician offices, 2009–2016*, FAM. MED. CMTY HEALTH (June 18, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8215241/.

205 *Braidwood Mgmt.*, 627 F. Supp. 3d. at 653.

or those engaging in sexual activities with more than one partner.[206] As such, mandated coverage of sexually transmitted infection screenings aligns closely with the successful challenge to employer-sponsored HIV PrEP medications.[207] If a court were to face an objection to mandated coverage for sexually transmitted infection screenings, there's a real possibility such an objection would be successful under the reasoning used by the court in *Braidwood*.[208]

2. Substance Abuse Treatment.

Among the ten EHBs included in the ACA is mandated coverage for substance abuse treatments.[209] Like the discussion regarding sexually transmitted infection screenings, religious objections may succeed where coverage mandates have changed or evolved since the 2010 cutoff. As seen in the *Braidwood* case, some religious groups and individuals are against what they view as the promotion of drug use.[210] If funding the treatment of an illness commonly obtained through drug usage is enough to sustain an employer's objection, it is logical to connect such beliefs to the treatment of substance usage itself.

While the ACA requires the coverage of substance abuse treatment within the mandated EHBs, the actual practice of compiling and updating what care is required to be covered is managed by the individual states. For many of the EHBs, each state compiles its requirements for what types of care must be covered by plans based in that state.[211] Each time a state proposes a new set of requirements, it is then given to the federal government for final approval.[212] This process differs from the federally centralized PSTF that is designated

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[206] *Screening for Chlamydia and Gonorrhea*, U.S. PREVENTATIVE SERVS. TASK FORCE, at 950 (Sept. 14, 2021), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening; *Syphilis Infection in Nonpregnant Adolescents and Adults: Screening*, U.S. PREVENTATIVE SERVICES TASK FORCE, at 1244 (Sept. 27, 2022), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/syphilis-infection-nonpregnant-adults-adolescents-screening.

[207] *See Braidwood Mgmt.*, 627 F. Supp. 3d at 634.

[208] *See id.*

[209] 42 U.S.C. § 18022(b)(E).

[210] *Braidwood Mgmt.*, 627 F. Supp. 3d at 633–34.

[211] CMS, *supra* note 35.

[212] *See id.*

to determine what coverage is mandated under the preventive health services mandate.[213]

The coverage mandated in each individual state is not updated on the exact same schedule.[214] As such, discrepancies may exist when managing new and emerging treatment options. Even when dealing with tried and tested substance abuse treatments, what is considered essential coverage may differ between states. These differences increase the possibility that there are existing plans within the United States that do not cover certain treatment options. In the short term, coverage of new and emerging substance abuse treatment options could be greatly at risk if states on a differing update schedule have not yet mandated its coverage. In the long term, the risk may decrease as more states adopt mandates for such coverage. Regardless, the management of substance abuse treatments and other EHBs on a state-by-state basis introduces additional routes to successful religious objections by employers.

The potentially indefinite nature of the differences created by the state-based EHBs process may exacerbate the problems caused by the *Braidwood* decision.[215] For issues related to the preventive care mandate, the success of religious objections is tied to the existence of grandfathered plans.[216] The definite nature of grandfathered plans ensures that the loophole will be resolved at some point. While there is no way of knowing when the last grandfathered plans will be phased out, 2019 saw the share of employer-sponsored plans that were grandfathered drop from 16% to 13%.[217] Issues such as inflation and increased healthcare costs will likely contribute further to the die off of grandfathered plans over the coming years because a plan loses its grandfathered status if the cost to the customer increases significantly from what it was in 2010.[218] In contrast, differences in state-to-state mandated care under the EHBs may continue to exist for years into the future. Unlike the recommendations handed down by the USPSTF, there is no centralized requirement for each state to exactly match its required coverage; instead, each state proposes a benchmark plan

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213 *See* KFF HEALTH, *supra* note 190.

214 CMS, *supra* note 35.

215 *See generally Braidwood Mgmt.*, 627 F. Supp. 3d at 624.

216 *Id.* at 654; Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 699–700 (2014).

