COLUMBIA LAW REVIEW

VOL. 124 MARCH 2024 NO. 2

ARTICLES

EMPLOYER-SPONSORED REPRODUCTION

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This Article interrogates the current and future role of employer-sponsored health insurance in reproductive autonomy, revealing the impact that employers' coverage choices have on access to reproductive care and the legal infrastructure that prioritizes employer choice over individual autonomy.

Over half of the population depends on employers for health insurance. Laws regulating employer plans give employers exceptionally wide latitude to decide what reproductive care services, if any, to cover. In their role as health care funders, employers pursue interests that often conflict with employees' interests and the aims of reproductive justice. Employers balk at covering services related to conceiving and bearing children, which they view as costly to them as both employers and insurers. While some employers' plans cover contraception and abortion, which may help them avoid the costs of pregnancy and additional dependents, many other employers object to covering these services. The legal infrastructure validates this wide spectrum of employers' choices, subordinating individuals' autonomy to their employers' interests.

Decoupling health care access from employment is thus necessary to bolster reproductive justice. But the most effective means of decoupling—a public option and single-payer public benefits—raise tough questions about reproductive exceptionalism. Shifting the third-party payment role

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** Professor, Boston University School of Public Health and School of Law. We thank the hosts of UCLA Law's Mainstreaming Reproductive Health in Health Law, Policy and Ethics Conference, UCLA Law's Health Law and Policy Program, the Northeastern University School of Law's Faculty Colloquium, and the American Society of Law, Medicine & Ethics' Annual Health Law Professors Conference for featuring this work, and we thank the participants for engaging with it. Insights from B. Jessie Hill, Nicole Huberfeld, Lisa Ikemoto, Brendan Maher, Maya Manian, Wendy Parmet, Jessica Roberts, Elizabeth Sepper, Lindsay Wiley, and the Boston University School of Law faculty have strengthened this project. Deft research assistance from Brianna Frontuto, Michelle Kordis Hatfield, and Davis Henderson have improved it in all respects. Mary Claire Bartlett and the editors at the *Columbia Law Review* were outstanding partners in bringing this work to its published form. This Article was supported by the Hodges Fund at the West Virginia University College of Law.

from employers to governments does not truly remove the threat to reproductive justice, so progressive health reform risks sacrificing reproductive justice to the cause of universal benefits. This Article illuminates how vigilantly centering reproductive justice in single-payer reform proposals can make those reforms more feasible and durable.

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INTRODUCTION

In the summer of 2022, as reproductive rights advocates mourned the demise of the constitutional right to abortion after *Dobbs v. Jackson Women's Health Organization*,[1] Walmart and other nationwide corporations announced they would cover some legally available abortion services and

1. 142 S. Ct. 2228 (2022).

related travel under their health plans.[2] Walmart's actions seem like a victory for reproductive freedom. Walmart is the largest private employer in twenty-one states[3] and employs 1.6 million people in the United States,[4] not including their employees' spouses and dependents. The corporation is also based in Arkansas[5]—a state that, after *Dobbs*, bans abortions with an exception to save the mother's life, but not for rape or incest.[6] Walmart's actions could well save some lives.

Walmart's decision surprised many, given the company's significant financial contributions to state legislators responsible for enacting trigger laws, which became enforceable bans after *Dobbs*,[7] and its historically stingy approach to employee insurance coverage. For example, until 2010, Walmart had resolutely opposed providing insurance to its hourly workers, instead relying on state Medicaid programs to cover its lower-waged employees.[8] After the Affordable Care Act (ACA) required that large

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2. Haleluya Hadero, Walmart Expands Abortion Coverage for Employees, PBS (Aug. 19, 2022), https://www.pbs.org/newshour/economy/walmart-expands-abortion-coverage-for-employees [https://perma.cc/5ABE-V8D7]. Walmart's expansion of its employee health plan covers abortion services for its employees when there is "a health risk to the mother, rape or incest, ectopic pregnancy, miscarriage or lack of fetal viability." Id. (quoting a company memo sent to employees). Walmart's plan also covers "travel support" for employees and dependents who must travel more than 100 miles to access those services. Id. For a discussion of legal issues raised by such abortion policies, see generally Brendan S. Maher, Pro-Choice Plans, 91 Geo. Wash. L. Rev. 446 (2023) [hereinafter Maher, Pro-Choice Plans].

3. Nick Routley, Walmart Nation: Mapping America's Biggest Employers, Visual Capitalist (Jan. 24, 2019), https://www.visualcapitalist.com/walmart-nation-largest-employers/ [https://perma.cc/MQ24-AXD7].

4. How Many People Work at Walmart?, Walmart, https://corporate.walmart.com/askwalmart/how-many-people-work-at-walmart [https://perma.cc/R8C4-FQAH] (last visited Jan. 18, 2024) (describing a total number of 1.6 million U.S. workers and a total global workforce of 2.1 million by the end of 2023).

5. Welcome to Walmart's New Home Office in Bentonville, Arkansas, Walmart, https://corporate.walmart.com/about/newhomeoffice [https://perma.cc/UZX5-LJD4] (last visited Feb. 8, 2024).

6. Human Life Protection Act, Ark. Code Ann. § 5-61-304 (2023).

7. See Janet Burns, Dear AT&T, Boeing, Pfizer, Comcast, Walmart, Etc: Stop Funding Abortion Attackers, Forbes (Aug. 21, 2019), https://www.forbes.com/sites/janetwburns/2019/08/21/dear-att-boeing-pfizer-google-comcast-stop-funding-abortion-attackers/ (on file with the *Columbia Law Review*) (explaining Walmart's contributions to the Republican State Leadership Committee and individual legislators who played a role in passing "extremely restrictive" abortion legislation).

8. See Katie Sanders, Alan Grayson Says More Walmart Employees on Medicaid, Food Stamps Than Other Companies, PolitiFact (Dec. 6, 2012), https://www.politifact.com/factchecks/2012/dec/06/alan-grayson/alan-grayson-says-more-walmart-employees-medicaid-/ [https://perma.cc/QC36-ZRA4] (describing data sources showing percentages of Walmart employees on various public-benefits programs); see also Gov't Accountability Off., GAO-21-45, Federal Social Safety Net Programs: Millions of Full-Time Workers Rely on Federal Health Care and Food Assistance Programs 9 (2020), https://www.gao.gov/assets/gao-21-45.pdf [https://perma.cc/E86M-F4PK] (providing data on the number of full-time workers on SNAP and Medicaid); Erin C. Fuse Brown &

employers offer health benefits to their employees or else pay a tax, Walmart dropped health benefits for many of its part-time workers because the mandate required coverage only for people working thirty hours or more per week.[9]

Walmart's limited expansion of abortion benefits in reaction to *Dobbs* is just one example in a long history of some private employers taking high-profile positions on reproductive health issues through their employees' health insurance benefits.[10] Hobby Lobby memorably fought against covering contraception under its employer health plan, culminating in *Burwell v. Hobby Lobby Stores, Inc.* in 2014.[11] A private, for-profit craft store chain with over 43,000 employees across forty-seven states,[12] Hobby Lobby is owned by David and Barbara Green, Christians who object to abortion.[13] Because the Greens believed that certain FDA-approved oral contraceptives and intrauterine devices (IUDs) effectively facilitated abortions, they refused to cover those offerings in their employee health plan.[14] The ACA required group plans to cover these contraceptives as "preventive care,"[15]

Elizabeth Y. McCuskey, Federalism, ERISA, and State Single-Payer Health Care, 168 U. Pa. L. Rev. 389, 424–25 (2020) (detailing states' legislative efforts to discourage Walmart from having employees on public-benefits programs); Michael Barbaro, Appeals Court Rules for Wal-Mart in Maryland Health Care Case, N.Y. Times (Jan. 18, 2007), https://www.nytimes.com/2007/01/18/business/18walmart.html (on file with the *Columbia Law Review*) (describing Walmart's praise of a Fourth Circuit decision invalidating a state law that forced it to spend more on employee health care); Clare O'Connor, Report: Walmart Workers Cost Taxpayers $6.2 Billion in Public Assistance, Forbes (Apr. 15, 2014), https://www.forbes.com/sites/clareoconnor/2014/04/15/report-walmart-workers-cost-taxpayers-6-2-billion-in-public-assistance/ (on file with the *Columbia Law Review*) (providing total costs of public benefits assistance to Walmart workers).

9. David A. Graham, Walmart and the End of Employer-Based Health Care, The Atlantic (Oct. 7, 2014), https://www.theatlantic.com/politics/archive/2014/10/walmart-and-the-end-of-employer-based-health-care/381199/ (on file with the *Columbia Law Review*) (describing Walmart's and other large employers' responses to the ACA's employer mandate).

10. See, e.g., Trina Jones, A Different Class of Care: The Benefits Crisis and Low-Wage Workers, 66 Am. U. L. Rev. 691, 692–93 (2017) [hereinafter Jones, A Different Class] (highlighting family leave policy press releases by Virgin and Netflix); see also Asees Bhasin, Business Responses to *Dobbs*: The Return to a "Reproductive Rights" Approach, and Suspicions Around Corporate Care, *in* Health Law as Private Law (Wendy Netter Epstein & Christopher Robertson eds., forthcoming 2024) (manuscript at 3–5) (on file with the *Columbia Law Review*) (examining the motivations behind firms' statements on *Dobbs* in the context of corporate social responsibility); Jennifer S. Fan, Corporations and Abortion Rights in a Post-*Dobbs* World, 57 U.C. Davis L. Rev. 819, 846–48 (2024) (detailing the strategic values and inconsistencies in corporate responses to *Dobbs*).

11. 573 U.S. 682 (2014).

12. Our Story, Hobby Lobby, https://www.hobbylobby.com/about-us/our-story [https://perma.cc/JX38-MML5] (last visited Oct. 24, 2023); see also *Hobby Lobby*, 573 U.S. at 702.

13. *Hobby Lobby*, 573 U.S. at 702–03 (discussing the Green family's Christian faith and its influence on their business practices).

14. Id. (explaining the Greens' religious objections to the contraception mandate).

15. 42 U.S.C. § 300gg-13(a)(4) (2018); see also Women's Preventive Services Guidelines, Health Res. & Servs. Admin., https://www.hrsa.gov/womens-guidelines

however, so the Greens challenged the enforcement of this provision.[16] Justice Samuel Alito's majority opinion recognized the right of a closely held corporation to exercise its owners' religious beliefs and thereby exempted Hobby Lobby from providing federally mandated contraception coverage.[17]

Reproductive rights advocates might laud Walmart and loathe Hobby Lobby in these circumstances. But this Article exposes the real villain in these stories: the legal and regulatory infrastructure of health insurance in the United States, which grants employers wide latitude over access to reproductive health care and the health and autonomy of their employees. When Walmart wants to expand abortion coverage for its employees, the law allows it. When Hobby Lobby wants to avoid a federal statute requiring contraception coverage for its employees, the law allows that, too. When either company wants to exclude coverage for assisted reproduction, the law effectuates that choice.[18] This permissiveness is a problem for reproductive autonomy as well as the broader concept of reproductive justice, which encompasses the right to not reproduce and "also the right to have children and to raise them with dignity in safe, healthy, and supportive environments."[19]

Due to the prohibitively high cost of health care in the United States, employer-sponsored insurance is practically the gatekeeper for over 100 million people's access to all kinds of health care, including reproductive

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[https://perma.cc/L5M8-R4PQ] (last visited Oct. 24, 2023) (detailing the ACA's preventive-services mandate regarding women's health).

16. *Hobby Lobby*, 573 U.S. at 703–04.

17. Id. at 717, 736; see also Mary Agnes Carey, Hobby Lobby Ruling Cuts Into Contraceptive Mandate, NPR (June 30, 2014), https://www.npr.org/sections/health-shots/2014/06/30/327065968/hobby-lobby-ruling-cuts-into-contraceptive-mandate [https://perma.cc/NHN5-3YHU]. A similar challenge by employers who object to covering pre-exposure prophylaxis (PrEP) medication to prevent HIV infection based on the company owners' beliefs that PrEP encourages sexual behavior they consider immoral—*Braidwood Management Inc. v. Becerra*—is currently pending before the Fifth Circuit. 666 F. Supp. 3d 613 (N.D. Tex. 2023), appeal docketed, No. 23-10326 (5th Cir. Apr. 3, 2023); see also Michelle M. Mello & Anne Joseph O'Connell, The Fresh Assault on Insurance Coverage Mandates, 388 New Eng. J. Med. 1, 1–3 (2023) (discussing *Braidwood*).

18. See Karen Gilchrist, Egg Freezing, IVF and Surrogacy: Fertility Benefits Have Evolved to Become the Ultimate Workplace Perk, CNBC (Mar. 14, 2022), https://www.cnbc.com/2022/03/14/egg-freezing-ivf-surrogacy-fertility-benefits-are-the-new-work-perk.html [https://perma.cc/EW3N-Y6ZC] (last updated Oct. 4, 2022) (discussing how some, but not all, employers offer "fertility benefits" to their employees).

19. Dorothy Roberts, Reproductive Justice, Not Just Rights, Dissent (2015), https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights [https://perma.cc/G362-CXDL] [hereinafter Roberts, Reproductive Justice]; accord Rachel Rebouché, The Public Health Turn in Reproductive Rights, 78 Wash. & Lee L. Rev. 1355, 1431 (2021) ("Health justice and reproductive justice emphasize the limitations of strategies concerned only with the right to buy a service and support policies that lower or eliminate the costs of care, make child rearing more affordable, and address the country's tattered healthcare system.").

services.[20] Uninsurance and underinsurance remain entrenched problems that inhibit access to health care services generally and stymie the human flourishing and social benefit that effective care can enable.[21] Access to reproductive care is particularly important because it can have acute consequences for individuals' physical and mental health, financial security, participation in society, and self-determination, as the reproductive justice movement directly recognizes.[22] As the primary source of third-party funding during most people's reproductive years, employers play a dominant role in this especially profound aspect of human health and flourishing and, on the whole, have made very few shifts in response to *Dobbs*.[23]

This Article proceeds in three parts: First, it lays out the legal infrastructure that gives employers discretion in covering reproductive care; second, it exposes the power dynamics that put employer-sponsored insurance at odds with reproductive justice; and finally, it interrogates a range of reforms that could decouple the funding of reproductive care from employers.

Part I details the legal landscape that gives employers near-complete discretion over the coverage of reproductive care.[24] Employer-sponsored

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20. See How Much Does Health Insurance Cost?, Ramsey (Oct. 18, 2023), https://www.ramseysolutions.com/insurance/how-much-does-health-insurance-cost [https://perma.cc/YAZ7-8WHD] (showing that the cost of employer-sponsored insurance is significantly lower than that of market insurance); Michelle Long, Matthew Rae & Alina Salganicoff, Exclusion of Abortion Coverage From Employer-Sponsored Health Plans, KFF (May 12, 2020), https://www.kff.org/womens-health-policy/issue-brief/exclusion-of-abortion-coverage-from-employer-sponsored-health-plans/ [https://perma.cc/C3FC-CTW9] (noting that over 150 million employees receive diverse employer-sponsored insurance benefits, including reproductive health care).

21. See J.P. Ruger, The Moral Foundations of Health Insurance, 100 QJM 53, 55–56 (2007) (advancing a moral argument for universal health insurance); Sara R. Collins, Lauren A. Haynes & Relebohile Masitha, The State of U.S. Health Insurance in 2022, Commonwealth Fund (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey [https://perma.cc/Y7GA-U87U] (noting that forty-three percent of adults were inadequately insured in 2022).

22. See, e.g., Loretta J. Ross & Rickie Solinger, Reproductive Justice: An Introduction 9–10 (2017) (noting the importance of reproductive access to human flourishing and social well-being).

23. See Jessica L. Roberts, An Alternate Theory of *Burwell v. Hobby Lobby*, 22 Conn. Ins. L.J. 85, 86 (2016) [hereinafter Roberts, An Alternate Theory] (explaining how the necessity of insurance and the prominence of employer-sponsored insurance render employers "de facto health-care policy makers"); Michelle Long, Matthew Rae, Alina Salganicoff & Laurie Sobel, Coverage of Abortion in Large Employer-Sponsored Plans in 2023, KFF (Feb. 29, 2024), https://www.kff.org/womens-health-policy/issue-brief/coverage-of-abortion-in-large-employer-sponsored-plans-in-2023/ [https://perma.cc/8489-MWR4] (finding that the "vast majority" of firms whose plans excluded abortion coverage pre-*Dobbs* continue to do so, that only twelve percent of large firms that covered abortion pre-*Dobbs* have made any expansions since the ruling, and that only seven percent of large firms offer abortion travel coverage).

24. See Katherine Keisler-Starkey & Lisa N. Bunch, U.S. Census Bureau, Health Insurance Coverage in the United States: 2020, at 3–4 (2021), https://www.census.gov/content

insurance coverage for reproductive health services varies widely based on the size and type of the employer institution and its plan design choices. The variation is made possible by a complex legal infrastructure that mostly insulates employers' discretion over the extent of coverage for reproductive care.[25] Reproductive exceptionalism[26]—the practice of lawmakers and regulators treating reproductive services differently from other medical care—infuses insurance regulation, giving both public and private employers greater leeway to restrict coverage for reproductive care than other medical services.[27] Statutory and constitutional accommodations for religion widen the holes in coverage by exempting religious institutions—and even secular for-profit businesses such as Hobby Lobby—from certain coverage mandates.[28] Federal antidiscrimination statutes and state and local laws constrain discretion, but in limited ways that may sometimes give way to religious objections.[29] Public-sector employers, responsible for covering thirty-seven million people in the United States, are exempt from many of the regulations governing commercial insurance and so have even wider latitude to choose which services to cover.[30] These many loopholes and forces of exceptionalism have relegated the provision of reproductive care into separate funding and separate clinical settings, most apparently through treatments paid for by patients out of pocket,[31] Title X federally funded family-planning clinics, Planned Parenthood clinics, and privately funded independent abortion clinics.[32]

/dam/Census/library/publications/2021/demo/p60-274.pdf [https://perma.cc/UYE9-STAR] (stating that 54.4% of the population—nearly 178 million people—received employer-sponsored insurance).

25. See infra section I.A.

26. E.g., Courtney Megan Cahill, Reproductive Exceptionalism in and Beyond *Birth Rights*, 100 B.U. L. Rev. Online 152, 152–53 (2020), https://www.bu.edu/bulawreview/files/2020/07/CAHILL.pdf [https://perma.cc/8KW4-EK69] (offering examples of reproductive exceptionalism in the law).

27. See infra section I.A.

28. See infra notes 96–98 and accompanying text.

29. See Off. for C.R., Protection From Discrimination in Reproductive Health Care, HHS, https://www.hhs.gov/civil-rights/for-individuals/special-topics/reproductive-healthcare/index.html [https://perma.cc/2VVL-Z3XB] (last visited Oct. 24, 2023) (describing the ways that federal civil rights laws prohibit pregnancy discrimination).

30. See infra notes 203–221.

31. See Gabriela Weigel, Usha Ranji, Michelle Long & Alina Salganicoff, Coverage and Use of Fertility Services in the U.S., KFF (Sept. 15, 2020), https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/ [https://perma.cc/AN2T-DTFQ] ("Most patients pay out of pocket for fertility treatment . . . .").