217 KFF HEALTH, *supra* note 58.

218 *Health Insurance Rights & Protections: Grandfathered Health Insurance Plans*, HEALTHCARE.GOV., https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/ (last visited Jul. 2, 2025).

that fulfills all the EHBs as defined and approved by HHS.[219] As such, indefinite loopholes could theoretically exist where states differ in what substance abuse treatments they mandate. The potential for differences between coverage in each of the fifty states makes this issue both interesting and daunting. The continuously evolving nature of medical research and state EHB benchmark plans makes it difficult to predict which treatment options will potentially be the target of religious objections.

3. Treatments Developed through the Usage of Embryonic Materials

An area of concern that could touch upon several of the EHBs is opposition to treatment advancements that use cells or organs from embryos during their research, development, and production. Several religious denominations are vehemently opposed to abortion.[220] For some groups, that opposition extends beyond the act of abortion itself into the use of cells obtained from aborted fetuses.[221]

One example of this is the Catholic Church's guidance concerning vaccines that utilize aborted cells in their development.[222] The guidance recommends that Catholics only receive vaccines produced using aborted fetal cell lines where no viable alternative vaccines produced through different methods are available.[223] Many vaccines were originally developed and continue to be produced by utilizing cells that are descendants of fetal cells obtained from two aborted fetuses in the early 1960s.[224]

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219 CMS, *supra* note 35.

220 David Masci, *Where Major Religious Groups Stand on Abortion*, PEW RESH. CTR. (June 21, 2016), https://www.pewresearch.org/short-reads/2016/06/21/where-major-religious-groups-stand-on-abortion/.

221 Kyle Christopher McKenna, *Use of Aborted Fetal Tissue in Vaccines and Medical Research Obscures the Value of All Human Life*, 85(1) THE LINACRE QUARTERLY 13, 13 (Feb. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6027112/pdf/10.1177_0024363918761715.pdf.

222 Luis F. Card. Ladaria, S.I. & S.E. Mons. Giacomo Morandi, *Note on the Morality of Using Some Anti-Covid-19 Vaccines*, THE VATICAN (Dec. 21, 2020), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html.

223 *Id.*

224 The cells utilized in the development of vaccines are millions of generations removed from those taken from the original terminated pregnancies. Vaccines for chicken pox, rubella, rabies, and COVID-19 have been created using such cells. Paul A. Moffit, *Vaccine Ingredients: Fetal Cells*, CHILD.'S HOSP. OF PHILA. (Oct. 21, 2021), https://www.chop.edu/centers-programs/vaccine-education-center/vaccine-ingredients/fetal-tissues.

Another widespread example of this issue is opposition to the use of embryonic stem cells in medical research and treatment.[225] Embryonic stem cells have been used in the development of countless treatments for a wide range of diseases.[226] Some experimental treatments aim to utilize embryonic stem cells directly in the treatment process.[227] For both research and treatment purposes, embryonic stem cells are retrieved by isolating stem cells from discarded IVF embryos.[228] Embryonic stem cells have made significant contributions to medical progress, from providing insight into the regenerative properties of the brain and the spine to serving as the first test subject for new drugs.[229]

Despite the groundbreaking impact embryonic stem cells have had in the medical field, some Christian religious groups have strongly opposed their usage.[230] While embryonic stem cells are not obtained from aborted fetuses, several Christian denominations believe life begins at the point of conception.[231] As such, groups including the Roman Catholic, Eastern Orthodox, and Fundamentalist Christian churches view the use of embryonic stem cells obtained from fertilized discarded IVF embryos as morally equivalent to utilizing aborted materials.[232] Despite these reservations, none of the aforementioned churches have at this time formally dissuaded their members from utilizing such treatments.[233]

Direct embryonic stem cell treatments for spinal cord injuries, strokes, Type 1 Diabetes, Parkinson's, and a wide array of other serious and chronic conditions are currently in development.[234] While Christian churches have yet to condemn advancements developed using embryonic stem cells, the direct usage of such cells in new treatments may result in stronger responses. As a result, such treatments could fall under several of the ACA's EHBs categories, particularly mandated

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225 MAHTAB JAFARI ET AL., *Religious Perspectives on Stem Cells, in* RELIGIOUS PERSPECTIVES, 79, 80 (2008), https://escholarship.org/content/qt9rj0k7s3/qt9rj0k7s3_noSplash_f9aca2e02c3777c7fb76ea768ba458f0.pdf.