32. See, e.g., Usha Ranji, Alina Salganicoff, Laurie Sobel & Ivette Gomez, Financing Family Planning for Low-Income Women: The Role of Public Programs, KFF (Oct. 25, 2019), https://www.kff.org/womens-health-policy/issue-brief/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/ [https://perma.cc/9YHG-SS5M] (describing a patchwork of clinical settings that distribute reproductive services).

Dobbs further complicated the intricate legal landscape by allowing states to ban the provision of abortion care, even when insurance covers it.[33] This patchwork sows chaos for reproductive care access broadly,[34] including for employer plans that already covered aspects of abortion care. Employers typically design their plans to promise coverage for one year at a time, beginning on January 1 of the next year.[35] When the Supreme Court formally issued the *Dobbs* opinion on June 24, 2022,[36] state trigger laws immediately went into effect, and new bans quickly followed, forcing employers and insurers to consider the immediate impacts on their coverage in the middle of a plan year and to calibrate their responses.[37] For those in states that further restricted or criminalized abortion, employer plans that covered some abortion services had to determine whether and how to expand coverage to account for the additional travel and leave required to access those services across state lines[38] as well as how to safeguard their claims data, lest those data potentially implicate employees or administrators.[39]

Part II explores employers' coverage decisionmaking, revealing how coverage of reproductive benefits is informed by employers' business and personal interests rather than their employees' reproductive autonomy. Firms' incentives frequently misalign with the robust coverage of reproductive services. Companies perceive pregnancy as costly and disruptive,

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33. See Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2259 (2022) (entrusting abortion regulation "to the people and their elected representatives").

34. See Nicole Huberfeld, High Stakes, Bad Odds: Health Laws and the Revived Federalism Revolution, 57 U.C. Davis L. Rev. 977, 1001 (2023) ("[T]he variety of state actions in the wake of *Dobbs* have created chaos, conflict, and confusion . . . .").

35. See Lacie Glover, Open Enrollment for Health Insurance, NerdWallet (Oct. 18, 2019), https://www.nerdwallet.com/article/health/health-insurance-open-enrollment [https://perma.cc/TX7N-GBHR] (noting that coverage usually lasts for a full calendar year); see also When Can I Enroll in My Employer Health Plan?, KFF, https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/when-can-i-enroll-in-my-employer-health-plan/ [https://perma.cc/MZ66-V3ZY] (last visited Oct. 24, 2023) (explaining the open-enrollment process).

36. *Dobbs*, 142 S. Ct. at 2228.

37. See, e.g., Tara Siegel Bernard, Abortion Insurance Coverage Is Now Much More Complicated, N.Y. Times (July 12, 2022), https://www.nytimes.com/2022/07/12/your-money/health-insurance/abortion-health-insurance-coverage.html (on file with the *Columbia Law Review*) (charting the impact of *Dobbs* on insurance benefits for abortions); Greg Ash & Laura Fischer, How the *Dobbs* Decision Will Impact Benefit Plans and Sponsors, ALM BenefitsPro (July 21, 2022), https://www.benefitspro.com/2022/07/21/how-the-dobbs-decision-will-impact-benefit-plans-and-sponsors/ [https://perma.cc/MXH7-6E3D] (detailing the decisions that plans need to make in response to *Dobbs*).

38. See, e.g., Shea Holman & Hannah Naylor, The *Dobbs* Decision: Emerging Trends in Corporate Response, Purple Campaign (July 21, 2022), https://www.purplecampaign.org/purple-post/2022/7/20/the-dobbs-decision-emerging-trends-in-corporate-response [https://perma.cc/X7EL-LGEB] (tracking public corporate responses to *Dobbs*).

39. See HIPAA Privacy Rule and Disclosures of Information Relating to Reproductive Health Care, HHS (June 29, 2022), https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html [https://perma.cc/XB4N-YLJN] (describing the HIPAA provisions that safeguard disclosures of reproductive services).

pointing to lost productivity and the need to accommodate pregnant workers.[40] Pregnancy also increases employers' insurance premiums; childbirth is one of the costliest medical procedures for employers annually and results in more dependents for the plan to cover.[41] But employers have also resisted covering contraception for decades[42]—long before Hobby Lobby publicly took its fight to the Supreme Court. When employers refuse to cover reproductive care, they externalize the costs of that care onto public programs or the employees themselves.

Although employers' interests may at times align with some employees' choices, this interest convergence is fragile and ultimately subordinates individuals' choices to the dominant forces of an entity's commercial interests. Decoupling health care from employment would begin to remedy this subordination, which contradicts reproductive justice.[43] Other health benefits models, including public programs like Medicaid, also impose burdens on reproductive justice and may carve such care out of their ambit. Yet employers pose a greater threat to reproductive justice given the power they exert over employees and their various conflicts of interest.

Part III offers tough but essential considerations for the future of health reform if it is to meaningfully support reproductive justice. Public-option and single-payer reforms would directly decouple employers from reproductive care access by placing health care coverage in the hands of government officials. Based on how federal and state governments already act in their capacity as employers and insurers, however, the outlook for reproductive justice is still bleak. As an insurer, the federal government has long excluded abortion from coverage in its employee benefits plan.[44] Through the Hyde Amendment, the federal government has also avoided paying federal funds toward abortions for almost fifty years, and politicians have constantly raised objections to abortion funding, even by stymieing measures unrelated to health care.[45] Though some states reject Hyde and

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40. See infra section II.A.1.

41. See infra notes 236–239 and accompanying text.

42. See, e.g., Sylvia A. Law, Sex Discrimination and Insurance for Contraception, 73 Wash. L. Rev. 363, 368–72 (1998) (describing the historical responses to contraception coverage by employers).

43. See Ross & Solinger, supra note 22, at 8, 93 (introducing the reproductive justice framework).

44. See Alina Salganicoff, Laurie Sobel & Amrutha Ramaswamy, The Hyde Amendment and Coverage for Abortion Services, KFF (Mar. 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/ [https://perma.cc/3SY3-D8U7] [hereinafter Salganicoff et al., Hyde Amendment] (describing the federal Hyde Amendment).

45. See, e.g., Karoun Demirjian, Tuberville Blockade Over Abortion Policy Threatens Top Military Promotions, N.Y. Times (July 10, 2023), https://www.nytimes.com/2023/07/10/us/politics/tuberville-abortion-joint-chiefs.html (on file with the *Columbia Law Review*) (describing Alabama Senator Tommy Tuberville's decision to block hundreds

cover the full range of reproductive care for their employees, a majority have enacted their own Hyde-style restrictions.[46] Any plan that places funding discretion in the hands of the government—or any third-party payer—must contend with this reality.

The direct-care model already serves as an alternative to traditional insurance-based, third-party funding. In direct care, the funding flows from the funder directly to the provider without a claims processor or insurance contract as an intermediary. Thus, providers receive payment (or salary) to treat whatever patients they serve, for whatever services fall within their scope of practice. For example, Title X clinics provide patients with nonabortion family-planning services, directly funded by federal grants.[47] Planned Parenthood and other independent private clinics, meanwhile, provide a fuller range of services, including abortion, using private funding (typically from nonprofit organizations).[48] Privately funded direct care largely removes the intervening influence of employers and political actors, but it nonetheless reflects and perpetuates the reproductive exceptionalism that undermines autonomy by isolating and treating differently from any other medical service the financing of reproductive care.

Using the framework of confrontational incrementalism,[49] this Article assesses whether the incremental changes that appear most feasible actually advance or thwart the ends of reproductive justice. This framework counsels that incremental reforms should be assessed based not just on their feasibility but ultimately on whether each increment also confronts the sources of subordination and inequity or accommodates them.[50] Applied to the reproductive health insurance context, the assessment compares the

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of military promotions until the DOD scraps its policy offering time off and travel reimbursement to service members traveling out of state for abortions).

46. See State Funding of Abortion Under Medicaid, Guttmacher Inst., https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid [https://perma.cc/PHY7-8SCP] (last updated Aug. 31, 2023) (providing an overview of state abortion funding in all fifty states).

47. See Angela Napili, Cong. Rsch. Serv., IF10051, Title X Family Planning Program, https://crsreports.congress.gov/product/pdf/IF/IF10051 [https://perma.cc/L7CP-LMNF] (last updated June 8, 2023) (describing the prohibition on the use of Title X funds for abortion).

48. See Abortion Care Network, Communities Need Clinics: The New Landscape of Independent Abortion Clinics in the United States 3 (2022), https://abortioncarenetwork.org/wp-content/uploads/2022/12/communities-need-clinics-2022.pdf [https://perma.cc/W8G6-8V8L] (noting that hospitals and physician practices account for only four percent of all abortion procedures provided in the United States and that Planned Parenthood and independent clinics provide the rest).

49. See Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, Health Reform Reconstruction, 55 U.C. Davis L. Rev. 657, 665 (2021) [hereinafter Wiley et al., Health Reform Reconstruction] (explaining the concept of confrontational incrementalism as applied to health policy).

50. See id.

impacts on reproductive justice of incremental reforms that would merely constrain employer discretion in the current system with measures that would instead supplant employers' influence over health care funding and establish universal public programs.[51] The assessment further compares the potentially subordinating influences of private health care funding reforms and government funding reforms.[52] Applying these perspectives to recent experiences with state-level single-payer proposals, the Article concludes by observing some narrow openings for eroding reproductive exceptionalism to advance reproductive justice and by arguing that achieving universal care reforms that are feasible, durable, and equitable may require an embrace of reproductive justice.

I. THE INFRASTRUCTURE OF EMPLOYERS' REPRODUCTIVE CHOICE

In 2022, 159 million nonelderly people in the United States—nearly half of the nation's population—were covered by an employer-sponsored health insurance plan.[53] This reliance on employers as the predominant source of health insurance is unique to America and the trajectory of its health policy movements.[54] First, when other industrialized nations enacted national public health care programs in the early twentieth century, the United States did not.[55] Although Congress debated establishing a public health

51. See infra Part III.

52. See infra Part III.

53. See Gary Claxton, Matthew Rae, Emma Wager, Gregory Young, Heidi Whitmore, Jason Kerns, Greg Shmavonian & Anthony Damico, KFF, Employer Health Benefits 2022 Annual Survey 6 (2022), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf [https://perma.cc/3FLJ-PGZP] [hereinafter 2022 Employer Health Benefits Survey].

54. See Munira Z. Gunja, Evan D. Gumas & Reginald D. Williams II, U.S. Health Care From a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes, Commonwealth Fund (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 [https://perma.cc/R88B-GZHT] (noting that "[t]he U.S. is the only high-income country that does not guarantee [government or public] health coverage" to all its residents); Shanoor Seervai, Arnav Shah & Robin Osborn, How Other Countries Achieve Universal Coverage, Commonwealth Fund (Oct. 27, 2017), https://www.commonwealthfund.org/blog/2017/how-other-countries-achieve-universal-coverage [https://perma.cc/92J8-NWTK] (comparing the United States to countries like England, France, and the Netherlands, all of which have achieved near-universal insurance coverage).

55. Cf. Erin C. Fuse Brown & Aaron S. Kesselheim, The History of Health Law in the United States, 387 New Eng. J. Med. 289, 289–90 (2022) (tracing the history of health law into distinct eras); see also Brendan S. Maher, Regulating Employment-Based Anything, 100 Minn. L. Rev. 1257, 1267 (2016) [hereinafter Maher, Employment-Based Anything] (explaining how the failure to enact national health care legislation in the 1930s drove reliance on employer-based insurance); George B. Moseley III, The U.S. Health Care Non-System, 1908–2008, 10 AMA J. Ethics 324, 324 (2008) (noting that, in the decade after 1908, "many European nations would adopt some form of compulsory national health insurance, but similar proposals in the U.S. were rejected because of lack of interest and resistance from physicians and commercial insurers").

insurance system in the New Deal era, it abandoned those plans and forged ahead with Social Security solely for retirement benefits.[56] This failure left health care financing largely to the private market and private charities.[57] As scholar Lawrence D. Brown put it, "Thus was the cultural die cast: [The U.S.] government's role in health coverage was 'officially' confined to filling in the gaps of an otherwise robust private system."[58] On a deeper level, the political and philosophical underpinnings of treating health care primarily as a benefit of work, rather than as a social good, reflect the forces of racism, sexism, and ableism that exclude vulnerable groups from the paid labor market.[59]

In 1965, Congress established the Medicare and Medicaid programs for retirees and those unable to work, thereby filling a large gap in the private, employment-based system of coverage.[60] Older people and people

56. See Moseley, supra note 55, at 325 (noting that the Social Security Act was passed without a health insurance component during a time when physicians were concerned about compulsory national health insurance).

57. See Deborah A. Stone, The Struggle for the Soul of Health Insurance, 18 J. Health Pol., Pol'y & L. 287, 289–90 (1993) (noting that, unlike in "most societies," the private insurance industry is "the first line of defense in the U.S." and depends on "charging the sick"). Likewise, the United States, "compared to other developed nations . . . has some of the least favorable family-friendly policies" and "is one of only two economically developed democracies that does not guarantee basic benefits like paid family leave." Jones, A Different Class, supra note 10, at 699.

58. Lawrence D. Brown, The More Things Stay the Same the More They Change: The Odd Interplay between Government and Ideology in the Recent Political History of the U.S. Health-Care System, *in* History and Health Policy in the United States 32, 45 (Rosemary A. Stevens, Charles E. Rosenberg & Lawton R. Burns eds., 2006).

59. See, e.g., Angela P. Harris & Aysha Pamukcu, The Civil Rights of Health: A New Approach to Challenging Structural Inequality, 67 UCLA L. Rev. 758, 762 (2020) (discussing how "markers of social stigma such as such as race, gender, sexuality, and class" contribute to the disparities in access to "health-promoting opportunities and resources"); Stone, supra note 57, at 290 (noting how the private health insurance industry's focus on actuarial fairness "foster[s] in people a sense of their differences, rather than their commonalities"); Wiley et al., Health Reform Reconstruction, supra note 49, at 664, 712–13, 723 (explaining how four fixtures of American health care—federalism, fiscal fragmentation, individualism, and privatization—have created and reinforced racial subordination); Ruqaiijah Yearby, Brietta Clark & José F. Figueroa, Structural Racism in Historical and Modern US Health Care Policy, 41 Health Affs. 187, 187–92 (2022) (noting "racial and ethnic minority populations' inequitable access to health care, which persists because of structural racism in health care policy"); Jeneen Interlandi, Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do With Race., N.Y. Times Mag. (Aug. 14, 2019), https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html (on file with the *Columbia Law Review*) (quoting science historian Evelyn Hammonds's argument that "[t]here has never been any period in American history where the health of blacks was equal to that of whites," revealing that "[d]isparity is built into the system").

60. See Wiley et al., Health Reform Reconstruction, supra note 49, at 736 ("[Medicare] partially confronted privatization (established as a public program), individualism (automatic enrollment), fiscal fragmentation (federally financed without segmentation), and federalism (federally administered)."); see also Fuse Brown & Kesselheim, supra note 55, at 291 ("Medicare and Medicaid responded to the pressing social problem that health care was increasingly inaccessible to people who were left out of the . . . employment-

with disabilities are likelier to have more intensive, sometimes unique, health needs that private insurers would prefer not to add to their risk pools. For those without public coverage, private insurance plans are concerned about adverse selection, in which people wait to enroll in (and pay into) health insurance plans until they develop an expensive medical condition.[61] Adverse selection makes private insurance more expensive because plans must collect enough money to cover higher-cost medical needs from a smaller number of people.[62] Working people and their dependents, however, are grouped together by employment, rather than intensity of health needs, and therefore make attractive risk pools for private insurers to court.[63]

Without a universal public insurance program, the United States has resorted to enacting a pastiche of measures to prop up and nudge private employer-sponsored insurance, mainly through tax treatment and deregulation.[64] After World War II, the "federal decision to provide tax benefits for employers who established private health insurance for workers—a form of government-funded 'welfare capitalism'—galvanized the growth of private health insurance organized through the workplace."[65] Employ-

based health insurance system: [older patients], people with disabilities, and poor mothers and children.").

61. Mark A. Hall & Michael J. McCue, Does Making Health Insurance Enrollment Easier Cause Adverse Selection?, Commonwealth Fund Blog (Apr. 4, 2022), https://www.commonwealthfund.org/blog/2022/does-making-health-insurance-enrollment-easier-cause-adverse-selection [https://perma.cc/7E4B-48Q2].

62. Id.

63. See Am. Acad. Of Actuaries, Critical Issues in Health Reform: Risk Pooling 1 (2009), https://www.actuary.org/sites/default/files/pdf/health/pool_july09.pdf [https://perma.cc/4VWV-42KF] ("Pools created as a by-product of membership in a group that is formed for other reasons [such as employment], rather than a group that is formed for the specific purpose of obtaining health insurance, tend to be less subject to adverse selection."); see also Thomas C. Buchmueller, The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature 1 (2000), https://www.chcf.org/wp-content/uploads/2017/12/PDF-BusinessCaseReport.pdf [https://perma.cc/5ND8-YMEN] (explaining that economies of scale and preferential tax treatment lower the cost of employer-sponsored insurance); Maher, Employment-Based Anything, supra note 55, at 1281–83 (explaining adverse selection in the insurance context).

64. See Timothy Jost, Neither Public nor Private: A Health-Care System Muddling Through, The Atlantic (May 18, 2012), https://www.theatlantic.com/health/archive/2012/05/neither-public-nor-private-a-health-care-system-muddling-through/257123/ (on file with the *Columbia Law Review*) (noting how employment-sponsored insurance is "heavily subsidized through tax expenditures to the tune of roughly $200 billion a year").

65. Rosemary A. Stevens, Medical Specialization as American Health Policy: Interweaving Public and Private Roles, *in* History and Health Policy in the United States, supra note 58, at 49, 58; see also Moseley, supra note 55, at 325 (noting the "spur [in] health insurance sales . . . during World War II"); Aaron E. Carroll, The Real Reason the U.S. Has Employer-Sponsored Health Insurance, N.Y. Times (Sept. 5, 2017), https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html (on file with the *Columbia Law Review*) (explaining how the IRS's decision

ers offering benefit plans got two tax advantages: deductions from employers' taxable business income for the cost of providing benefits and exclusions of the value of the benefits from employees' taxable income.[66] This preferential tax treatment "firmly entrenched" employers as the primary source of health insurance[67] and currently represents "one of the federal government's largest tax expenditures," resulting in hundreds of billions of dollars in cumulative lost tax revenue.[68]

The Employee Retirement Income Security Act of 1974 (ERISA)[69] further nudged employers to offer these tax-preferred benefits by creating a uniform but sparse set of federal rules to govern them and preempting many additional state laws. For the past forty-nine years, ERISA has had a largely deregulatory effect on employer-sponsored health benefits.[70] The ACA ultimately doubled down on the tax-and-deregulation treatment of employer-sponsored insurance, building its other insurance reforms around a tax-enforced mandate for large employers to provide insurance[71] and a comparatively lighter set of new federal rules for employer plans versus individual private plans.[72] This reliance on employer-sponsored insurance and the piecemeal approach that it reflects contribute to the gestalt of a health care "*non*-system" in the United States.[73]

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to exempt employer-based insurance from taxation "made it cheaper to get health insurance through a job than by other means").