226 *Stem Cells: What They Are and What They Do*, MAYO CLINIC (Mar. 19, 2022), https://www.mayoclinic.org/tests-procedures/bone-marrow-transplant/in-depth/stem-cells/art-20048117.

227 *Id.*

228 JAFARI ET AL., *supra* note 225, at 88.

229 MAYO CLINIC, *supra* note 226.

230 JAFARI ET AL., *supra* note 225, at 81.

231 *Id.*

232 *Id.*

233 *Id.* at 84.

234 MAYO CLINIC, *supra* note 226.

coverage for the treatment of chronic illnesses.[235] As new embryonic stem cell treatments emerge, new approvals may not line up perfectly with the updated schedules or fall within the benchmark plans of all states. As such, differing coverage state-to-state may emerge as a tool to exempt Christian business owners from covering embryonic stem cell research.

The ACA also includes a separate mandate requiring that employer-sponsored health insurance plans cover the cost of participation in clinical trials and the utilization of experimental treatment options.[236] Unlike the EHBs, the clinical trial coverage mandate does not vary state-to-state.[237] Like the preventive services mandate, however, this mandate does not apply to grandfathered plans.[238] Consequently, the dangers raised by the *Braidwood* decision's reliance on grandfathered plans could also emerge as barriers to coverage for experimental embryonic stem cell treatments.[239]

Embryonic stem cell treatments have the potential to change the lives of those suffering from a wide variety of chronic diseases, but they are also likely to be extremely expensive. While many clinical trials are fully funded, stem cell treatments beyond the experimental stage are likely to have a high price tag. The only FDA-approved adult stem cell treatment that is currently available, the bone marrow transplant, can cost upwards of $250,000.[240] Allowing a religious employer to prevent its employees from receiving coverage for embryonic stem cell treatments could be equivalent to allowing it to financially bar them from accessing the treatment at all. Regardless of what mandate embryonic stem cells are challenged under, continuing down the path of allowing employers to deny mandated care to their employees could force some patients to choose between their physical health and financial stability.

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[235] An example of an embryonic stem cell treatment potentially covered by this category would be a treatment for Type 1 Diabetes. *See* CMS, *supra* note 35.

[236] Paul J Martin et al., *Responsibility for Costs Associated With Clinical Trials*, J. CLIN. ONCOL. (Sept. 15 2014) https://pmc.ncbi.nlm.nih.gov/articles/PMC4876354/.

[237] 42 U.S.C. § 300gg–8(a)(4) (West).

[238] Samilia Obeng-Gyasi et al., *Oncology Clinical Trials and Insurance Coverage: An Update in a Tenuous Insurance Landscape*, 125 AM. CANCER SOC'Y 3488, 3489 (2019).

[239] *See Braidwood Mgmt.*, 627 F. Supp. 3d at 654.

[240] Michael S. Broder et al., *The Cost of Hematopoietic Stem-Cell Transplantation in the United States*, 10 NAT'L LIBRARY OF MED. 366, 369 (Oct. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5726064/.

4. Animal-to-Human Heart Transplants.

While human-to-human heart transplants have successfully occurred for decades, there are always a large number of individuals waiting for a heart to become available.[241] Additionally, patients are regularly deemed ineligible to receive a human heart transplant due to preexisting comorbidities, low provider confidence in their ability to complete post-operation treatment regimens, and other factors.[242] These realities have prompted research into the viability of animal-human transplants.[243] Porcine and bovine transplants are the most viable transplant options with heart valve replacements from each animal already occurring.[244] Full heart animal-to-human transplants are still early in the development process, with two porcine transplants attempted and an artificial heart made of bovine tissues currently in development.[245] It is possible, however, that such surgeries could become regular and reliable treatment options in the future. The evolving nature of EHBs on a state-by-state basis creates possibilities for loopholes. This risk is further exacerbated by the existence of grandfathered plans. As such, some exempted plans may exist when animal-to-human heart transplants become more widely available.