66. See Moseley, supra note 55, at 326; see also Comm. on Emp.-Based Health Benefits, Inst. of Med., Emp. & Health Benefits: A Connection at Risk 64, 70–71 (Marilyn J. Field & Harold T. Shapiro eds., 1993), https://www-ncbi-nlm-nih-gov.ezproxy.cul.columbia.edu/books/NBK235992/pdf/Bookshelf_NBK235992.pdf [https://perma.cc/32TP-RJ9U] (explaining how tax advantages boosted employer-sponsored health care).

67. Moseley, supra note 55, at 326.

68. Options for Reducing the Deficit: Reduce Tax Subsidies for Employment-Based Health Insurance, CBO (Dec. 7, 2022), https://www.cbo.gov/budget-options/58627 [https://perma.cc/U9QY-933L] (estimating lost tax revenues of $641 billion by 2032).

69. 29 U.S.C. § 1001 (2018).

70. See Elizabeth Y. McCuskey, ERISA Reform as Health Reform: The Case for an ERISA Preemption Waiver, 48 J.L. Med. & Ethics 450, 451–52 (2020) [hereinafter McCuskey, ERISA Reform] (noting ERISA preemption's "deregulatory" effect due to the consolidation of "authority in a single federal regulatory regime"); see also David A. Hyman, Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?, 78 N.C. L. Rev. 5, 14 (1999) (noting "that ERISA effectively creates a health benefits free-fire zone" and with a majority of those covered by self-insured plans "in a regulatory no-man's-land," ERISA leaves "employment-based health insurance . . . effectively unregulated").

71. The employer penalty for large employers can be found at I.R.C. § 4980H (2018). Small businesses can receive tax credits but are not mandated to purchase benefits. Id. § 45R.

72. See 79 Fed. Reg. 8542, 8545 (Feb. 12, 2014) (codified at 26 C.F.R. pts. 1, 54, 301).

73. See Wiley et al., Health Reform Reconstruction, supra note 49, at 666–67 ("Many have acknowledged that [the U.S. health care system] is, more accurately, a non-system."); see also Moseley, supra note 55, at 324–28 (describing the history of "[t]he U.S. [h]ealth [c]are [n]on-[s]ystem").

The prohibitively high cost of most health care relative to average wages makes health insurance necessary for the purchase of health care.[74] Private employers' decisions about their health insurance benefits therefore drive a significant portion of health policy.[75]

As the remainder of this Part explains, this is even more acutely true for coverage of reproductive care. The complex legal infrastructure that has accumulated to regulate health insurance reflects reproductive exceptionalism and largely effectuates employers' choices about whether and how to cover reproductive care.[76] Since long before *Dobbs,* U.S. health insurance policy's deferential posture has made employers the de facto gatekeepers of their employees' access to reproductive care. When employers frequently choose *not* to cover reproductive care, they leave patients *under*-insured and shift the financial burden of care (as well as the consequences of not paying for it) onto individuals, public programs, and private nonprofits.[77] People in low-wage jobs experience this burden most acutely.[78]

A. *The Legal Infrastructure of Employer Choice*

Most Americans in their prime reproductive and working years (ages nineteen to sixty-four) have health insurance coverage through an employer health plan[79] with state-to-state variation based on demographics, economy, and labor markets.[80] Employer-based plans also constitute a significant source of coverage for adolescents (ages ten to eighteen) who receive coverage as dependents of employees during their initial years of reproductive capacity.[81] For all these people, employers effectively control access to many health care services by virtue of their control over what benefits they offer. In theory, employers could offer a

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74. See Lunna Lopes, Marley Presiado & Liz Hamel, Americans' Challenges With Health Care Costs, KFF (Dec. 21, 2023), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ [https://perma.cc/Q5NA-2W35] (noting that about one in four adults in the United States have delayed or forgone medical care in the last year due to cost).

75. See Roberts, An Alternate Theory, supra note 23, at 96 ("[T]he employer-provided [insurance] system renders employers de facto health-care policy makers.").

76. See infra section I.A.

77. See infra sections I.A.3, I.B.

78. See infra section I.A.1.

79. See Health Insurance Coverage of Adults 19–64, KFF, https://www.kff.org/other/state-indicator/adults-19-64/ [https://perma.cc/WTX9-NL9C] (last visited Jan. 18, 2024) (noting that 60.9% of adults in the United States were insured through employer-based plans in 2022).

80. See id.

81. See Donna L. Spencer, Margaret McManus, Kathleen Thiede Call, Joanna Turner, Christopher Harwood, Patience White & Giovann Alarcon, Health Care Coverage and Access Among Children, Adolescents, and Young Adults, 2010–2016: Implications for Future Health Reforms, 62 J. Adolescent Health 667, 669 tbl.2 (2018).

choice among plans, but in practice, seventy-five percent of employers that offer benefits offer only one health plan to employees.[82] Employers' choices reflect wide variation in coverage based on type of employer, size of employer firm, type of benefit plan, and type of reproductive care service described in this section.[83]

A complex legal infrastructure effectuates employers' choices in reproductive health care. While some aspects of state insurance laws, ERISA, the ACA, and antidiscrimination laws encourage employers to cover reproductive care, this web of laws predominantly grants employers discretion over the design of their health plans.[84] Sometimes, the law's deference to employer choice means expanded access to services, as in Walmart's recent action.[85] But employers who wish to restrict access to reproductive care also find their preferences validated by law.[86]

While states were historically the primary regulators of insurance providers, there has been a steady march of federal health insurance regulation since World War II.[87] The dominant source of regulation is now the federal government, though states add important requirements and play an implementation role for some federal programs.[88]

Most laws governing employer-sponsored insurance either incentivize coverage or patch up holes or inequities in coverage. ERISA, for example, offered the carrot of deregulation—that is, preemption of state laws in favor of minimal federal ones—to entice employers to offer benefits.[89] The statute implements standardized claims processing and imposes

82. See 2022 Employer Health Benefits Survey, supra note 53, at 68.

83. See, e.g., id. (noting that "[l]arge firms are more likely than small firms to offer more than one plan type").

84. See McCuskey, ERISA Reform, supra note 70, at 451–52 (tracing ERISA plans' discretion about substantive coverage decisions).

85. See supra notes 2–6 and accompanying text.

86. See infra section I.A.3.

87. See supra note 65 and accompanying text; see also Elizabeth Y. McCuskey, Body of Preemption: Health Law Traditions and the Presumption Against Preemption, 89 Temp. L. Rev. 95, 135–44 (2016) (describing the interplay between state and federal health insurance regulation in the second half of the twentieth century).

88. See Abbe R. Gluck & Nicole Huberfeld, What Is Federalism in Healthcare for?, 70 Stan. L. Rev. 1689, 1697 (2018) ("While state authority over areas of healthcare certainly remains, the major decisions about allocation of power in healthcare now typically come . . . from political and policy decisions by *Congress* to incorporate states into federal schemes.").

89. See Phyllis C. Borzi, There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform, 36 J.L. Med. & Ethics 660, 663 (2008) (explaining how ERISA preemption "was deliberately designed to shield multi-state employers from the onerous burden of complying with . . . varying state or local laws" and spur coverage offerings); James A. Wooten, A Legislative and Political History of ERISA Preemption (pt. 1), 14 J. Pension Benefits 31, 31 (2006) (noting how the concern that "states would regulate employee-benefit plans if Congress failed to do so" motivated ERISA).

fiduciary responsibility on fund managers for some aspects of plan design and administration.[90] Congress has added a few more substantive coverage requirements to ERISA in piecemeal fashion while maintaining the preemption of state laws.[91] The Health Insurance Portability and Accountability Act of 1996 (HIPAA), another example, sustained the practice of employer-sponsored insurance but amended ERISA to limit the extent to which these plans could exclude care relating to preexisting conditions.[92]

The ACA built on the ERISA framework, adding an employer-mandate "stick" to ERISA's deregulation "carrot."[93] Most notably, the ACA expressly stated its intent *not* to alter ERISA's preemption.[94] Taken together, ERISA and the ACA give private employers choice in designing their health plans and leeway for deciding to cover or reject some main items of reproductive care.

Certain categories of employers enjoy even greater flexibility. Most regulation and data collection classify employers as private industry or public, and public employees as civilian or military.[95] Within the private employer category, religious organizations are exempt from many rules that govern other private firms, especially when it comes to coverage for reproductive care that the institutional dogma does not support.[96] Over

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90. See ERISA, DOL, https://www.dol.gov/general/topic/health-plans/erisa [https://perma.cc/3MYF-HNY4] (last visited Oct. 25, 2023) (emphasizing the administrative and fiduciary requirements for ERISA plans).

91. See McCuskey, ERISA Reform, supra note 70, at 452 (describing the "piecemeal statutory amendments" to ERISA which have left section "1144 preemption unscathed").

92. 29 U.S.C. § 1181 (2018).

93. See Elizabeth Y. McCuskey, Agency Imprimatur & Health Reform Preemption, 78 Ohio State L.J. 1099, 1144–45 (2017) (describing the ACA's employer mandate, which "filled the vast regulatory void created by ERISA preemption").

94. See 29 U.S.C. § 1191(a)(2) (providing that the new ACA provisions shall not be construed to affect or modify the ERISA preemption clause as applied to group health plans); 42 U.S.C § 300gg-23(a)(2) (2018) (same); see also Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312, 326 (2016) (finding that the ACA had no bearing on ERISA preemption analysis).

95. See, e.g., Employment Cost Index: Classification Systems Used by the National Compensation Survey (NCS), U.S. Bureau Lab. Stats. (May 11, 2021), https://www.bls.gov/eci/factsheets/national-compensation-survey-classification-systems-mapping-files.htm (on file with the *Columbia Law Review*) (identifying survey classifications based on ownership by "civilian, private industry, and . . . government employers" and differentiating the military).

96. E.g., Women's Preventive Services Coverage and Non-Profit Religious Organizations, Ctr. for Medicare & Medicaid Servs., https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/womens-preven-02012013 [https://perma.cc/MGZ7-2JLN] (last modified Sept. 6, 2023).

1.6 million people currently work for religious organizations,[97] which include, for example, hospital systems owned by religious organizations.[98]

The public-civilian employer classification includes plans maintained by federal, state, and local governments for their employees, some of which are also subject to collective bargaining with public-sector unions. The U.S. military, as an employer, usually receives a distinct classification because it maintains a unique set of coverage options: TRICARE as health coverage for active-duty military members and their dependents, the Veterans Administration (VA) as a funded direct-care provider of care for veterans, and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) for veterans' dependents and beneficiaries.[99] Public employers are subject to a few of the same rules as private employers, but many distinct ones, too—most notably the Hyde Amendment prohibiting federal funding for abortions.

In sum, the legal infrastructure at a minimum gives employers their choice of:

1. whether to offer health benefits to employees at all;

2. what type of plan to offer—a fully insured plan run by a state-regulated insurance provider, or a self-insured plan maintained by a third-party administrator and not subject to state insurance law;

3. what services to cover, including many aspects of reproductive care; and

4. which providers to include, and how much of the cost of covered care to shift onto employees and their dependents.

These are substantial choices bearing on the fundamental features of health benefits.[100]

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97. Religious Organizations Industry in the US—Market Research Report, IBIS World (Jan. 13, 2023), https://www.ibisworld.com/united-states/market-research-reports/religious-organizations-industry/ [https://perma.cc/7GQC-92A2] (using the 1.67 million estimate for 2023); Religious Organizations, Data USA, https://datausa.io/profile/naics/religious-organizations [https://perma.cc/9SAM-R6ZP] (last visited Feb. 19, 2023) (reporting a 1.73 million estimate from the 2019 Bureau of Labor Statistics data).

98. Three of the five largest health systems in the United States are operated by religious organizations. See Anna Falvey, 100 of the Largest Hospitals and Health Systems in America—2023, Becker's Hosp. Rev. (Feb. 28, 2023), https://www.beckershospitalreview.com/lists/100-of-the-largest-hospitals-and-health-systems-in-america-2023.html [https://perma.cc/AP2C-AKWB] (listing Commonspirit Health, Ascension, and Trinity Health—all Catholic organizations—in the top five).

99. See CHAMPVA Benefits, VA (Oct. 16, 2023), https://www.va.gov/health-care/family-caregiver-benefits/champva/ [https://perma.cc/Z6YZ-C6Z6]; TRICARE, https://www.tricare.mil/ [https://perma.cc/WTZ3-J9HA] (last visited Oct. 26, 2023); VA Health Care, VA (Aug. 30, 2023), https://www.va.gov/health-care/ [https://perma.cc/UQ7Q-VNF4].

100. See, e.g., Ogletree Deakins, Summary Checklist of Health Plan Design Options 1–5 (2019), https://www.acc.com/sites/default/files/resources/upload/Summary%20Checklist%20of%20Health%20Plan%20Design.pdf [https://perma.cc/M4TK-7NE4]

The following sections untangle the notoriously complex legal infrastructure governing these categories of choices, ultimately illustrating how these policies protect employer discretion in the financing of reproductive care. The analysis also illuminates the creep of reproductive exceptionalism in existing U.S. laws, which results in less protection for reproductive care than other types of care.[101]

1. *Whether to Offer Benefits.* — Employers of different sizes have various legal incentives to offer health benefits, but all maintain the option *not* to offer them.[102] The ACA's employer mandate pushes employers with fifty or more full-time employees to offer insurance by taxing their choice not to.[103] These so-defined "large" employers must decide whether to offer "minimum essential coverage" or instead pay the "shared responsibility payment" to the IRS,[104] which can be significant.[105] Under the ACA, the "small" employers with fewer than fifty employees who choose not to offer benefits owe nothing to the IRS for that choice.[106]

(listing best practices for employers designing their health benefits plans); Suzanne F. Delbanco, Roslyn Murray, Robert A. Berenson & Divvy K. Upadhyay, Urban Inst., A Typology of Benefit Designs 2 (2016), https://www.urban.org/sites/default/files/publication/80321/2000780-A-Typology-of-Benefit-Designs.pdf [https://perma.cc/UQ3W-6WXH] (providing a "typology of benefit designs" highlighting "the array of options available for health plan sponsors").

101. See, e.g., Greer Donley, Medication Abortion Exceptionalism, 107 Cornell L. Rev. 627, 703 (2022) (discussing the FDA-imposed limits on medication abortion despite it being "effective and safe").

102. While this Part deals with the incentives built into the law, other business and social interests inform employers' motivations in offering and designing benefits, as further explored in Part II. See, e.g., Mathematica Pol'y Rsch., Inc., HHS, Employer Decision Making Regarding Health Insurance, Off. of the Assistant Sec'y for Plan. & Evaluation (Apr. 30, 2000), https://aspe.hhs.gov/reports/employer-decision-making-regarding-health-insurance [https://perma.cc/GYV2-4Y5H] [hereinafter HHS, Employer Decisionmaking] (reporting on employers' perceived "social contract notion of employer-sponsored health insurance").

103. See I.R.C. § 4980H (2018).

104. See Determining if an Employer Is an Applicable Large Employer, IRS (Oct. 23, 2023), https://www.irs.gov/affordable-care-act/employers/determining-if-an-employer-is-an-applicable-large-employer [https://perma.cc/KCC7-B5P7] (explaining the ACA provisions that apply to "large" employers). Note that "large" employers are eligible to buy policies on the "small" business exchanges, which are subject to those exchanges' rules. See Affordable Care Act Tax Provisions for Large Employers, IRS (Jan. 31, 2023), https://www.irs.gov/affordable-care-act/employers/affordable-care-act-tax-provisions-for-large-employers [https://perma.cc/A9X3-GKMG].

105. See Julie M. Whittaker, Cong. Rsch. Serv., R43981, The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential Employer Penalty 5–6 (2016), https://crsreports.congress.gov/product/pdf/R/R43981 [https://perma.cc/6GQY-6XCF] (explaining how to calculate the employer penalty); cf. Kip Piper & F. Randy Vogenberg, Implications of the Employer Mandate Delay on the Healthcare Marketplace, 6 Am. Health & Drug Benefits 303, 304 (2013) (noting the "employer mandate penalty—$2000 or $3000 per full-time employee" was designed to incentivize employer coverage).

106. See Whittaker, supra note 105, at 1.

ERISA broadly preempts all state and local laws that "relate to" employer benefits,[107] effectively prohibiting states from enforcing more robust employer coverage mandates.[108] ERISA also expressly exempts government and religious employers' plans from its framework.[109] The "church plans" exempt from ERISA include both plans for the direct employees of churches (and other organizations organized and operated for religious purposes)[110] and plans for church-affiliated organizations,[111] such as hospitals owned by the Catholic Church.[112] While religious employers do not have to comply with ERISA rules,[113] they likewise cannot use ERISA preemption to shield them from state regulation.[114]

The ACA's employer mandate, however, applies to both governmental and religious employers with at least fifty employees.[115] Thus, employers who choose *not* to offer benefits may face a variety of financial consequences, depending on their size and status. Their employees are left to find individual coverage on the ACA's insurance exchanges (which have some abortion coverage limitations and hurdles),[116] through their state's Medicaid or Children's Health Insurance

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107. 29 U.S.C. § 1144(a) (2018).

108. Hawaii passed an employer mandate just before ERISA was signed and later received a statutory exemption from preemption so that it could enforce its law. See Hawaii Prepaid Health Care Act, Haw. Rev. Stat. Ann. §§ 393-3(8), 393-11 (West 2023); Highlights of the Hawaii Prepaid Health Care Law, State of Haw. Dep't of Lab. & Indus. Rels., Disability & Comp. Div., https://labor.hawaii.gov/dcd/files/2013/01/PHC-highlights.pdf [https://perma.cc/V5CQ-KUB4] (last visited Oct. 24, 2023) (explaining how Hawaii's Prepaid Health Care Act was preempted by ERISA in 1981 but reinstated in 1983). States and cities may, however, impose payroll taxes to fund public health insurance programs which may have an indirect economic effect on employers' incentives for offering insurance. See ERISA Indus. Comm. v. City of Seattle, 840 F. App'x 248, 248–49 (9th Cir. 2021) (holding that Seattle's public health payroll tax provision does not trigger ERISA preemption); Golden Gate Rest. Ass'n v. City & County of San Francisco, 546 F.3d 639, 642 (9th Cir. 2008) (holding that ERISA does not preempt San Francisco's employer health care spending requirements).

109. See 29 U.S.C. § 1002(32), (33) (defining both a "governmental plan" and a "church plan").

110. Id. § 1002(33)(C)(ii).

111. Id. § 1002(33)(C)(iv).

112. See Advoc. Health Care Network v. Stapleton, 581 U.S. 468, 472 (2017) (clarifying that the exemption applies even to plans established by the hospitals rather than those established by the church that owns them).

113. Though they may elect to be treated as ERISA plans. See I.R.C. § 410(c)(1)(B) (2018).

114. See, e.g., Rebecca Miller, Note, God's (Pension) Plan: ERISA Church Plan Litigation in the Aftermath of *Advocate Health Care Network v. Stapleton*, 61 B.C. L. Rev. 3007, 3028 (2020) (noting how states "have an open door to create legislation that places affirmative duties on church plan sponsors").

115. Whittaker, supra note 105, at 1.

116. See Lisa C. Ikemoto, Abortion, Contraception and the ACA: The Realignment of Women's Health, 55 How. L.J. 731, 758 (2012) (explaining that the ACA explicitly excludes

Program (CHIP) offerings (most of which restrict abortion coverage under the Hyde Amendment),[117] or go uninsured if they do not qualify for Medicaid in their state and cannot afford exchange insurance.

Even with the ACA's employer mandate, there exists a "benefits gap" between high-wage, typically salaried employees, and low-wage, often part-time employees.[118] Women and people of color make up a disproportionate share of low-wage workers.[119] Low-wage workers are much less likely to be offered employer-sponsored insurance and are more likely to be underinsured or unable to afford employer-sponsored insurance when it is offered.[120] Loopholes in the Family Medical Leave Act and the ACA's employer mandate based on firm size and part-time status perpetuate gaps in coverage for low-wage workers.[121]

2. *Type of Plan.* — Any employer (large or small, private or public) can choose among different ways to fund its benefits. A "fully-insured" health plan refers to one sold by an insurance company to the employer, who works with the insurer to design the plan and project costs.[122] The insurer ultimately bears the risk if the plan collects insufficient money to pay all the claims. Alternatively, employers can use third-party administrators to run a "self-insured" plan.[123] With a self-insured (or "self-funded") style of plan, the employer has control over most aspects of the plan design and is responsible for collecting enough money to pay for all the benefits it has promised, though employers usually purchase "stop-loss" insurance to protect them if the claimed benefits exceed the funds they have set aside.[124]

abortion from the list of required benefits, prohibits those insurers that cover abortion from using federal subsidy money to do so, and "leaves state insurance mandates and restrictions intact").

117. See Salganicoff et al., Hyde Amendment, supra note 44 (noting how the Hyde Amendment limits abortion coverage under Medicaid and other federal programs).

118. See Jones, A Different Class, supra note 10, at 695, 701, 714–15 (describing how high-wage workers typically enjoy better retirement benefits, health care benefits, and work-leave arrangements relative to low-wage workers).

119. See id. at 704, 737.

120. See id at 715. As Trina Jones points out, these low-wage workers lack protections, despite the "precarious nature of many low-wage jobs," which "can be physically demanding, emotionally degrading, and dangerous." Id. at 716.

121. See id. at 717 n.91; see also Rachel Garfield, Matthew Rae, Gary Claxton & Kendal Orgera, Double Jeopardy: Low Wage Workers at Risk for Health and Financial Implications of COVID-19, KFF (Apr. 29, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/double-jeopardy-low-wage-workers-at-risk-for-health-and-financial-implications-of-covid-19/ [https://perma.cc/ULL8-7568] (noting that forty-three percent of low-wage workers are employed in small firms).

122. See Fully-Insured Health Plan, healthinsurance.org, https://www.healthinsurance.org/glossary/fully-insured-health-plan/ [https://perma.cc/JG7R-GYRN] (last visited Oct. 25, 2023) (defining "a fully-insured health plan").

123. See Self-Insured Group Health Plans, Self-Ins. Inst. Am., https://www.siia.org/i4a/pages/Index.cfm?pageID=7533 [https://perma.cc/HW6B-HBC9] (last visited Oct. 25, 2023).

124. See Al Stewart, DOL, Annual Report to Congress on Self-Insured Group Health Plans 14 (2021), https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/

In addition, employers can arrange for providers to deliver medical care directly to their employees.[125] The military serves as the main model for direct care because it operates health care facilities, employs doctors that serve covered veterans through the VA, and operates facilities on military bases that provide care to TRICARE members.[126]

Despite its capacious preemption of all state law that merely "relate[s] to" employer benefits, ERISA expressly preserves states' ability to regulate insurance companies located in their jurisdiction.[127] Thus, if an employer chooses to offer benefits *and* chooses to get those benefits fully insured from a state-licensed insurance carrier, then the employer's plan will need to comply with state insurance law in addition to the ERISA rules.

The Supreme Court has further interpreted ERISA's preemption provisions as exempting employers' "self-funded" plans from state insurance rules by deciding that self-funded plans are not the kind of "insurance" business that the savings clause had in mind,[128] thereby deregulating self-funded plans even more than fully insured ones. So, an employer that chooses to offer benefits may also choose to "self-fund" them, thereby shedding its responsibility to comply with state insurance laws.[129] The ACA did not alter the availability of fully insured or self-funded types of plans.[130]

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retirement-bulletins/annual-report-on-self-insured-group-health-plans-2021.pdf [https://perma.cc/PFU4-9N2U].

125. See Benefits of Choosing a Direct Primary Care Provider for Your Employees, Assurance Healthcare & Counseling Ctr. (Jan. 17, 2022), https://assurancehealth.org/benefits-of-choosing-a-direct-primary-care-provider-for-your-employees/ [https://perma.cc/6QPM-62V4].

126. See, e.g., Getting Care, TRICARE, https://www.tricare.mil/GettingCare [https://perma.cc/9BTL-FWYD] (last updated Aug. 2, 2023).

127. 29 U.S.C. § 1144(b)(2)(A) (2018). This is commonly referred to as ERISA preemption's "savings clause." Elizabeth McCuskey, ERISA Preemption Reform: Unlocking States' Capacity for Incremental Reform, Harv. L. Petrie–Flom Ctr.: Bill of Health (May 10, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/10/erisa-preemption-reform/ [https://perma.cc/E3W3-2NPN].

128. See Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985) (interpreting ERISA's "deemer clause" in 29 U.S.C. § 1144(b)(2)(B) as preventing states from enforcing insurance law on self-funded plans). For background on the interaction between ERISA's "relate to," "savings," and "deemer" clauses, see generally Mary Ann Chirba-Martin & Troyen A. Brennan, The Critical Role of ERISA in State Health Reform, 13 Health Affs. 142 (1994).

129. See Phyllis C. Borzi, Ctr. for Health Servs. Res. & Pol'y, ERISA Health Plans: Key Structural Variations and Their Effect on Liability 12 (2002), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1837&context=sphhs_policy_facpubs [https://perma.cc/VFQ3-CM5A] (noting how "self-insured ERISA plans can dramatically affect consumer protections" because of "the inapplicability of state consumer protection laws and insurance regulation"); Brinna Ludwig, Who Is Your Health Insurer?, Regul. Rev. (Apr. 28, 2022), https://www.theregreview.org/2022/04/28/ludwig-who-is-your-health-insurer/ [https://perma.cc/WDK3-3N73] (noting that "[m]any employers self-fund health insurance" but these plans "lack state law protections" due to ERISA preemption).

130. See Paul Fronstin, Self-Insured Health Plans Since the ACA: Trends Remain Unclear, Emp. Benefits Rsch. Inst., Brief No. 566, Aug. 25, 2022, at 1, 3–7, https://

And employers of various sizes have long chosen self-funded plans for the deregulation that ERISA preemption offers them.[131]

Most notably for reproductive care, the employer's plan type determines whether it will have to abide by state prohibitions or mandates to cover various reproductive services.

3. *Covered Services.* — Neither ERISA nor the ACA establishes a set of required services that employer plans must cover. While the ACA requires that plans sold to *individuals* cover a minimum set of "essential health benefits," most employer plans have no such minimum.[132] Even within a particular institution or firm (large or small), employers can offer different health benefits to different types of employees, such as salaried versus hourly employees and executives versus nonexecutives.[133] Unionized workers may get coverage from a multiemployer health plan through collective bargaining, which often results in more comprehensive coverage.[134]

Identifying the subset of covered services relevant to reproductive care requires some winnowing of a working definition because reproductive health care encompasses a broad range of needs and services. At its most general level, "reproductive health" refers to "a state of complete physical, mental and social well-being in all matters relating to the reproductive system"[135] and usually includes maternal and infant health and sexually transmitted infections.[136] Medical and health sciences' concepts of

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www.proquest.com/docview/2708431371?accountid=10226 [https://perma.cc/XXE3-A8WH] (revealing the trends in self-insured health plans since the passage of the ACA).

131. See, e.g., HHS, Employer Decisionmaking, supra note 102 (noting the "importance of . . . ERISA preemption" to companies' decision to self-insure).

132. See 42 U.S.C. § 300gg-6(a) (2018) (requiring only individual and small group plans to cover the "essential health benefits"); see also Christen Linke Young, USC–Brookings Schaeffer Initiative for Health Pol'y, Taking a Broader View of "Junk Insurance" 9 (2020), https://www.brookings.edu/wp-content/uploads/2020/07/Broader-View_July_2020.pdf [https://perma.cc/PY38-UMP5] ("[T]here is no provision in federal law that requires employer health plans to cover a comprehensive array of benefits.").

133. See Are Employers Allowed to Offer Different Benefits to Different Employees and to Charge More for the Same Benefit, or Is This a Discriminatory Practice?, Soc'y for Hum. Res. Mgmt., https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/offeringdifferentbenefitsfordifferentemployees.aspx (on file with the *Columbia Law Review*) (last visited Jan. 18, 2024).

134. See 29 C.F.R. § 825.211(a) (2023). Union plans produced by collective bargaining tend to have more comprehensive benefits and less cost-sharing than employer-provided plans. See Jon R. Gabel, Heidi Whitmore, Jennifer L. Satorius, Jeremy Pickreign & Sam T. Stromberg, Collectively Bargained Health Plans: More Comprehensive, Less Cost Sharing Than Employer Plans, 34 Health Affs. 461, 465 (2015).

135. Sexual & Reproductive Health, UN Population Fund, https://www.unfpa.org/sexual-reproductive-health [https://perma.cc/TGC2-U4QJ] (last visited Nov. 6, 2023).

136. See Report of the International Conference on Population and Development, 40, U.N. Doc. A/CONF.171/13/Rev.1 (1995) ("Reproductive health . . . [involves] appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. . . . It also includes sexual health . . . and care related to reproduction and sexually transmitted [infections].").

reproductive care include both sexual and reproductive health, the main components of which advocate Ann Starrs and her coauthors recently defined as contraception, abortion, fertility and infertility, maternal and newborn health, reproductive cancers, sexually transmitted infections, and gender-based violence.[137] Many regulatory definitions of "reproductive health care" are similarly broad, encompassing whatever care relates to the human reproductive system.[138] The insurance industry does not use a standard definition of reproductive care, but insurers (both private and public) rely heavily on the standardized International Classification of Diseases (ICD) codes for diagnoses and Current Procedural Terminology (CPT) codes to describe procedures performed when gathering data and processing claims.[139] These codes describe all aspects of care, including reproductive care, at a very granular level,[140] though insurance policies typically describe coverage at a very general, categorical level.

For the purposes of describing insurance coverage of reproductive services, this Article focuses on the following services and treatments in the components identified by Starr and her coauthors that bear most directly on whether and when an individual may reproduce, and the immediate consequences of reproduction: (a) contraception; (b) fertility, conception, infertility; (c) maternity care: pregnancy, prenatal, labor, delivery, postnatal; (d) newborns, infants; and (e) pregnancy loss, abortion.

Although this definition of reproductive services does not expressly include gender-affirming care, the issues raised in this Part have many parallel applications.[141]

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137. Ann M. Starrs et al., Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–*Lancet* Commission, 391 Lancet 2642, 2643, 2645–46, 2652 fig.3 (2018).

138. See, e.g., 18 U.S.C. § 248(e)(5) (2018) (defining "reproductive health services" in the Freedom of Access to Clinic Entrances Act as including "medical, surgical, counselling or referral services relating to the human reproductive system, including services relating to pregnancy or the termination of a pregnancy").

139. Overview of Coding and Classification Systems, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coding/overview-coding-classification-systems [https://perma.cc/NB8A-4B7B] (last updated Sept. 6, 2023) (explaining Medicare and Medicaid's use of Centers for Medicare and Medicaid Services and ICD coding systems); see also CPT Overview and Code Approval, AMA, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval [https://perma.cc/4Z9X-F7N9] (last visited Oct. 25, 2023) (explaining how most AMA professionals use the CPT system); International Statistical Classification of Diseases and Related Health Problems (ICD), WHO, https://www.who.int/classifications/classification-of-diseases [https://perma.cc/HXK7-8JBM] (last visited Oct. 25, 2023) (explaining the functions of the ICD system).

140. See, e.g., Commonly Used ICD-10 Codes in Reproductive Healthcare, Fam. Plan. Nat'l Training Ctrs., https://rhntc.org/sites/default/files/resources/fpntc_icd10_codes.pdf [https://perma.cc/8N3J-W258] (last visited Oct. 25, 2023) (categorizing reproductive health care conditions using specific labels).

141. There exist few data at present about the coverage or denial of gender-affirming care among employer plans, although the ACA's antidiscrimination provision protects

Which reproductive care services do plans cover? Most health plans promise coverage for all care that is "medically necessary" and define that term.[142] Initially, many insurance coverage decisions thus depend on the employers' administrator determining whether the services fit their definition of medical necessity.[143] Because the medical necessity catchall standard gives the insurer the authority to determine most coverage decisions,[144] it is the subject of consumer protection regulation and frequently of administrative appeals and litigation.[145] It is the also the source of many coverage denials for abortion and infertility treatments, as discussed below.[146]

ERISA, HIPAA, and the ACA have a few requirements for all private employer plans. ERISA's coverage requirements mostly rely on an if–then conditional application in which the ERISA requirement applies only *if* the employer has already chosen to cover a particular type of service. For example, *if* a self-insured plan covers hospitalizations *and* maternity, *then* it

transgender individuals. See William V. Padula & Kellan Baker, Coverage for Gender-Affirming Care: Making Health Insurance Work for Transgender Americans, 4 LGBT Health 244, 244–45 (2017) (noting that "many U.S. health insurers deny coverage for transgender healthcare services" but that the landscape is changing). There is no federal law requiring that employer plans specifically cover gender-affirming care, but courts have held that their refusal to do so under the same terms as other "medically necessary" care unlawfully discriminates on the basis of sex and therefore violates Title VII. See, e.g., Lange v. Houston County, 608 F. Supp. 3d 1340, 1356–60 (M.D. Ga. 2022). And some states have added their own coverage mandates and protections. See Katie Keith, Unpacking Colorado's New Guidance on Transgender Health, Commonwealth Fund (Nov. 10, 2021), https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health [https://perma.cc/JX38-NGC5] (reporting that Colorado's essential health benefits benchmark marketplace plan will require insurers to cover gender-affirming care beginning in 2023).

142. See Amy B. Monahan & Daniel Schwarcz, The Rules of Medical Necessity, 107 Iowa L. Rev. 423, 427 (2022) (explaining the health insurance industry's recent shift to "rules rather than standards" to define what is medically necessary); see also Nat'l Ass'n of Ins. Comm'rs, Understanding Health Bills: What Is Medical Necessity? 1 (n.d.), https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf [https://perma.cc/T5ZN-UTQP] (last visited Oct. 26, 2023) (explaining that health insurance plans will "provide a definition of 'medical necessity' or 'medically necessary services'" in their policies).

143. See Wendy K. Mariner, Patients' Rights After Health Care Reform: Who Decides What Is Medically Necessary?, 84 Am. J. Pub. Health 1515, 1517 (1994) ("[D]ecisions about what counts as medically necessary care will be made, in the first instance, by individual health plans.").

144. See id. (noting the "considerable leeway" that health plans have "to make plausible choices about what is medically necessary").

145. See Sara Rosenbaum, Brian Kamoie, D. Richard Mauery & Brian Walitt, HHS, Pub. No. 03-3790, Medical Necessity in Private Health Plans: Implications for Behavioral Health Care 19–26 (2003), https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1170&context=sphhs_policy_facpubs [https://perma.cc/S7V9-GYQF] ("Since the introduction of the concept of medical necessity into insurance contracts, countless challenges have been made to insurer and health plan denials of coverage based on medical necessity criteria.").

146. See infra text accompanying notes 175–179.

must cover hospital stays for up to 48 hours after vaginal delivery and up to 96 hours after cesarean section.[147] Federal laws requiring plans to cover certain services have been aptly described as piecemeal "single-service mandates" or "legislation by body-part."[148]

ERISA does not require that employer plans cover pregnancy or maternity, but the Pregnancy Discrimination Act of 1978 (PDA) requires that employers with fifteen or more employees cover maternity services.[149] Even so, employers with fifty or more employees have no obligation to cover labor and delivery for the employees' dependents,[150] many of whom are of reproductive age thanks to the ACA's requirement that plans enroll dependents through age twenty-six.

Fifteen states require some health plans to cover at least some infertility treatments, with great variation in the types of infertility treatments covered and with numerous exceptions, exclusions, and caps on these offerings.[151] Self-insured plans do not have to abide by these fifteen state mandates, thanks to ERISA. For the most part, however, even under fully insured plans, "[e]mployers make that decision . . . . Most insurance companies would offer [fertility coverage] if their customers—the employers—push[ed] for it."[152]

The ACA requires coverage of contraception for all plans, albeit indirectly.[153] The ACA's requirement that all plans cover "preventive health services" extends to items listed by the U.S. Preventive Services Task Force (Task Force) and, for women, any additional preventative care and screenings

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147. 29 U.S.C. § 1185(a), (c)(2) (2018).

148. Cynthia Dailard, Guttmacher Inst., Contraceptive Coverage: A 10-Year Retrospective 7 (2004), https://www.guttmacher.org/sites/default/files/article_files/gr070206.pdf [https://perma.cc/YMY3-DLX4] [hereinafter Dailard, Contraceptive Coverage]; cf. Hyman, supra note 70, at 18–24 (criticizing the empirical basis for enacting a protection against early postpartum hospital discharges, known as "drive-through" or "drive-by" deliveries).

149. 42 U.S.C § 2000e(k) (2018); see also EEOC, EEOC-CVG-2015-1, Enforcement Guidance on Pregnancy Discrimination and Related Issues (2015), https://www.eeoc.gov/laws/guidance/enforcement-guidance-pregnancy-discrimination-and-related-issues [https://perma.cc/7SMK-7Q9Q] [hereinafter EEOC PDA Guidance].

150. See FAQs: Health Insurance Marketplace and the ACA—Women's Health, KFF, https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/im-covered-as-a-dependent-under-my-parents-plan-and-im-pregnant-will-my-parents-plan-cover-my-prenatal-care-and-delivery-will-my-parents-plan-cover-my-ba/ [https://perma.cc/9UGS-XM5X] (last visited Oct. 26, 2023). These employers do have to cover prenatal care. Id.

151. See Weigel et al., supra note 31. Two states (California and Texas) require group health plans to *offer* at least one policy with infertility coverage (a "mandate to offer"), but employers are not required to choose these plans. Id.

152. Fertility Benefits: Who Pays the Price, WinFertility, https://www.winfertility.com/blog/fertility-benefits-pays-price/ [https://perma.cc/TS5P-KCMN] (last visited Jan. 19, 2024) (second alteration in original) (referring to a quotation from Sean Tipton, the American Society for Reproductive Medicine's Chief Advocacy, Policy, and Development Officer at a national meeting of the Society).

153. Ikemoto, supra note 116, at 764–65.

in the Health Resources and Services Administration (HRSA) guidelines.[154] Those statutory provisions do not mention contraception. But HRSA and the Task Force, in consultation with the Institute of Medicine, determined that preventative coverage should include prevention of pregnancy and therefore the "full range" of FDA-approved contraceptive methods.[155] The requirement to cover contraception could be lifted if courts accept the argument raised by opponents of the ACA in *Braidwood Management Inc. v. Becerra* that HRSA and the Task Force's authority are improper delegations of power.[156] And plans that did not cover preventative services before the ACA can still refuse to do so now under the "grandfather" exception in the statute.[157] Many employers also qualify for religious exemptions from the contraceptive coverage requirement, which extends to closely held for-profit businesses with religious objections thanks to *Hobby Lobby*.[158]

Antidiscrimination statutes restrict employers from selecting covered services in ways that discriminate based on enrollees' sex, gender, or disability.[159] The ACA expressly prohibited[160] some of the most common forms of past discrimination, like excluding prescription contraceptives from a prescription drug benefit.[161] But, under the PDA, even for services not

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154. 42 U.S.C. § 300gg-13(a)(1), (4).