Bovine heart transplants are interesting for this analysis because they present potential objections from non-Christian groups. In the Hindu religion, cows are seen as sacred symbols of wealth and strength.[246] As such, many practicing Hindus refrain from eating beef or utilizing cow-based products.[247] For Hindu business owners, their reverence

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241 As of October 2023, 3,456 patients were waiting for a heart transplant in the United States. *Patients on the Waiting List by Organ (Sept. 2024)*, ORGANDONOR.GOV (Oct. 2024), https://www.organdonor.gov/learn/organ-donation-statistics/detailed-description.

242 *Heart Transplant Patient Selection Criteria*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/transplant/referring-physicians/heart-transplant-criteria (last visited Jul. 2, 2025).

243 Wei Wang et al., *First Pig-to-Human Heart Transplantation*, NAT'L LIBRARY OF MED. (Mar. 29, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8961469/.

244 A porcine heart transplant is the transplantation of a pig heart in a human. A bovine heart transplant is the transplantation of a cow heart in a human. *Id.*; Anne Eisenberg, *The Artificial Heart Is Getting a Bovine Boost*, N.Y. TIMES (July 23, 2013), https://www.nytimes.com/2013/07/14/business/the-artificial-heart-is-getting-a-bovine-boost.html.

245 Wei Wang et al., *First Pig-to-Human Heart Transplantation*, NAT'L LIBRARY OF MED. (Mar. 29, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8961469/; Eisenberg, *supra* note 244.

246 *Sanctity of the Cow*, BRITANNICA, https://www.britannica.com/topic/sanctity-of-the-cow (last visited Jul. 2, 2025).

247 *See id.*

towards cows may clash with an employee or their dependent's need to receive a bovine heart transplant. Being forced to fund a bovine heart transplant may lead to a request for an exemption to mandated care by such employers. If a court were to apply the same reasoning that the Texas court did in *Braidwood*, the existence of grandfathered plans or differences state-to-state in EHB benchmark plans could potentially allow employers to block employees or their family members from receiving coverage for a life-saving transplant.[248]

Since bovine transplants may be a viable option in the future, objections to their coverage could become an issue. Like the discussion of embryonic stem cell treatments, the cost of an animal-to-human heart transplant will most likely be extremely high. A human-to-human heart transplant can cost over $1 million without insurance coverage.[249] While an animal-to-human heart transplant has no donor costs, the experimental nature of the surgery means the cost of such surgeries will likely rival that of human-to-human transplants. As such, an employer's denial of coverage with no alternative means of providing funding could force its employees or dependents to choose between significant financial costs and their lives.

B. *Overturning Essential Healthcare With No Alternative Coverage Option Could Seriously Impact the Health of Employees and their Dependents*

In *Hobby Lobby*, an important aspect of the Supreme Court's decision to exempt religious for-profit organizations from covering contraceptives was the existence of a readily available alternative method of coverage.[250] While controversial, that decision at least ensured there was some form of alternate coverage in place when the exemption was granted.[251] In *Braidwood*, however, the court failed to establish any alternative coverage for affected employees.[252] Unlike the employees affected by the contraceptive mandate exemption, no employees required HIV PrEP coverage at the time of the court's

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[248] *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 654 (N. D. Tex. 2022).

[249] Mary West, *What to Know About Heart Transplants*, MEDICALNEWSTODAY (Aug. 31, 2022), https://www.medicalnewstoday.com/articles/heart-transplant-cost.

[250] *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 692 (2014).

[251] *See id.*

[252] *See Braidwood Mgmt.*, 627 F. Supp. 3d at 654.

decision.[253] The court, however, provided no solutions for future employees of the businesses involved in the case.[254]

This failure was a dangerous expansion of an already controversial precedent.[255] The element that saved the *Hobby Lobby* decision from massively expanding the power of religious objections was the preexisting, established framework for non-profit religious organizations that could be easily applied to affected employees of for-profit religious corporations.[256] While still a significant limitation on the right to access contraceptives, the decision ensured the ACA's requirement that contraceptives be covered with no cost-sharing measures maintained its protections for the majority of employees. Allowing exemptions where such a robust backup option does not exist can have direct, profound consequences for employees and their families.