155. Women's Preventative Services Guidelines, Health Res. & Servs. Admin., https://www.hrsa.gov/womens-guidelines [https://perma.cc/2ZDD-FPDX] (last visited Jan. 20, 2024).

156. *Braidwood*, 627 F. Supp. 3d 624, 649 (N.D. Tex. 2022); see also Ian Millhiser, There's a New Lawsuit Attacking Obamacare—and It's a Serious Threat, Vox (Apr. 2, 2021), https://www.vox.com/2021/4/2/22360341/obamacare-lawsuit-supreme-court-little-sisters-kelley-becerra-reed-oconnor-nondelegation [https://perma.cc/3FJQ-2JZT] (explaining plaintiffs' arguments against the preventative care provisions of the ACA).

157. See Health Insurance Rights & Protections, HealthCare.gov, https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/ [https://perma.cc/9FWB-L2EU] (last visited Oct. 25, 2023) (noting that grandfathered plans are not required to cover preventative care).

158. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 719 (2014) (holding that an HHS mandate requiring employer-sponsored health insurance plans to cover contraceptives "substantially burdened" a closely held corporation's exercise of religion).

159. See Section 1557 of the Patient Protection and Affordable Care Act, HHS, https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html [https://perma.cc/QC6P-TJ7J] (last updated Nov. 15, 2023); see also Law, supra note 42, at 373 (discussing Title VII of the Civil Rights Act).

160. See Ikemoto, supra note 116, at 766 (noting "the ACA rule requiring new plans to cover contraception without cost-sharing").

161. Compare Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1274 (W.D. Wash. 2001) (holding that the Pregnancy Discrimination Act prohibited the exclusion of contraceptives from a plan), with In re Union Pac. R.R. Emp. Pracs. Litig., 479 F.3d 936, 942 (8th Cir. 2007) (holding that contraception was not "related to" pregnancy and therefore not required to be in a prescription drug plan under the PDA).

expressly required by the ACA, employer plans cannot offer benefits in a way that excludes benefits used solely by potentially pregnant people.[162]

Except for abortion. Abortion remains the reproductive service about which employer plans have nearly total discretion in coverage. Republicans used abortion as a wedge issue in negotiations over the ACA and other health reform efforts; consequently, federal law does not require coverage and explicitly preserves plans' ability to exclude it.[163] Some states require coverage; some states prohibit it.[164] So employers who choose to offer fully insured plans subject to state law must also abide by that state's requirements or prohibitions.[165] But ERISA preempts the application of any of these laws to self-funded plans.[166] An employer in a state that prohibits insurance coverage of abortion can self-fund a plan that covers it. Likewise, an employer in a state that requires insurance coverage of abortion can self-fund a plan that excludes it. And, because the ERISA preemption extends to those laws that merely "relate to" employer benefits, it should preempt states from enforcing

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162. For example, no statute requires large group employer plans to cover dependents' pregnancies, so many employers' plans exclude this coverage. See, e.g., Michelle Andrews, Some Plans Deny Pregnancy Coverage for Dependent Children, KFF Health News (Aug. 6, 2012), https://kffhealthnews.org/news/under-26-pregnancy-coverage-michelle-andrews-080712/ [https://perma.cc/ZDV7-62SJ]. Yet the exclusion of dependents' pregnancies from group plan coverage unlawfully discriminates on the basis of pregnancy, as the Biden Administration's proposed rule for implementing the ACA's Section 1557 nondiscrimination provision would formally recognize. See Letter from Nat'l Women's L. Ctr. to Fontes Rainer, Dir. of the Off. of C.R., HHS (Oct. 5, 2022), https://nwlc.org/resource/nwlc-submits-comment-on-nondiscrimination-in-health-programs-and-activities-section-1557/ [https://perma.cc/B8NQ-NKD3]; cf. *Erickson*, 141 F. Supp. 2d at 1270–71 (explaining that "the intent of Congress in enacting the PDA" was to override precedents from Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 135 (1976), and Geduldig v. Aiello, 417 U.S. 484, 496–97 (1974), under which pregnancy- and abortion-related provisions were not unlawful sex discrimination); Rory Akers, Dependent Child Pregnancy . . . To Cover or Not Cover? What's Required?, Lockton (Dec. 4, 2017), https://locktonbenefitsblog.com/dependent-child-pregnancy-to-cover-or-not-cover-whats-required/ [https://perma.cc/2ZBT-ZTQL] (reflecting a private benefits consulting firm's advice to employers during the Trump Administration about covering maternity expenses for dependent children).

163. Nicole Huberfeld, With Liberty and Access for Some: The ACA's Disconnect for Women's Health, 40 Fordham Urb. L.J. 1357, 1383–87 (2013); Ikemoto, supra note 116, at 757–64; see also Tony Perkins, Don't Fund Abortions With Health Bill, Politico (July 28, 2009), https://www.politico.com/story/2009/07/dont-fund-abortions-with-health-bill-025475 [https://perma.cc/5JM5-RLWZ] (providing a contemporary example of how abortion concerns are leveraged in the public discourse surrounding the ACA).

164. Long et al., supra note 20 (showing that eleven states prohibit coverage for abortion and five states require insurers to cover it).

165. See Maher, Pro-Choice Plans, supra note 2, at 459 ("For insured plans, states can regulate the plan's insurer.").

166. See id. at 458–59 (noting that "states *cannot* directly regulate self-insured plans because of the deemer clause").

most of their antiabortion laws against self-funded plans like Walmart's that cover abortion and related travel expenses.[167]

This discretion has resulted in 10% of employees being covered by employer plans that expressly exclude abortion coverage in some (6%) or all (4%) circumstances,[168] in addition to those workers in states whose laws ban abortion coverage by fully insured plans. Employees of companies with 5,000 or more employees are more likely to be subject to an express abortion exclusion policy than those at smaller firms, and self-funded plans are more likely to have these exclusions.[169] Private not-for-profit employers (many of whom are religious institutions) are much more likely to exclude abortion from their plans than private for-profit employers.[170] Even plans that do cover abortion often have restrictions on the circumstances in which an abortion will be covered, including those relating to method, gestational age, and number of services covered per employee.[171]

"Elective" versus "medically necessary" abortion has long been a contested distinction, even under *Roe v. Wade*.[172] In *Doe v. Bolton*, decided on the same day as *Roe*, the Supreme Court considered a Georgia state law that criminalized abortion except in cases of rape, of fetal abnormality, or in which a licensed physician certified the procedure to be "necessary" to protect the pregnant person's life and health.[173] Responding to a vagueness challenge to the medical necessity determination, the Court held that the provision was sufficiently clear to be enforceable in postviability abortion scenarios, even under *Roe*, because it left space for the "attending physician . . . to make [their] best medical judgment."[174] The Hyde Amendment debate about whether Congress could withhold public funding for both "therapeutic or medically necessary" abortions and "elective" ones[175] perpetuated a binary view, which continued to influence all manner of abortion regulations.[176] And

167. See id. at 455 (noting that if the state law "relate[s] to" employee benefit plans, it is preempted (alteration in original) (quoting 29 U.S.C. § 1144(a) (2018))).

168. See Long et al., supra note 20.

169. See id. (finding those who work at the largest firms and at firms with self-funded plans to have a 17% and 14% chance, respectively, of having a policy expressly excluding abortion).

170. See id. (finding covered workers at not-for-profit firms to have an 18% chance of having a policy excluding abortion coverage compared to a 6% chance for covered works at private for-profit firms).

171. See id. (observing that these types of restrictions are prevalent in private plans without complete abortion bans).

172. 410 U.S. 113 (1973).

173. 410 U.S. 179, 183 (1973) (citing Ga. Code Ann. § 26-1202 (1969) (current version at Ga. Code Ann. § 16-12-141 (2023))).

174. Id. at 192.

175. See, e.g., Jon O. Shimabukuro, Cong. Rsch. Serv., RL33467, Abortion: Judicial History and Legislative Response 16–17 (2022) (reviewing cases in which the Court found "no statutory or constitutional obligation of the federal government or the states to fund medically necessary abortions").

176. See B. Jessie Hill, Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic, 106 Va. L. Rev. Online 99, 112–13 (2020),

insurers of all types frequently classify fertility treatments as not "medically necessary" and therefore as services not covered under their plans.[177] Medical necessity continues to circumscribe private-employer coverage of abortions, too,[178] and remains a point of great contention for antichoice activists.[179] Within the insurance context, the medical-necessity determination gives employer plans exceptional discretion to deny coverage for abortion and fertility treatments.

4. *Provider Networks and Cost-Sharing.* — Even if they choose to cover aspects of reproductive care, employers may design their plans with restrictions on choice of providers or impose patient cost-sharing, both of which impede access to that covered care. Even before *Dobbs* prompted some states to criminalize abortion care, the cost of reproductive care and the dearth of doctors and facilities to provide it imposed practical hurdles to accessing reproductive care, including for people with health insurance, which persist today.[180] The cost-sharing and provider network features of group health plans further limit that access.[181]

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https://virginialawreview.org/wp-content/uploads/2020/12/Hill_FinalCheck.pdf [https://perma.cc/84ZC-LSLG] [hereinafter Hill, Essentially Elective] (explaining the problematic definition of "elective" used to justify abortion restrictions during the COVID-19 pandemic); B. Jessie Hill, What Is the Meaning of Health? Constitutional Implications of Defining "Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act, 38 Am. J.L. & Med. 445, 453 (2012) (noting how medical-necessity abortions "seemed to play a role in the legislative debates in the 1970s over the reauthorization and scope of the Hyde Amendment"); Katie Watson, Why We Should Stop Using the Term "Elective Abortion," 20 AMA J. Ethics 1175, 1177 (2018) (arguing that when hospitals prevent willing physicians from performing elective abortions, institutions are imposing moral judgment on patients and robbing them of medical care access).

177. Weigel et al., supra note 31.

178. See Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (2018) (requiring employer-plan coverage for abortion only when "the life of the mother would be endangered if the fetus were carried to term, or . . . whe[n] medical complications have arisen from an abortion").

179. See, e.g., Robert P. Casey, No, Abortion Isn't a Health Care Service, *in* Abortion Services and President Clinton's Health Plan: Two Views, 3 J. Am. Health Pol'y 27, 29, 31 (1993) (arguing that, because the majority are "elective," abortions should not be included in a standard benefits package); "Medically Necessary" or "Health" Abortions: Abortion on Demand by Another Name, U.S. Conf. of Catholic Bishops (Nov. 13, 1995), https://www.usccb.org/issues-and-action/human-life-and-dignity/abortion/medically-necessary-or-health-abortions-abortion-on-demand-by-another-name [https://perma.cc/S5KS-3TD7] (arguing that "medically necessary" abortion is merely a "term[] of art for abortion on demand").

180. See Luciana E. Hebert, Erin E. Wingo, Lee Hasselbacher, Kellie E. Schueler, Lori R. Freedman & Debra B. Stulberg, Reproductive Healthcare Denials Among a Privately Insured Population, 23 Preventive Med. Reps. 1, 2 (2021) (noting how institutional restrictions filter down from the health care system to individual hospitals and physicians to effectively deny even insured patients access to reproductive health care).

181. See, e.g., Lee A. Hasselbacher, Erin Wingo, Alex Cacioppo, Ashley McHugh, Debra Stulberg & Lori Freedman, Beyond *Hobby Lobby*: Employer's Responsibilities and Opportunities to Improve Network Access to Reproductive Healthcare for Employees, 4

The provider restrictions that employer plans impose typically take the form of referrals and "networking." Employers may choose to require a primary care referral as a prerequisite to receiving care by a specialized doctor.[182] Because the great majority of reproductive care services are provided by specialists (with limited roles for primary care in straightforward matters like prescribing birth control), designing a plan to require primary-care referral can impose an additional hurdle to receiving reproductive care. If private employers' plans cover gynecological services *and* require primary care referrals, then an ERISA regulation restricts the plan from imposing this referral requirement on OB-GYN providers.[183]

Networking refers to the practice by which employers and their insurers may choose the providers that they will (and will not) reimburse for covered services.[184] The supply of reproductive care providers is limited, even in states that have not already banned abortion care: The United States has among the fewest maternal health providers per capita of any high-income country.[185] Many employer plans attempt to control costs by selecting a "narrow" network of covered providers, which also tends to curb patients' use of their insurance to visit doctors.[186] "Even if the costs of a specific health service like contraception are *covered*, people can still experience barriers to reproductive health care because of the limited providers in their insurance network."[187]

The choice of providers for the plan network has additional ramifications for reproductive care because Catholic hospitals and health systems operate under a religious directive to refuse to perform many covered reproductive services like contraception, sterilization, fertility treatment, and abortion.[188] So even if the law permits it and insurance covers it, many

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Contraception: X, at 1, 1 (2022) (pointing to the "barriers" that persist, even with coverage, from "limited providers" in network).

182. See generally Referral, HealthCare.gov, https://www.healthcare.gov/glossary/referral/ [https://perma.cc/6SUW-DMDM] (last visited Oct. 25, 2023) (defining "referral").

183. 29 C.F.R. § 2590.715-2719A(a)(1)–(3) (2023) (protecting patients' choice of health care professional for their obstetrical and gynecological care).

184. Cf. What You Should Know About Provider Networks, HealthCare.gov: Health Ins. Marketplace 1, https://marketplace.cms.gov/outreach-and-education/what-you-should-know-provider-networks.pdf [https://perma.cc/4K3V-7XVC] (last visited Oct. 25, 2023) ("A provider network is a list of the doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members.").

185. See Munira Z. Gunja, Shanoor Seervai, Laurie C. Zephyrin & Reginald D. Williams II, Health and Health Care for Women of Reproductive Age, Commonwealth Fund (Apr. 5, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/health-and-health-care-women-reproductive-age [https://perma.cc/25B3-V7YW].

186. See Alicia Atwood & Anthony T. Lo Sasso, The Effect of Narrow Provider Networks on Health Care Use, 50 J. Health Econ. 86, 90 (2016) (noting that offering a narrow network plan is a way for firms to control health care spending).

187. Hasselbacher et al., supra note 181, at 1.

188. See U.S. Conf. of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services 18–19 (6th ed. 2018), https://www.usccb.org/resources/ethical-

seeking reproductive care are denied either the service or coverage or both. Among those with employer-sponsored insurance through S&P 500 companies, eleven percent reported someone on their health plan being denied a reproductive service that their health plan explicitly covered.[189] Even though the ACA requires plans to cover contraception, prenatal care, and labor and delivery, these services were the most commonly reported denials.[190] The prevalence of Catholic health systems in insurance networks contributes to this phenomenon.[191] In some states, Catholic hospitals make up nearly forty percent of the health system.[192]

And even outside of Catholic facilities, federal laws protect individual providers who refuse some reproductive services as a matter of religious belief.[193] While employer plans have some duties to contract with an adequate network of providers for the services they have promised to cover,[194] the large number of Catholic-owned facilities, and the increasing use of individual providers' objections even in non-Catholic facilities, can undermine the actual availability of covered services through the plan's network.[195]

Even if an employer plan covers reproductive services, the plan may impose additional out-of-pocket charges for patients who use those services.[196] Cost-sharing requirements tend to curb patients' use of those services and can create financial barriers to access even though the patient is insured.[197] To combat this effect, the ACA prohibits plans from imposing

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religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf [https://perma.cc/U8KD-KM8V]; see also Hebert et al., supra note 180, at 1.

189. See Hebert et al., supra note 180, at 4. For women, the reported denial rate was fourteen percent. Id.

190. See id.

191. See id. at 1.

192. See Hasselbacher et al., supra note 181, at 2.

193. Id.

194. Cf. Karen Pollitz, Network Adequacy Standards and Enforcement, KFF (Feb. 4, 2022), https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/ [https://perma.cc/JF64-ATT6] (assessing ACA-required network adequacy in qualified health plans offered through the marketplace).

195. Women in states that allow abortions only in limited circumstances frequently encounter providers that are unwilling to provide the service even under those circumstances. See, e.g., Amy Schoenfeld Walker, Most Abortion Bans Include Exceptions. In Practice, Few Are Granted., N.Y. Times (Jan. 21, 2023), https://www.nytimes.com/interactive/2023/01/21/us/abortion-ban-exceptions.html (on file with the *Columbia Law Review*).

196. See Cost Sharing, HealthCare.gov, https://www.healthcare.gov/glossary/cost-sharing/ [https://perma.cc/9KJP-589U] (last visited Oct. 25, 2023) (defining "cost sharing").

197. See, e.g., Geetesh Solanki & Helen Halpin Schauffler, Cost-Sharing and the Utilization of Clinical Preventive Services, 17 Am. J. Preventive Med. 127, 132 (1999) (finding lower utilization by employees in cost-sharing plans for eleven out of sixteen preventative services).

cost-sharing requirements on preventative services, including contraception.[198] Despite this federal mandate, twenty-five percent of women with private insurance report having to pay at least part of the cost of prescription contraception out of pocket, and many do not know that cost-sharing is prohibited.[199]

Federal laws requiring coverage of maternity and newborn care, however, expressly permit employer plans to impose cost-sharing rules on these services.[200] The cost-sharing rules applied to covered reproductive services add up quickly because the cost of reproductive care is often substantial. For example, "health costs associated with pregnancy, childbirth, and post-partum care average a total of $18,865," for which "women enrolled in large [employer] plans" paid an average of $2,854 out-of-pocket through cost-sharing.[201] Women in employer plans paid even more out-of-pocket for cesarean section deliveries (an average of $3,214).[202]

Public employers provide a unique example of the government acting as both the regulator and the provider of employee benefits.[203] The federal

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198. 42 U.S.C. § 300gg-13(a)(4) (2018); see also Lois Kaye Lee, Michael Carl Monuteaux & Alison Amidei Galbraith, Women and Healthcare Affordability After the ACA, 35 J. Gen. Internal Med. 959, 959 (2020) (noting that, despite the ACA mandating maternity and preventative service coverage without cost sharing, "disparities in cost-related medication nonadherence still remains greater for women when compared with men").

199. Brittni Frederiksen, Usha Ranji, Michelle Long, Karen Diep & Alina Salganicoff, Contraception in the United States: A Closer Look at Experiences, Preferences, and Coverage, KFF (Nov. 3, 2022), https://www.kff.org/womens-health-policy/report/contraception-in-the-united-states-a-closer-look-at-experiences-preferences-and-coverage/ [https://perma.cc/4WC2-TUYB]. Some paid out of pocket for specific forms of contraception that were not covered, others paid because they received out-of-network care, and many did not know why they paid out of pocket. Id.

200. E.g., 29 U.S.C. § 1185(c)(3) (2018) (explaining that "[n]othing in [the Newborn's and Mothers' Health Protection Act] shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits" required by the Act); id. § 1185b(a) (explaining that the Women's Health and Cancer Rights Act permits employer group plans to impose "annual deductibles and coinsurance provisions" as long as they are "consistent with those established for other benefits"); see also Krauss v. Oxford Health Plans, Inc., 517 F.3d 614, 626 (2d Cir. 2008) (construing the provisions of the Women's Health and Cancer Rights Act).