This is especially true within the context of the American healthcare system. Employer-sponsored plans dominate the market by providing coverage at lower prices than alternative options.[257] The government has encouraged the continued dominance of employer-sponsored plans by providing subsidies for mid-to-large employers and encouraging savings from purchasing group health plans.[258] For many employees, being unable to access care through their employer-sponsored plan leaves them with no viable alternative route to coverage. This issue is compounded by the high cost of the new and emerging treatments most likely to become subject to employer exemptions. The average American cannot reasonably afford to pay for HIV PrEP medications, substance abuse treatments, heart transplants, or other potentially objected to healthcare out of pocket if their employer receives an exemption. The government has enticed most of the population to employer-sponsored health insurance through subsidies and a lack of alternative options; continued destabilization of the established coverage mandates could leave many Americans without alternative means to access the care they need.

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253 *See id.* at 634.

254 *See generally id.* at 653–55.

255 *See generally* Ira C. Lupa, Hobby Lobby *and the Dubious Enterprise of Religious Exemptions*, 38 HARV. J. L. & GENDER 35, 77–78, 82, 85 (2015).

256 *Hobby Lobby*, 573 U.S. at 692.

257 Roth, *supra* note 30.

258 *See* Katherine Keisler-Starkey et al., *Health Insurance Coverage in the United States: 2022*, U.S. CENSUS (Sept. 12, 2023), https://www.census.gov/library/publications/2023/demo/p60-281.html.

Failing to provide an alternative means of coverage when overturning employer funding for certain treatments contradicts the ACA's foundational purpose.[259] The ACA was passed as a massive overhaul of health insurance regulation in the United States.[260] Prior to the ACA, the health insurance industry was minimally regulated with regard to what treatments and conditions they were required to cover.[261] The ACA greatly expanded access to health insurance by ensuring the average American could afford decent insurance coverage.

While the ACA has been weakened in some ways, the sections requiring the coverage of preventive services, contraceptives, and other EHBs remain in place.[262] However, allowing religious exemptions for employers with no alternative coverage option for their employees weakens their protective power. If the *Braidwood* holding is upheld by higher courts or replicated in other districts, the necessary coverage protections provided by the ACA will be diminished.

C. *The Broader Intersection with "Culture War" Politics*

This issue is most importantly a clash between healthcare access and religious freedoms. Within that clash, however, is the added nuance of a broader "culture war" that has come to dominate the social and political spheres in the United States.[263] The healthcare treatments that have faced objections are tied to disagreements over contraceptive care

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[259] Silvers, *supra* note 23, at 402 ("The Patient Protection and Affordable Care Act (ACA) has 3 main objectives: (1) to reform the private insurance market—especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level, and (3) to change the way that medical decisions are made.").

[260] Jared Ortiliza & Cynthia Cox, *The Affordable Care Act 101*, KFF HEALTH (May 28, 2024), https://www.kff.org/health-policy-101-the-affordable-care-act/?entry=table-of-contents-what-is-the-affordable-care-act (explaining that the ACA marked "a significant overhaul of the U.S. health care system.").

[261] *See generally* Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 115, 128 (2005).

[262] Assistant Secretary for Planning and Evaluation, *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (Mar. 23, 2023), https://aspe.hhs.gov/reports/current-health-coverage-under-affordable-care-act.

[263] *See generally* Kiara Alfonseca, *Culture wars: How identity became the center of politics in America*, ABC NEWS (Jul. 7, 2023), https://abcnews.go.com/US/culture-wars-identity-center-politics-america/story?id=100768380.

and LGBTQ+ rights.[264] Treatments that are vulnerable to objections are related to similarly controversial topics.[265]

There has been an increasingly public battle between conservative beliefs and progressive ideals.[266] While there are a myriad of issues contributing to growing polarization, disagreements over the right to abortion, contraceptive access, and the rights of the LGBTQ+ community have been particularly prominent.[267] These issues are reflected in the most high-profile objections to employer-sponsored care.[268] In *Hobby Lobby*, the for-profit religious corporations' anti-contraceptive stance was rooted in their conservative Christian beliefs.[269] In return, the backlash that followed the Supreme Court's decision was more closely tied to fear of the impact such a precedent would have on access to contraceptives, abortion rights, and LGBTQ+ rights.[270] The plaintiffs in *Braidwood* also used religious liberty protections as a tool to remove themselves from healthcare they deemed immoral due to its common usage within the LGBTQ+ community.[271] The success of both these arguments helps to illustrate the increasingly high pedestal afforded to religious freedoms in America.

The right to the free exercise of religion is extremely important; it was protected by the founding fathers within the First Amendment for a reason.[272] The focal point of this issue is not all religious protections, but instead those that elevate religion to a protected status that exceeds what was mandated by the Constitution. The RFRA is an example of this. The Supreme Court, the preeminent body for the interpretation of the Constitution, determined that a less-stringent level of scrutiny was admissible for considering burdens on religious expression from neutral laws of general application.[273] Congress, however, disagreed with the Court, instead deciding to elevate religious freedoms back

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264 *See* Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 633–34 (N. D. Tex. 2022).

265 *See infra* Section I.B.

266 *See* Alfonseca, *supra* note 263.

267 *See, e.g.*, Obergefell v. Hodges, 576 U.S. 644 (2015); Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022); Bostock v. Clayton Cnty., 590 U.S. 644 (2020).

268 *See Braidwood Mgmt.*, 627 F. Supp. 3d 624; *see also* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 688–91 (2014).

269 *See Hobby Lobby*, 573 U.S. at 701–02.

270 Velte, *supra* note 125, at 6.

271 *See Braidwood Mgmt.*, 627 F. Supp. 3d at 634.

272 *See* U.S. CONST. amend. I.

273 *See* Emp't Div. v. Smith, 494 U.S. 872, 908 (1990) (Blackmun, J., dissenting).

to their original standing.[274] In doing so, Congress elevated the protection of religious beliefs beyond what the Supreme Court had deemed necessary.[275] In the two decades since the passage of the RFRA, precedent has continued to elevate religious exercise over other important rights.[276]

The elevation of religious liberties in this way results in the relegation of rights for other protected classes. By statutorily granting strict scrutiny protections against neutral laws of general application to religious freedoms, Congress made it more difficult for protections granted to other protected classes to succeed when challenged by a religious group.[277] This issue has been further exacerbated by court decisions that have made it easier for a plaintiff to establish a burden on their religious beliefs and more difficult for the government to establish that an action was the least restrictive means.[278] The long-term implications of such decisions remain to be seen.

III. COURTS SHOULD PROVIDE ALTERNATIVE MEANS OF OBTAINING EXEMPTED CARE

The most immediate problem this expansion presents is the lack of coverage for affected employees and their families. The short-term solution to this problem requires a court that grants an exemption to provide an alternative means of obtaining the treatment options affected in each case. In doing so, the dangers associated with gaps in coverage are avoided while the free exercise of religion remains protected.

The ACA requires that employers provide mandated healthcare with no employee cost-sharing.[279] Along the lines of the existing framework in *Hobby Lobby*, all that is needed to ensure that exemptions granted to religious employers continue to comply with the ACA

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[274] 42 U.S.C. § 2000bb ("The purposes of this Act are . . . to restore the compelling interest . . . and to guarantee its application in all cases where free exercise of religion is substantially burdened.").

[275] *See generally Emp't Div.*, 494 U.S. at 908–09 (Blackmun, J., dissenting).

[276] *See, e.g.*, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 700–03, 707 (2014) (holding that religious liberties succeeded over contraceptive care access).

[277] *See generally id.*; *Emp't Div.*, 494 U.S. at 908–09 (Blackmun, J., dissenting).

[278] Braidwood Mgmt., Inc. v. Becerra, 627 F. Supp. 3d 624, 653 (N. D. Tex. 2022) (quoting *Hobby Lobby*, 573 U.S. at 725–26) ("Defendants may not 'tell the plaintiffs that their beliefs are flawed' because the connection between the morally objectionable conduct and complicity in the conduct 'is simply too attenuated.'").