201. Matthew Rae, Cynthia Cox & Hanna Dingel, Health Costs Associated With Pregnancy, Childbirth, and Postpartum Care, Peterson–KFF: Health Sys. Tracker (July 13, 2022), https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/ [https://perma.cc/9AUX-7ADK].

202. Id.

203. See, e.g., Isaac D. Buck, The Drug (Pricing) Wars: States, Preemption, and Unsustainable Prices, 99 N.C. L. Rev. 167, 180–201 (2020) (examining how state governments function as third-party payers, consumers, and regulators of prescription drugs); see also Sabrina Corlette, Karen Davenport & Emma Walsh-Alker, Geo. Univ. Ctr. on Health Ins. Reforms, Mixed Results: State Employee Health Plans Face Challenges, Find Opportunities to Contain Cost Growth 5 (2023), https://sehpcostcontainment.chir.georgetown.edu/documents/Mixed-Results-Cost-Growth.pdf [https://perma.cc/XP3B-K6EP] (noting that state health plan administrators can often "face pressure from state policymakers to generate savings").

government covers more than twenty million employees and their dependents[204] through several programs: civilian and tribal employees through the Federal Employees Health Benefits Program (FEHB),[205] active-duty military employees through TRICARE,[206] veterans through Veterans Affairs,[207] and veterans' families through CHAMPVA.[208] Although Congress initially applied appropriations restrictions only to Medicaid, it soon passed Hyde Amendment–style appropriation restrictions for federal employers too, restricting abortion coverage for employees of the Departments of Defense, Treasury, Postal Service, and Justice, and finally for all employees through the FEHB program.[209] Initially, the Office of Personnel Management (OPM) had eliminated abortion coverage for federal civilian employees in all circumstances other than to save the life of the pregnant person. Federal employee unions sued OPM to challenge the restriction, and the district court held that OPM had acted "outside the scope of its authority" in limiting the benefits this way without a statutory directive.[210] Within a year, Congress responded by imposing Hyde Amendment–style budget restrictions to the same effect.[211]

FEHB must cover maternity care under the PDA, and the plan has chosen to cover only diagnostic and iatrogenic fertility treatments.[212] It covers contraception, and the OPM "strongly encourages" FEHB plans to cover the full range of FDA-approved contraceptives, in line with the ACA requirement.[213] TRICARE covers contraceptives but not Plan B; the plan

204. See Long et al., supra note 20.

205. See Healthcare, U.S. Off. of Pers. Mgmt., https://www.opm.gov/healthcare-insurance/healthcare/ [https://perma.cc/CZ52-8EYC] (last visited Oct. 24, 2023).

206. See Eligibility, TRICARE, https://www.tricare.mil/Plans/Eligibility [https://perma.cc/54SJ-4DV5] (last updated July 25, 2023).

207. See Eligibility for VA Health Care, VA, https://www.va.gov/health-care/eligibility/ [https://perma.cc/2ZAL-VFLZ] (last updated Sept. 30, 2023).

208. See CHAMPVA Benefits, VA, https://www.va.gov/health-care/family-caregiver-benefits/champva/ [https://perma.cc/NE3R-NTUA] (last updated Oct. 16, 2023).

209. See Act of Oct. 30, 1986, Pub. L. No. 99-591, § 209, 100 Stat. 3341, 3341–56 (DOJ); Act of Oct. 19, 1984, Pub. L. No. 98-525, § 1401(e)(5)(A), 98 Stat. 2492, 2618 (codified at 10 U.S.C. § 1093(a) (2018)) (DOD); Act of Nov. 14, 1983, Pub. L. No. 98-151, § 101(f), 97 Stat. 964, 973 (Treasury, USPS, and Federal Employees Health Benefits); Act of Oct. 13, 1978, Pub. L. No. 95-457, § 863, 92 Stat. 1231, 1254 (military).

210. See Am. Fed'n of Gov't Emps. v. Devin, 525 F. Supp. 250, 252 (D.D.C. 1981).

211. See Act of Nov. 14, 1983, Pub. L. No. 98-151, § 101(f), 97 Stat. 964, 973 (codified at scattered sections of 22 U.S.C.).

212. See Molly Weisner, Why Don't Federal Health Plans Cover More Infertility Treatments?, Fed. Times (Nov. 7, 2022), https://www.federaltimes.com/fedlife/benefits/2022/11/07/why-dont-federal-health-plans-cover-more-infertility-treatments/ [https://perma.cc/ARL8-5757] (reporting on legislator statements that expanding coverage for infertility would be "prohibitively expensive").

213. See U.S. Off. of Pers. Mgmt., Letter Number 2024-03, FEHB Program Carrier Letter (Jan. 30, 2024) (listing the various contraceptive methods that are covered); see also Exec. Order No. 14,101, 88 Fed. Reg. 41815 (Jun. 23, 2023) (directing OPM to consider

covers contraceptives without copay at military medical facilities but imposes a copay for service members' dependents who obtain contraception off base.[214]

TRICARE covers all the maternity care mandated by the PDA but covers very few Assisted Reproductive Technology (ART) services—except when infertility results from injury while on active duty.[215]

State and local governments employed 19.6 million people in 2002; local governments accounted for almost 75% of that number through employment of public schools and other services.[216] Thirteen percent of employees covered by state and local government plans are subject to abortion-coverage restrictions and exclusions because twenty states had bans on coverage of abortion in their public employee plans even before *Dobbs*.[217] But other states both require coverage of abortion in commercial insurance plans and provide coverage for their employees.[218] Fifteen states require commercial insurers to cover infertility treatment at some level,[219] and some cover the full range of infertility treatments including ART for state employees, too.[220] Many of these state and local governments collectively bargain their benefits with public-sector unions.[221]

B. *The Burdens of Employers' Choices*

Workers have become increasingly concentrated in large firms, as nearly 70% of people with employer-sponsored insurance are employed by firms with more than 200 employees and 38% of workers are at firms with more than 5,000 employees.[222] This heavy reliance on employers for health

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additional steps to "ensure, where appropriate, robust coverage of contraception under Federal programs").

214. See Health & Wellness: Contraception Chart, TRICARE, https://www.tricare.mil/HealthWellness/Public-Health/SexualHealth/Contraception-Chart [https://perma.cc/YL43-SGH6] (last updated Mar. 15, 2023).

215. See Covered Services: Assisted Reproductive Services, TRICARE, https://www.tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices [https://perma.cc/H2ML-2KWZ] (last updated Dec. 14, 2022).

216. See Current Employment Statistics, Bureau Lab. Stats., https://www.bls.gov/ces/ (on file with the *Columbia Law Review*) (last visited Oct. 26, 2023).

217. See Long et al., supra note 20.

218. See id.

219. See Weigel et al., supra note 31.

220. See, e.g., Div. of Pensions & Benefits, N.J. Dep't of Treasury, Member Guidebook for Employees and Retirees Enrolled in the State Health Benefits Program 16, 36–37 (2023), https://www.nj.gov/treasury/pensions/documents/guidebooks/hb0814a.pdf [https://perma.cc/E5K6-6J4E].

221. See Monique Morrissey, Unions Can Reduce the Public-Sector Pay Gap, Econ. Pol'y Inst. (June 17, 2021), https://www.epi.org/publication/unions-public-sector-pay-gap/ [https://perma.cc/7DV5-KXZB].

222. 2019 Employer Health Benefits Survey, KFF (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-survey-design-and-methods/ [https://perma.cc/GXY4-CGVE].

insurance and heavy concentration of workers in a few large firms gives large employers considerable sway in health policy. Walmart's health benefit decisions alone affect millions of people.[223] While small firms' benefit decisions do not have the same scope of impact on the population, they have as much impact on individual employees.

Employers' choices reflect a variety of factors but most directly reflect their economic concerns about costs, workforce recruitment, retention, and productivity.[224] For the majority of employer firms, who do not collectively bargain about benefits with unionized employees, a combination of firm executives and outside consultants control the decisions whether to offer benefits and how to design them.[225] They often solicit employee input through surveys.[226] The process takes months and culminates in the selection of a vendor to provide or administer the benefits for a twelve-month period.[227]

With cost and administrative burdens cited by employers as first-order concerns in their benefits decisions,[228] the cost implications of covering reproductive care services and providers—and *not* covering them—reveal where the financial burdens of employers' choices fall.

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223. See Walmart, supra note 4 (describing a Walmart workforce of 1.6 million in the United States). Walmart's benefits decisions also affect many of the workers' spouses and children.

224. See, e.g., Buchmueller, supra note 63, at 2 (discussing the attractiveness of employer-sponsored health plans for acquiring and retaining employees); Oriana González & Arielle Dreher, Employers Expand Reproductive Health Benefits Amid Tight Labor Market, Axios (Oct. 11, 2022), https://www.axios.com/2022/10/11/fertility-benefit-reproductive-health-labor (on file with the *Columbia Law Review*) ("[C]ompanies are aware that offering [fertility] benefits [can] improve employee retention rates and attract new talent.").

225. See HHS, Employer Decisionmaking, supra note 102 (noting the involvement of a firm's CFO, CEO, and hired consultants in its health care decisionmaking); see also Joanne Sammer, It's Probably Time to Re-Bid Your Benefits Contracts, Soc'y for Hum. Res. Mgmt. (Mar. 5, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/time-to-re-bid-benefit-contracts (on file with the *Columbia Law Review*) (describing factors employers should consider when selecting a health plan).

226. HHS, Employer Decisionmaking, supra note 102.

227. See id.

228. See, e.g., AON Health Solutions, Accolade: The Claims Cost Impact of Implementing Personalized Advocacy 5 (2021) (on file with the *Columbia Law Review*) (touting cost savings to self-insured plans from employing consulting service in benefits design); Imagine360, Broker Guide 4 (2023) (on file with the *Columbia Law Review*) (explaining the move to self-funded plans was based on a desire for "customization" and "cost-containment"); Jones, A Different Class, supra note 10, at 718–19 (describing how cost is the driving concern behind employers' refusal to extend family-friendly benefits to low-wage workers); Jake Spiegel & Paul Fronstin, What Employers Say About the Future of Employer-Sponsored Health Insurance, Commonwealth Fund (Jan. 26, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/what-employers-say-future-employer-health-insurance [https://perma.cc/523V-3U4Q] (providing employers' concerns about employer-sponsored insurance). They also tend to believe that their benefit plan designs will be better at controlling costs than the plans offered on the insurance exchanges will. See Spiegel & Fronstin, supra.

1. *Actuarial Costs of Covering Reproductive Care.* — The price of health benefits to the employer starts with projecting the likely medical and administrative costs for the twelve-month plan year ahead.[229] That actuarial projection, performed by insurance companies or consultants, models the likely costs using the plan's covered services and network of providers' rates, the portion of costs enrollees will pay through cost-sharing, the likely features of people who will enroll in the plan, and claims data from prior years for similar groups.[230] The projected cost for the full year is then divided into twelve monthly payments and by the number of people covered by the plan to get the monthly *premium* rate, which is the usual point of price comparison among plans.[231] (The employer typically pays a portion of the premium as the benefit, and the employee pays the remainder.[232]) The plan premium can account for the age distribution, gender makeup, and other features of the firm's actual workforce. Plan premiums for employer plans covering fifty or more employees can also account for the actual medical usage of those employees in the past.[233] But the ACA, HIPAA, ERISA, and some state laws prohibit plans from charging different premiums to different employees based on their individual medical needs, gender, or age.[234]

When an employer plan adds an optional item to its covered services, it thus changes the premium price of the plan. Adding a covered item that employees or their dependents are likely to use during the plan year adds to the projected cost. Employing a greater proportion of people who are likely to use the covered service would also add to the plan's cost. Because most plans cover a catchall category of "medically necessary" care, adding an item that is likely to help avoid the need for more costly or less effective care can bring premium projections down. Plans frequently use coverage

229. See generally Tammy Feit, What Goes Into Pricing a Group Health Insurance Plan?, Physicians Health Plan, https://www.phpni.com/blog/what-goes-into-pricing-a-group-health-insurance-plan [https://perma.cc/X3LF-4SJ4] (last visited Oct. 23, 2023) (explaining the various factors that determine health insurance premiums).

230. See Louise Norris, What Actuarial Value Means for Health Insurance, Verywell Health, https://www.verywellhealth.com/actuarial-value-and-your-health-insurance-4147819 [https://perma.cc/XWH9-HEA7] (last updated Oct. 21, 2023).

231. See Spiegel & Fronstin, supra note 228.

232. See Russ Banham, The Cure for Healthcare Costs, Chief Executive, https://chiefexecutive.net/the-cure-for-healthcare-costs/ [https://perma.cc/SS8G-ME3T] (last visited Oct. 24, 2023).

233. See DOL, Compliance Assistance Guide: Health Benefits Coverage Under Federal Law 25 (2014), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf [https://perma.cc/469P-KF95].

234. Id. at 25–26; see also 42 U.S.C. § 300gg-1(b) (2018); 27 R.I. Gen. Laws § 27-18-88 (2024) (prohibiting gender-rated premiums in individual and group health plans); 26 C.F.R. § 54.9802-1 (2018) (HIPAA); Michelle Long & Alina Salganicoff, Pre-Existing Condition Prevalence Among Women Under Age 65, KFF (Nov. 4, 2020), https://www.kff.org/womens-health-policy/issue-brief/pre-existing-condition-prevalence-among-women-under-age-65/ [https://perma.cc/2JJ9-X9LH].

of preventative services as a mechanism to help control costs.[235] And plans may pass the costs of preventative care on to enrollees and their dependents through deductibles, copays, coinsurance, and other cost-sharing mechanisms.

Each of the main items of reproductive care coverage thus has actuarial impacts on the plans' premiums. For example, pregnancy is one of the costliest medical conditions for employers. The average cost of covering a pregnancy, labor and delivery, and postpartum care is around $19,000.[236] Pregnancy complications are becoming more prevalent, and this contributes further to cost.[237] A plan that covers those services would use statistical modeling to project how many enrollees would be likely to get pregnant and give birth during the plan year in calculating that portion of the overall plan cost. The fact that people who give birth average $1,040 less in prescription drug costs during pregnancy would also factor into the projection,[238] as would the cost-sharing provisions the plan imposes that push an average of $3,000 of the pregnancy costs back to the patient.[239]

After birth, the plan must then cover the newborn as a dependent potentially through age twenty-six, adding to the cost of coverage (though plans are allowed to exclude the children of dependents).[240] Premature births cost employer plans 12.7 billion dollars annually in actuarial costs alone.[241] Not included in this calculation is the time away from work that pregnancy and any related leave may prompt for an employee who needs these covered services.

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235. See Feit, supra note 229.

236. See Rae et al., supra note 201.

237. See So O'Neil, Isabel Platt, Divya Vohra, Emma Pendl-Robinson, Eric Dehus, Laurie Zephyrin & Kara Zivin, The High Costs of Maternal Morbidity Show Why We Need Greater Investment in Maternal Health, Commonwealth Fund (Nov. 12, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/nov/high-costs-maternal-morbidity-need-investment-maternal-health [https://perma.cc/EM8C-UQYG].

238. See Rae et al., supra note 201.

239. See id. (noting that women who give birth "pay almost $3,000 more out-of-pocket than those who do not give birth").

240. See, e.g., N.Y. Dep't of Fin. Servs., Report on Health Insurance Coverage for Childbirth 20–21 (2022), https://www.dfs.ny.gov/reports_and_publications/health_insurance_coverage_for_childbirth [https://perma.cc/X2HT-CCJA] (explaining New York's requirements for coverage of dependents but not their children); see also Sam Hughes, Emily Gee & Nicole Rapfogel, Health Insurance Costs Are Squeezing Workers and Employers, Ctr. for Am. Progress (Nov. 29, 2022), https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/ [https://perma.cc/677X-WA39] (observing that family plan premiums cost more for employers and employees).

241. Premature Babies Cost Employers $12.7 Billion Annually, March of Dimes (Feb. 7, 2014), https://www.marchofdimes.org/about/news/premature-babies-cost-employers-127-billion-annually [https://perma.cc/38PJ-JL9P] ("For premature and/or low birth weight babies . . . the average cost was $55,393, of which $54,149 was paid by the health plan.").

Fertility treatments aimed at producing a pregnancy are likewise very expensive: IVF treatments cost more than $12,000 per cycle and often require multiple cycles for success.[242] Unlike pregnancy, no federal law requires employers to cover common infertility treatments, and most employers choose not to cover the full range of treatments.[243]

In contrast to covering these services, covering contraception looks quite cost-effective.[244] Abortions too, while prohibitively expensive for many individuals, represent net cost-savings for an employer plan: Abortion care ranges from $500 to $2,000[245] compared to the $16,000+ cost of maternity care and the added coverage for a new dependent. Unintended pregnancies may account for a full one percent of the employer's health benefits spending per year.[246]

The benefits of robust coverage to employers extend beyond these actuarial projections. First, health care supports a workforce healthy enough to perform their jobs.[247] Second, benefits may boost employee satisfaction and improve retention, thereby enhancing productivity and avoiding turnover costs.[248] But while employers are undoubtedly interested in retaining the best employees, the average employee turnover rate was 47.2% in 2021.[249] In frontline retail—such as in the Walmart and Hobby Lobby examples—the turnover rate is around sixty percent and has been

242. See Weigel et al., supra note 31.

243. See id. ("[As of] 2017 . . . 56% of employers with 500 or more employees cover some type of fertility service, but most do not cover treatment services such as IVF, IUI, or egg freezing.").

244. See Michelle Andrews, Most Employers See a Benefit in Covering Contraceptives, NPR (July 15, 2014), https://www.npr.org/sections/health-shots/2014/07/15/331445402/most-employers-see-a-benefit-in-covering-contraceptives [https://perma.cc/8XMA-GX6G] (noting that "birth control is cheaper to cover than maternity and delivery"); see also KFF & Health Rsch. & Educ. Tr., Employer Health Benefits 186 (2010), https://www.kff.org/wp-content/uploads/2013/04/8085.pdf [https://perma.cc/8XMA-GX6G] (noting that the majority of firms' most-enrolled plans cover contraceptives).

245. Allison McCann, What It Costs to Get an Abortion Now, N.Y. Times (Sept. 28, 2022), https://www.nytimes.com/interactive/2022/09/28/us/abortion-costs-funds.html (on file with the *Columbia Law Review*).

246. Gabriela Dieguez, Bruce S. Pyenson, Amy W. Law, Richard Lynen & James Trussell, The Cost of Unintended Pregnancies for Employer-Sponsored Health Insurance Plans, 8 Am. Health & Drug Benefits 83, 88 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4437481/ [https://perma.cc/AN8M-2E5N].

247. Stephen Miller, Employees Are More Likely to Stay if They Like Their Health Plan, Soc'y for Hum. Res. Mgmt. (Feb. 14, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-benefits-foster-retention.aspx [https://perma.cc/JG8T-PZFR] (quoting from an executive interview that "CEOs care about their employees being healthy, because healthy employees show up to work" (internal quotation marks omitted (quoting Paula Harvey, the vice president for human resources at a manufacturing company))).