[279] *See generally* CMS, *supra* note 35.

is an outlined means of obtaining alternative coverage.[280] For cases like *Braidwood*, where there has yet to be a demonstrated need for coverage of a particular treatment,[281] the best solution may be directing HHS to be prepared to fill the gaps in funding that could arise in the future. For cases where the treatment option at issue is already utilized by employees or their families, the best solution may be to direct the creation of a system allowing employees to obtain the exempted care directly from their insurance company. Such a solution may require the employer and their insurance provider to create a carve-out scheme for employees to receive their treatments at no additional cost.[282] If an employer views any involvement in the administration of the exempted care to be a burden on their religious beliefs, HHS may be required to step in and facilitate a system similar to the one that was deemed satisfactory in *Hobby Lobby*.[283] The court must tailor each solution to the case before it. If the courts are unwilling to completely overturn the ACA's mandated healthcare—which they have so far been reluctant to do[284]—then employees must be provided with alternative means of obtaining mandated coverage without cost-sharing.

This solution is most likely to face opposition from religious groups that hold very strong beliefs with regard to complicity in actions they deem immoral. For some groups, even initiating a request for an exemption is a complicit action.[285] By initiating such a request, they are still indirectly facilitating the obtainment of treatment options they view as wrongful.[286] Such groups are also unlikely to support any solution that requires them to facilitate an alternative coverage scheme in any way. These concerns are difficult to address without allowing such employers to unilaterally prevent their employees from receiving coverage for exempted treatments altogether. The Supreme Court has not yet allowed such strict complicity arguments to establish an actionable burden on religious exercise. As a result, arguments along these lines are unlikely to impact the success of this solution in a meaningful way.

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280 *See Hobby Lobby*, 573 U.S. at 692.

281 *See Braidwood Mgmt.*, 627 F. Supp. 3d at 634.

282 *See, e.g.*, *Hobby Lobby*, 573 U.S. at 692 (explaining that employees were still able to obtain contraceptives through a separate program with the employer's insurance provider).

283 *See generally id.*

284 *See, e.g.*, *id.* at 719; *Braidwood Mgmt.*, 627 F. Supp. 3d at 655.

285 Helfand, *supra* note 97, at 1773.

286 *See id.*

Outside of the most extreme groups, a court's ability to tailor the alternative method of providing coverage to each case helps to decrease the number of objections this solution is likely to face. A benefit of this solution is that it ensures continued coverage for employees while relieving the burden on religious exercise claimed by the employer. Both sides are given what they need to continue to be successful.

For the government, the impact of this solution depends on what burden they receive from the court. While there may be issues of cost or increased workload, each depends on the level of responsibility placed on HHS. A positive aspect of this solution is that it ensures continued compliance with the ACA by continuing to provide care with no cost-sharing for the consumer.

CONCLUSION

Both mandated healthcare coverage and religious freedom protections are intended to protect important and inherently personal rights. As such, a consideration where the preservation of one has been allowed to completely override the consideration of the other is ripe for negative outcomes. There is no guarantee that the decision made in *Braidwood* will be replicated on a greater scale, but there is also no guarantee it will not. As such, it is extremely important to outline this problem and its potential impact on both the legal structure of healthcare and the personal healthcare options of employees. If this problem is allowed to grow and expand, it could have a much more significant impact on the already dysfunctional American healthcare system.

A potential further analysis of this issue is a consideration of whether denying employers coverage for healthcare seen as inherently LGBTQ+ intersects with anti-discrimination in employment protections. Additionally, potential solutions dissecting the larger problem of the supremacy of religious exercise over all other rights likely provide enough material for another article. This Comment provides the problem and a short-term solution; further discussion beyond that remains available for consideration.

The hope is that the potential exemptions with no backup option discussed here never occur. If they do, the courts must consider how granting such exemptions impact healthcare access and potentially violate the ACA. Protections for religious beliefs are important, but so are protections for life-saving healthcare.