248. See Jones, A Different Class, supra note 10, at 720–22.

249. Economic News Release: Job Openings and Labor Turnover Survey News Release, Bureau Lab. Stats. (Mar. 9, 2022), https://www.bls.gov/news.release/archives/jolts_03092022.htm# [https://perma.cc/5S4G-TYDJ].

since before the pandemic.[250] So, many employers view their role as actuaries in the short term, considering only what their employees' health care expenses may be in the present or forthcoming plan year, not on a long-term basis.[251] This churn in the workforce prevents employers from having a long-term commitment to the health outcomes of their employees. The rational employer might dream of having all the benefits of having a lot of women in its workforce while wishing to dodge the pregnant worker or premature baby, knowing the person may have newly joined the organization or may move on the following year to a competitor.

2. *Externalized Costs of Not Covering Reproductive Care.* — When employers do not provide coverage, they effectively externalize the costs of care. These costs may be borne by other sources of third-party funding—primarily public programs (mostly Medicaid) and nonprofit organizations—and individuals and their households. When employers do offer health insurance benefits but choose to exclude reproductive care from the benefit plan, the options for third-party funding are much narrower and the burdens on individuals greater.

Since its creation in 1965, Medicaid has provided a major source of public funding for reproduction and birth. Medicaid is a means-tested public program, limited to those people whose incomes fall below a set cap (between $14,580 and $31,347 a year for an individual in 2023),[252] and states may impose additional eligibility limitations as well.[253] Employers who pay wages below the Medicaid eligibility cap usually do not offer health benefits,[254] externalizing the cost of health care for millions of low-wage employees onto state Medicaid programs.[255] Low-wage employees

250. Id.

251. Cf. Am. Acad. of Actuaries, Drivers of 2023 Health Insurance Premium Changes 3–4 (2022), https://www.actuary.org/sites/default/files/2022-06/PremiumDrivers2023.pdf [https://perma.cc/25NT-HK54] (discussing factors for employers to consider when projecting costs in a single plan year).

252. See Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, KFF (Jan. 1, 2023), https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/ [https://perma.cc/UJE5-MXSJ] (showing that the Medicaid income eligibility limit ranges by state from the federal poverty line ($14,580) in several states to 215% of the federal poverty line ($31,347) in the District of Columbia).

253. See Medicaid Expansion & What It Means for You, HealthCare.gov, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/ [https://perma.cc/Y9L6-LGLD] (last visited Oct. 25, 2023) (highlighting residency and citizenship rules, and that states that have not implemented the ACA's Medicaid expansion may limit enrollment to those with a qualifying disability).

254. Employers who pay very low wages rarely offer benefits to their low-wage workers. See Jones, A Different Class, supra note 10, at 716.

255. Gov't Accountability Off., GAO-21-45, Federal Social Safety Net Programs: Millions of Full-Time Workers Rely on Federal Health Care and Food Assistance Programs 12 (2020), https://www.gao.gov/assets/gao-21-45.pdf [https://perma.cc/98JS-PFMT]

who qualify for Medicaid have coverage only for the reproductive care included in their state Medicaid program, which varies by state. Medicaid covers most (but not all) pregnancy and childbirth care,[256] and the program pays for more than forty percent of births in the United States.[257] State Medicaid programs typically cover contraception,[258] but a majority of states cover neither fertility treatments[259] nor abortion[260] in their Medicaid programs. And the states that do cover abortion must fund that coverage without any federal matching funds due to the Hyde Amendment.[261] The reproductive exceptionalism baked into Medicaid coverage thus leaves most enrollees in need of fertility treatment or abortion care to pay for it entirely out of pocket (also known as "self-pay,"[262] which they categorically cannot afford), find a nonprofit organization offering those services, or forgo care.

Employees with wages above the Medicaid threshold whose employers either offer no coverage or offer extraordinarily skimpy coverage can purchase their own insurance on the exchanges, with subsidies available to defray the costs of coverage for those making less than $58,321.[263] Repro-

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(noting that roughly seventy-two percent of wage-earning adults who rely on Medicaid and SNAP work in industries with a high proportion of low-wage workers).

256. See Amy Chen & Emily Hayes, Nat'l Health L. Program, Q&A on Pregnant Women's Coverage Under Medicaid and the ACA 3 (2018), https://healthlaw.org/wp-content/uploads/2018/09/QA-on-Pregnant-Women%E2%80%99s-Coverage.pdf [https://perma.cc/8SHK-BG5B] ("Full-scope Medicaid in every state provides comprehensive [pregnancy] coverage, including prenatal care, labor and delivery, and any other medically necessary services.").

257. Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, KFF, Medicaid Coverage of Pregnancy-Related Services: Findings From a 2021 State Survey 3 (2022), https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/ [https://perma.cc/4ZVS-JR4Z].

258. Usha Ranji, Ivette Gomez, Alina Salganicoff, Carrie Rosenzweig, Rebecca Kellenberg & Kathy Gifford, KFF, Medicaid Coverage of Family Planning Benefits: Findings From a 2021 State Survey 2 (2022), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/ [https://perma.cc/7889-TUDP].

259. See Weigel et al., supra note 31 ("Only one state Medicaid program covers any fertility treatment, and no Medicaid program covers artificial insemination or in-vitro fertilization.").

260. See State Funding of Abortions Under Medicaid, KFF (June 1, 2023), https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/ [https://perma.cc/6E9P-9VSX].

261. See Harris v. McRae, 448 U.S. 297, 302 (1980) (noting that, since its inception, the Hyde Amendment has prohibited "the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances").

262. See, e.g., Frank A. Sloan, Michael A. Morrisey & Joseph Valvona, Hospital Care for the "Self-Pay" Patient, 13 J. Health Pol. Pol'y & L. 83, 84 (1988).

263. See 26 U.S.C. § 36B (2018) (making premium-assistance tax credits apply to people with incomes 100–400% of the federal poverty level); 42 U.S.C. § 18071 (2018) (providing cost-sharing reduction); see also Brietta R. Clark, Erin C. Fuse Brown, Robert Gatter,

ductive exceptionalism again factored into the negotiation of the marketplace plan rules in the ACA, and although the statute does require that plans cover preventative services (including contraception) among the "essential health benefits" list, it does not include fertility treatments and explicitly excludes abortion from that list.[264] A majority of states have enacted rules prohibiting abortion coverage in marketplace plans, and in the states that permit or require such coverage, the Nelson Amendment requires that the plans themselves go through a morass of administrative steps to ensure that no federal subsidy money contributes to the benefit.[265] Thus, many employed people without employer-sponsored insurance have publicly subsidized private plans that still impose the costs of fertility and abortion care onto the patients and their households.

Employers who offer health benefits but choose not to cover the many aspects of reproductive care made optional under applicable law leave their employees and dependents with even fewer alternative options for funding. First, the jobs with health benefits tend to pay well over the Medicaid income threshold.[266] Second, the ACA generally does not make subsidized individual market coverage available to those with the option of employer-sponsored insurance.[267] So, an employee whose employer plan excludes

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Elizabeth Y. McCuskey & Elizabeth Pendo, Health Law: Cases, Materials and Problems 16 (9th ed. 2022) (explaining the history and operation of these subsidies). Note that there exists an even wider "coverage gap" for low-wage workers in non-expansion states because the ACA's income eligibility for subsidized individual market plans on the exchanges starts at one hundred percent of the federal poverty level (very near the Medicaid cap), meaning that people who have no qualifying disability and incomes below the Medicaid cap are neither eligible for subsidized individual market coverage nor eligible for Medicaid in nonexpansion states. Sara Rosenbaum, The Unfinished Business of Extending Health Care Coverage to All Low-Income Americans, Commonwealth Fund: To the Point (Oct. 31, 2022), https://www.commonwealthfund.org/blog/2022/unfinished-business-extending-health-care-coverage-all-low-income-americans [https://perma.cc/V3L3-W3WA] (estimating that there are 2.3 million people who are "too poor for Affordable Care Act (ACA) subsidies, yet ineligible for Medicaid").

264. See Ikemoto, supra note 116, at 733 (noting the ACA's "coverage of contraception of preventative case, in conjunction with the broad ban on abortion coverage").

265. See Alina Salganicoff, Laurie Sobel & Amrutha Ramaswamy, Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans, KFF (June 24, 2019), https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-in-medicaid-marketplace-plans-and-private-plans/ [https://perma.cc/9DHL-G75B] (arguing that "[t]he Nelson Amendment included in the final law requires plans to segregate funds used for abortion coverage, effectively collecting an additional fee for this coverage, and adding a layer of administrative complexity" that may have deterred many plans from offering coverage). The provision provides that "[a] *State* may elect to prohibit abortion coverage in *qualified health plans* offered through an Exchange in such *State* if such *State* enacts a law to provide for such prohibition." 42 U.S.C. § 18023(a)(1) (emphasis added).

266. See Jones, A Different Class, supra note 10, at 695 ("[H]igh-wage workers tend to receive greater employment benefits than low-wage workers.").

267. People who are eligible for employer-sponsored insurance may be eligible to instead receive subsidies to purchase insurance on the exchange if the employer plan is unaffordable; for 2023, this means the premium for self-coverage must be 9.12% or more of an

needed reproductive care confronts a host of bad options: (1) self-pay for the excluded care, (2) find a nonprofit organization that provides free or reduced-cost care, (3) buy a supplemental plan that covers that care,[268] (4) refuse the employer plan and its tax benefit to buy an individual exchange plan that covers the care and pay full freight, (5) be or become low-income enough to qualify for Medicaid, and even then, only in states that elect to cover the full slate of reproductive services, or (6) forgo the excluded care.

A growing number of people covered by employer-sponsored insurance are *underinsured* (have coverage that does not enable them to afford needed health care), shifting the costs of care directly onto the insured despite the fact that they pay for insurance.[269] The reproductive exceptionalism in the legal infrastructure of employer-sponsored plans makes the underinsurance problem even more acute for reproductive care.[270] Employers' decision to exclude from coverage or impose heavy cost-sharing requirements for reproductive care thus shifts even more of the costs of care—and the costs of forgoing care—directly onto patients themselves, particularly women. As costs of insurance have risen, employer plans have increasingly imposed cost-sharing on employees.[271] For childbirth, the average cost-sharing imposed on insured patients rose from 12.3% in 2008 to 19.6% in 2015.[272]

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individual's annual household income. Affordable Coverage, HealthCare.gov, https://www.healthcare.gov/glossary/affordable-coverage/ [https://perma.cc/XM6R-7K3B] (last visited Oct. 24, 2023) (defining "Affordable coverage").

268. Cf. Nat'l Women's L. Ctr., Supplemental Insurance Coverage of Abortion Only Further Encourages the End of All Private Insurance Coverage of Abortion 1–2 (2013), https://nwlc.org/wp-content/uploads/2015/08/supp_ins_covg_abortion_factsheet_12-6-13.pdf [https://perma.cc/NE2P-BF5G] ("Politicians who promote bans on insurance coverage of abortion and claim to offer women an alternative through supplemental coverage are holding out a false promise. Supplemental coverage of abortion is just another attempt to ban all private insurance coverage of abortion, thereby making abortion more difficult to obtain.").

269. See Collins et al., supra note 21 (highlighting that forty-three percent of adults were inadequately insured in 2022).

270. See Sara Rosenbaum, Women and Health Insurance: Implications for Financing Preconception Health, 18 Women's Health Issues S26, S26 (2008) (noting the uncertainty surrounding what reproductive services will be covered in State Insurance Exchanges); cf. Richard G. Stefanacci, Impact of Health Care Reform on Reproductive Service Providers, 58 J. Reprod. Med. 3, 3 (2013).

271. See Hughes et al., supra note 240.

272. Michelle H. Moniz, A. Mark Fendrick, Giselle E. Kolenic, Anca Tilea, Lindsay K. Admon & Vanessa K. Dalton, Out-of-Pocket Spending for Maternity Care Among Women With Employer-Based Insurance, 2008–15, 39 Health Affs. 18, 20 (2020). The ACA does, however, place upper limits on employers' ability to minimize costs. See The Health Plan Categories: Bronze, Silver, Gold & Platinum, HealthCare.gov, https://www.healthcare.gov/choose-a-plan/plans-categories/ [https://perma.cc/6BPD-C2MA] (last visited Oct. 25, 2023) (requiring employers to pay a minimum of 60% of premiums to satisfy the employer mandate and capping employees' out-of-pocket costs at 9.86% of household income).

In these gaps where third-party funding fails to cover reproductive care or make it affordable, providers may offer that care at reduced cost to patients in need. This model of care, in which the providers' services are available to patients without a claims-processing intermediary, has been described as *direct care*.[273] The providers themselves may receive salary or other compensation from public programs or from private institutions, but the compensation flows directly from the funding institution to the provider and not through the patient. At the federal level, Title X grants support clinics that provide patients with nonabortion family-planning services.[274] Because reproductive exceptionalism has excluded so much reproductive care from public funding and publicly funded facilities, direct-care clinics specializing in reproductive care funded by private nonprofits have proliferated.[275] Private funding for Planned Parenthood and the networks of independent clinics that provide reproductive care shoulder some of the burden of employers' choice not to cover abortion.

For the great majority of excluded care, however, the individual bears the burden of paying for it or, more likely, not receiving it.

Employers have used their legally enshrined flexibility in plan design to make a variety of choices about coverage for major reproductive services. Thus, for the 159 million Americans covered by employer-sponsored health insurance, the practical ability to pay for these services varies widely based on the characteristics and choices of their employers. This practical dimension of financial access has long placed employers in a gatekeeping role for reproductive care. The numerous insurance carveouts for contraception, abortion, and fertility enable employers to more readily deny coverage for these aspects of care, making health insurance regulation a source of reproductive exceptionalism in law.[276] These financial hurdles compound the effects of *Dobbs*, which has allowed states to more severely limit the number of available providers for these services, even if they are covered by insurance. They drive more of the burden of reproductive care

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273. See, e.g., Leona Rajaee, What Is Direct Care?, Elation Health Blog (June 8, 2022), https://www.elationhealth.com/resources/blogs/what-is-direct-care [https://perma.cc/B3QR-XADS].

274. See Cong. Rsch. Serv., IF10051, Title X Family Planning Program 2 (n.d.), https://crsreports.congress.gov/product/pdf/IF/IF10051 [https://perma.cc/VE5P-GJDC] (last updated June 8, 2023).

275. See Abortion Care Network, supra note 48, at 3 (noting that hospitals and physician practices account for only four percent of all abortion procedures provided in the United States and that Planned Parenthood and independent clinics provide the rest).

276. See, e.g., Maya Manian, The Consequences of Abortion Restrictions for Women's Healthcare, 71 Wash. & Lee L. Rev. 1317, 1318–20 (2014) (discussing the negative effects of isolating abortion from other areas of women's health); Gillian E. Metzger, Abortion, Equality, and Administrative Regulation, 56 Emory L.J. 865, 898 (2007) (arguing for a shift away from "abortion-specific regulation[s]" toward regulations that focus on "legitimate health concerns" affecting women's health more generally); see also Caitlin E. Borgmann, Abortion Exceptionalism and Undue Burden Preemption, 71 Wash. & Lee L. Rev. 1047, 1048 (2014) (describing "abortion exceptionalism" specifically).

onto the direct-care clinics that have responded to reproductive exceptionalism and, ultimately, onto the patients themselves.

II. THE TENSION BETWEEN REPRODUCTIVE JUSTICE AND EMPLOYER-SPONSORED INSURANCE

Political and legal discourse consider reproductive autonomy an individual choice made in concert with one's health care providers.[277] In reality, employers enjoy great power over access to reproductive services for most Americans, and this power undercuts individual reproductive autonomy.

While employers' ostensible role is to arrange health care benefits on behalf of their employees and dependents,[278] employers are not bound to serve these individuals' interests and have long resisted providing coverage for many facets of reproductive care or for leave to support caring for children. Far from centering reproductive justice and autonomy, the actuarial interests of benefits providers and the economic interests of businesses largely inform employers' coverage decisions. This puts employer-sponsored insurance in inherent tension with reproductive justice, both conceptually and practically. That employers' interests may sometimes converge with the expansion of access to reproductive care does not resolve the inherent tension. Instead, this Part argues that the pursuit of reproductive justice demands decoupling reproductive care access from employers' control.

A. *Employers' Actuarial and Ideological Interests Versus Individuals' Reproductive Autonomy*

Perhaps the most fulsome framework to explore individual reproductive autonomy is the reproductive justice framework, which distills individual reproductive autonomy into three essential determinations: whether to have a child, when to have a child, and how to raise one's children in a

277. See, e.g., Yvonne Lindgren, The Rhetoric of Choice: Restoring Healthcare to the Abortion Right, 64 Hastings L.J. 385, 386 (2013) (explaining feminist language of reproductive choice as in tension with "the medical model [which] sought to characterize abortion as an aspect of healthcare and thereby to vest the final decisionmaking authority with doctors").

278. See John Bronsteen, Brendan S. Maher & Peter K. Stris, ERISA, Agency Costs, and the Future of Health Care in the United States, 76 Fordham L. Rev. 2297, 2304–05 & n.24 (2008) (explaining how covered employees lack the "strict authority" to ensure that their employer insurer serves their interests); Maher, Employment-Based Anything, supra note 55, at 1294 (employers "are not . . . good agents" of their employees' interests in benefits, "absent extensive interventionist regulation"); Dayna Bowen Matthew, Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire, 31 Wake Forest L. Rev. 1037, 1040–41 (1996) (discussing how the health care interests of employees and employers diverge).

safe, healthy, and supportive environment.[279] The determination to reproduce and to not reproduce are two sides of the same coin of reproductive autonomy. Thus, access to medical services that *prevent* reproduction and enable timing are as important as those that *enable* reproduction. Reproductive justice also looks behind these conceptual dimensions of autonomy, too, emphasizing that legal rights alone are insufficient for reproductive autonomy.[280] Thus, reproductive justice recognizes that rights are meaningless without the economic and social resources needed to effectuate them, especially for groups long excluded from those resources, such as low-income women and people of color.[281]

The employer-sponsored insurance model lies in direct tension with the primary goals of the reproductive justice framework regarding individpush thual interests to both reproduce and avoid or delay reproduction.

1. *Conception, Pregnancy, and Childrearing*. — There is an antinatalist bent among American employers.[282] While the Pregnancy Discrimination Act forbids many employers from taking discriminatory actions against their pregnant employees,[283] this law does not change the reality that employee reproduction can often run counter to the business and economic interests of the employer, the actuarial interests of the employer's health plan, and sometimes the interests of the larger employee group

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279. See Roberts, Reproductive Justice, supra note 19.

280. See Rebouché, supra note 19, at 1431.

281. See id.

282. "Natalism" and "antinatalism" describe attitudes and policies about the desirability of reproduction; natalists encourage reproduction, while antinatalists discourage it. Compare Natalism, Merriam-Webster, https://www.merriam-webster.com/dictionary/natalism [https://perma.cc/G5EC-8HSE] (last visited Oct. 25, 2023) (defining "natalism" as "an attitude or policy favoring or encouraging population growth"), and Emma Green, The Rebirth of America's Pro-Natalist Movement, The Atlantic (Dec. 6, 2017), https://www.theatlantic.com/politics/archive/2017/12/pro-natalism/547493/ (on file with the *Columbia Law Review*) (citing the Child Tax Credit as a pronatalist policy), with Kirk Lougheed, Antinatalism, Internet Encyc. of Phil., https://iep.utm.edu/anti-natalism/ [https://perma.cc/AM5U-R4RK] (last visited Oct. 25, 2023) (describing the different modes and philosophies of antinatalism), and Joshua Rothman, The Case for Not Being Born, New Yorker (Nov. 27, 2017), https://www.newyorker.com/culture/persons-of-interest/the-case-for-not-being-born (on file with the *Columbia Law Review*) (describing one antinatalist philosopher's belief that "life is so bad, so painful, that human beings should stop having children for reasons of compassion").

283. 42 U.S.C. § 2000e-2 (2018) makes it unlawful for an employer "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex." 42 U.S.C. § 2000e(k) defines "because of sex" or "on the basis of sex" to include "because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits . . . as other persons not so affected."

given workload issues and insurance costs.[284] Faced with the vast discretion the law gives employers over whether and what reproductive services to cover, many employers will privilege these many interests over the reproductive justice interests of employees.

Much of America's social policy has been organized around the traditional family wage model, in which all income and benefits are supplied by the household's male head while a female dependent remains at home to handle childbearing, childrearing, and other domestic obligations.[285] For instance, in the 1970s, schools regularly required that their female teachers take unpaid leave upon reaching months four or five of pregnancy and remain on leave for at least one year after delivering a baby.[286] These practices were motivated by the false idea that it was unsafe to work while pregnant, fears of lewdness because of the association between pregnancy and sex, and concerns about pregnant workers' productivity.[287] Feminists challenged this treatment of pregnancy in the workplace as a major barrier to women's equality both in the workplace and outside of it.[288]

Alongside the passage of pregnancy discrimination laws, the number of pregnant women in the workforce has grown dramatically,[289] as has the total number of women in the workforce.[290] Women are more likely now than in previous generations to work, remain working into the third trimester of pregnancy, and return to work after having a baby.[291]

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284. See, e.g., Daisuke Wakabayashi & Sheera Frenkel, Parents Got More Time Off. Then the Backlash Started., N.Y. Times (Sept. 5, 2020), https://www.nytimes.com/2020/09/05/technology/parents-time-off-backlash.html (on file with the *Columbia Law Review*) (last updated July 28, 2021) (reporting on how the extension of family leave during the COVID-19 pandemic was viewed negatively by some childfree workers).

285. See Nancy Fraser, After the Family Wage: Gender Equity and the Welfare State, 22 Pol. Theory 591, 591 (1994).

286. See Deborah Dinner, Recovering the *LaFleur* Doctrine, 22 Yale J.L. & Feminism 343, 346–47 (2010) (documenting practices in some industries of firing women or forcing them into leave once they reported their pregnancies or reached a certain stage of pregnancy).

287. Joanna L. Grossman, Pregnancy, Work, and the Promise of Equal Citizenship, 98 Geo. L.J. 567, 595 (2010).

288. See Reva B. Siegel, Employment Equality Under the Pregnancy Discrimination Act of 1978, 94 Yale L.J. 929, 952–55 (1985) [hereinafter Siegel, Employment Equality] (arguing for the doctrine of sex equality to recognize reproductive difference "in order to scrutinize inegalitarian relations predicated upon it in the . . . economic sphere[]").

289. See Carly McCann & Donald Tomaskovic-Devey, Ctr. for Emp. Equity, Pregnancy Discrimination at Work 8 (2021), https://www.umass.edu/employmentequity/sites/default/files/Pregnancy%20Discrimination%20at%20Work.pdf [https://perma.cc/MZ63-BLGY]. The number has grown from about 45% continuing to work in the 1960s up to 65% in 2008. Id.

290. See Grossman, supra note 287, at 574–75.

291. See id.; see also Brian Knop, Are Women Really Opting Out of Work After They Have Babies?, U.S. Census Bureau (Aug. 19, 2019), https://www.census.gov/library/stories/2019/08/are-women-really-opting-out-of-work-after-they-have-babies.html [https://perma.cc/LF9L-2R56] (explaining census data that reveals that most women return to the

Employers have had to accommodate pregnancy, but the transition has not been an easy one. The EEOC received over 40,000 complaints of pregnancy discrimination between 2010 and 2022.[292] Almost forty percent of all gender-based job discrimination suits involve pregnancy,[293] and an estimated 250,000 women are denied a pregnancy-related accommodation at work each year.[294]

The most common type of EEOC pregnancy complaint is wrongful termination.[295] Pregnancy-related firings are often swift, occurring on the day the employee announces the pregnancy to the employer.[296] The health care and insurance industries have the most complaints;[297] discrimination is also more likely to occur the more male-dominated the field.[298]

Employers may be acting in what they perceive as their own self-interest, viewing pregnant people as "financial liabilit[ies]."[299] Concerns about the capabilities and commitment of pregnant workers, loss of qualified workers from the workplace, and expenses to accommodate job modifications and leave during and after pregnancy influence employers' decisions.[300] Employers may also be accommodating other workers' concerns about organizational fairness and workload in occupations in which pregnant

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workforce within one year of childbirth, though women with a graduate or professional degree are more likely to resume work than women with a high school degree or less).

292. Pregnancy Discrimination Charges FY 2010–FY 2022, EEOC, https://www.eeoc.gov/data/pregnancy-discrimination-charges-fy-2010-fy-2021 [https://perma.cc/DNW8-57V2] (last visited Oct. 25, 2023).

293. Reginald A. Byron & Vincent J. Roscigno, Relational Power, Legitimation, and Pregnancy Discrimination, 28 Gender & Soc'y 435, 444 (2014) (finding forty percent of gender-based firing cases filed by women to be related to pregnancy in a study of all such cases filed in Ohio between 1986 and 2003).

294. This estimate is conservative, given other data suggesting that about one-third of women do not seek accommodations despite needing one. McCann & Tomaskovic-Devey, supra note 289, at 8–9; see also Byron & Roscigno, supra note 293, at 436 (noting that "[v]ulnerability to being terminated is an especially widespread issue for pregnant women").

295. McCann & Tomaskovic-Devey, supra note 289, at 15–16; see also Byron & Roscigno, supra note 293, at 436. Employers often justify these terminations ex post facto by citing neutral meritocratic policies or financial concerns. See McCann & Tomaskovic-Devey, supra note 289, at 15; see also Byron & Roscigno, supra note 293, at 452–54.

296. See McCann & Tomaskovic-Devey, supra note 289, at 15–16.

297. Id. at 18–20, figs.1 & 2.

298. Id. at 20, fig.2.

299. Reginald A. Byron, Discrimination, Complexity, and the Public/Private Sector Question, 37 Work & Occupations 435, 460 (2010).

300. See Byron & Roscigno, supra note 293, at 439 ("Compared to other workers, pregnant employees are, on average, viewed as less competent and committed to their job . . . ."); see also Grossman, supra note 287, at 577 (citing research which found that pregnant women "were viewed as overly emotional, often irrational, physically limited, and less than committed to their jobs" (quoting Jane A. Halpert, Midgle L. Wilson & Julia L. Hickman, Pregnancy as a Source of Bias in Performance Appraisals, 14 J. Organizational Behav. 649, 652–55 (1993))).

people receive accommodations[301] or accommodating customers' sensibilities.[302]

Though not as clearly captured by law, there is evidence of discrimination by employers into the "fourth trimester," in employers' failure to accommodate breastfeeding, increased care obligations, and the bodily recovery of their workers after giving birth.[303]

Pregnancy discrimination claims steadily persist decades after the passage of the PDA.[304] What one advocacy group—the National Partnership for Women & Families—finds striking is not that this discrimination persists but that "frequently cases involve straightforward violations of the PDA that seem to be fueled by a fundamental resistance to having pregnant women in the workplace."[305] Particularly, the year 2020 saw a sharp increase in cases, likely related to the pandemic and job market stressors.[306] Employers have historically attempted to avoid paying for contraception and maternity care for pregnant spouses of employees.[307] More recently, after the ACA extended family plans to cover adult children up to age

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301. Byron & Roscigno, supra note 293, at 440 ("[C]oworkers sometimes express concern about organizational fairness surrounding the workload accommodations that pregnant employees receive." (citations omitted)); see also Grossman, supra note 287, at 614 (noting that the PDA requires an employer to "provide accommodations only to the extent it provides them for other temporarily disabled employees").

302. See Byron & Roscigno, supra note 293, at 440 ("[T]he pregnant body itself—a body that is often portrayed as ailing, hormonal, and uncontrollable—is sometimes thought to disrupt organizational space by affecting coworker and patron comfort levels." (citation omitted)).

303. See Saru M. Matambanadzo, The Fourth Trimester, 48 U. Mich. J. Legal Reform 117, 120–21, 138 (2014) (arguing that current discrimination law "fails to account for the challenges of the fourth trimester," including "breastfeeding, infant care, and post-pregnancy recovery").

304. McCann & Tomaskovic-Devey, supra note 289, at 8–9 (discussing a study of pregnancy complaints from 2012–2016 which concluded that "an estimated 250,000 women are denied accommodations related to their pregnancies each year"). For less recent data on EEOC complaints, see Nat'l P'ship for Women & Fams., The Pregnancy Discrimination Act: Where We Stand 30 Years Later 5 (2008), https://nationalpartnership.org/wp-content/uploads/2023/02/pregnancy-discrimination-act-30-years-later.pdf [https://perma.cc/NE5F-PLH4] [hereinafter Nat'l P'ship for Women & Fams., PDA] (discussing the main findings from a study of EEOC pregnancy discrimination charges filed between 1996 and 2005).

305. Nat'l P'ship for Women & Fams., PDA, supra note 304, at 10.

306. See Katie Sear & Dori Goldstein, Analysis: Pregnancy Bias Suits Keep Rising Amid Pandemic, Bloomberg L. Analysis (Jan. 29, 2021), https://news.bloomberglaw.com/bloomberg-law-analysis/analysis-pregnancy-bias-suits-keep-rising-amid-pandemic (on file with the *Columbia Law Review*) (noting a sixty-seven percent rise in claims between 2016 and 2020, with 2020 seeing the biggest rise of claims in three years).

307. See Erickson v. Bartell Drug Co., 141 F. Supp. 2d 1266, 1271 (W.D. Wash. 2001) (finding that an employer's "exclusion of prescription contraception from its prescription plan is inconsistent with the requirements of federal law"); Steven Lee Lapidus, Note, Pregnancy Discrimination, Equal Compensation and the Ghost of *Gilbert*: Medical Insurance Coverage for Spouses of Employees, 51 Fordham L. Rev. 696, 721 (1983) (noting that employers seeking to "trim costs" excluded coverage of "expenses resulting from the pregnancy-related conditions of [employees'] spouses").

twenty-six, many employers chose not to cover maternity care for these dependents.[308] Anticipation of these costs may drive employers to disfavor their employees who have the mere *potential* to become pregnant.[309]

In addition to punishing pregnancy, employers have generally not been supportive of policies that facilitate employee reproduction more broadly, such as coverage for fertility treatments and ART (which very few companies currently opt to cover).[310] The United States is also an outlier among other developed nations for its failure to mandate paid parental leave.[311] The Family Medical Leave Act of 1993 requires employers to grant up to 12 weeks of *unpaid* leave in certain circumstances.[312] But less than half of employed women have access to *paid* parental, family, and medical leave.[313] Such leave is even less likely for workers in part-time positions, lower wage workers, workers with less education, and those living in rural locations.[314] More than three-quarters of lower-income female workers and thirty-eight percent of higher-wage female workers report losing pay to stay at home and care for sick children, in part owing to insufficient family and sick leave.[315] Federal workers gained access to twelve weeks of parental

308. See Michelle Andrews, Insurance Still Doesn't Cover Childbirth for Some Young Women, NPR (June 16, 2015), https://www.npr.org/sections/health-shots/2015/06/16/414688210/insurance-still-doesnt-cover-childbirth-for-some-young-women [https://perma.cc/Z3D7-D63Z] (noting that denying coverage for the maternity care of dependent children under large employer plans is "common").

309. See id. (emphasizing how "some employers have long tried to sidestep paying for maternity care").

310. Tom Murphy & Associated Press, Most of the Biggest U.S. Employers Now Cover Fertility Treatments, but Many Americans Still Can't Afford It, Fortune (May 16, 2023), https://fortune.com/2023/05/16/most-biggest-us-employers-cover-fertility-treatments-many-americans-still-cant-afford/ [https://perma.cc/9P3V-MPRV] (explaining that over half of large employers cover infertility treatments, but coverage gets "spotty" the smaller the employer).

311. Siegel, Employment Equality, supra note 288, at 942 ("Seventy-five countries, including . . . every industrialized country except the United States, provide some form of statutory maternity leave or parental benefit.").

312. 29 U.S.C. § 2601 (2018).

313. See Usha Ranji, Michelle Long, Brittni Frederiksen, Karen Diep & Alina Salganicoff, Workplace Benefits and Family Health Care Responsibilities: Key Findings From the 2022 KFF Women's Health Survey, KFF (Nov. 16, 2022), https://www.kff.org/womens-health-policy/issue-brief/workplace-benefits-and-family-health-care-responsibilities-key-findings-from-the-2022-kff-womens-health-survey/ [https://perma.cc/GWP5-REQV]. According to the 2022 Kaiser Family Foundation Women's Health Survey, "43% of employed women ages 18–64 say their employer offers paid parental leave and 44% say their employer offers paid family and medical leave," compared with 63% reporting paid sick leave. Id.

314. Seventy-three percent of full-time female workers report employers offering paid sick leave compared to 31% of part-time workers and 18% of those self-employed. Women with a college degree are likelier to have access to paid parental leave than those without a college degree (52% versus 36%). Id.

315. Id.; see also Jones, A Different Class, supra note 10, at 712 (discussing the effects of low-wage workers having less access to parental and sick leave than high-wage workers).

leave only recently, in 2020.[316] Less than ten percent of female workers report receiving assistance with childcare through their work, whether through on-site childcare or childcare subsidies.[317]

Fortune 500 companies have long lobbied against federal efforts to mandate any form of parental leave. When major business interest groups have come out in support of such regulations, they have advocated for preemption from state and local standards for employers that meet a minimum floor of coverage.[318] Where states have encouraged the creation of family leave policies, those voluntary policies are often less generous and more costly than a mandated public program.[319]

Despite the antinatalist bent among American employers, firms do, in certain circumstances, find it useful to expand benefits to attract and retain their desired workforce—or even their customer base. For example, a 2022 survey of benefits executives found that "[a] sense of paternalism, the desire to use health benefits as a recruitment and retention tool, and the preference to retain control over plan design" motivate employers to continue offering health benefits.[320] Considering employee satisfaction as a recruitment and retention tool, employers may respond to different preferences among their workers or desired hires. Employers with a younger workforce or a more predominantly female one may try to design a benefit plan that is attractive to them by covering more

316. National Defense Authorization Act for Fiscal Year 2020, Pub. L. No. 116-92, § 7602, 133 Stat. 1198, 2306 (2019) (codified at 5 U.S.C. § 6382 (2021)) (establishing twelve workweeks of paid parental leave for federal employees).

317. Ranji et al., supra note 313.

318. See, e.g., Letter from David N. Barnes, Vice President of Glob. Workforce Pol'y, IBM Corp., to Joan Harrigan-Farrelly, Deputy Dir., DOL (Sept. 14, 2020), https://aboutblaw.com/Ta5 [https://perma.cc/8JRP-2FAC] (advocating that employers that meet federal sick-, family-, and medical-leave requirements not be subject to state or local requirements); Letter from Timothy J. Bartl, President & CEO, HR Pol'y Ass'n, to Joan Harrigan-Farrelly, Deputy Dir., DOL 2, https://aboutblaw.com/Ta2 [https://perma.cc/FM6D-KU56] (last visited Oct. 24, 2023) (arguing that compliance with either federal or state paid leave laws should exempt employers from compliance with the other); Letter from Aliya Robinson, Senior Vice President, Ret. & Comp. Pol'y, ERISA Indus. Comm., to Joan Harrigan-Farrelly, Deputy Dir., DOL 1 (Sept. 14, 2020), https://aboutblaw.com/Ta0 [https://perma.cc/C5ZL-RMF8] (urging lawmakers to establish a national paid leave exemption that relieves firms that already provide generous paid leave benefits from state and local mandates).

319. See Deborah A. Widiss, Privatizing Family Leave Policy: Assessing the New Opt-In Insurance Model, 55 Seton Hall L. Rev 1543, 1548–49 (2023) (noting that "mandatory paid leave policies implemented by states . . . tend[] to keep per-person costs exceptionally low" as compared to opt-in approaches).

320. Spiegel & Fronstin, supra note 228. But cf. HHS, Employer Decisionmaking, supra note 102 (finding in 2000, before the ACA, that employers' "[b]enefits philosophies in general [we]re seen as becoming less paternalistic and more sensitive to marketplace competition").

of the reproductive care they are likely to need.[321] But that responsiveness is often confined to the higher-wage, benefits-rich jobs occupied less often by women.[322]

Increasingly, women in the workplace expect comprehensive coverage of reproductive care as part of their benefits packages and do consider these benefits in particular during job selection.[323] The growing rates of women with children in the workplace, in higher-skilled positions, and with higher educational attainment[324] might increase pressure on employers to meet the needs of their female employees. Now that *Dobbs* has enabled state legislatures to ban or strictly limit abortion, companies headquartered in abortion-restricting states particularly may seek to fend off a loss of talent.[325] At the same time, not every employee shares these preferences, and employers and employees alike worry about the rising costs of health insurance.[326]

Consider the question whether an employer plan will cover fertility treatments and assisted reproductive technologies.[327] Because the forces of

321. See, e.g., HHS, Employer Decisionmaking, supra note 102 (noting the "[c]ultural and generational differences between younger and older workers" and how "employers . . . have to adjust their [benefit] programs to respond to this evolution in employee careabouts").

322. See Jones, A Different Class, supra note 10, at 732–42 ("[L]ow-wage workers are disproportionately women.").

323. See Hasselbacher et al., supra note 181, at 3 (describing a 2018 survey of employed women in which "more than half . . . said benefits offering full reproductive care would be a deciding factor between two employment offers").

324. Rakesh Kochhar, Women Make Gains in the Workplace Amid a Rising Demand for Skilled Workers, Pew Rsch. Ctr. (Jan. 30, 2020), https://www.pewresearch.org/social-trends/2020/01/30/women-make-gains-in-the-workplace-amid-a-rising-demand-for-skilled-workers/ [https://perma.cc/SBS8-6E22]; see also Matt Gonzales, More Mothers of Small Children Are Working Than Ever Before, SHRM (Sept. 14, 2023), https://www.shrm.org/topics-tools/news/inclusion-equity-diversity/mothers-small-children-working-ever (on file with the *Columbia Law Review*).

325. Some employers support relocation to abortion-friendly states. See, e.g., Memorandum from Sec'y of Def. to Senior Pentagon Leadership (Oct. 20, 2022), https://media.defense.gov/2022/Oct/20/2003099747/-1/-1/1/MEMORANDUM-ENSURING-ACCESS-TO-REPRODUCTIVE-HEALTH-CARE.PDF [https://perma.cc/C6D9-536X] (noting that service members' locations, dictated by staffing, operational, and training requirements, "should not limit their access to reproductive care").

326. E.g., Irina Ivanova, Male Employees Seem to Really Hate It When Their Companies Advertise Abortion Access—But It Makes the Job Applications Roll In, Fortune (Aug. 9, 2023), https://fortune.com/2023/08/09/healthcare-reproductive-rights-male-employees-companies-abortion-access-job-application-polarization-workplace/ [https://perma.cc/5PPP-JT4U].

327. See Valarie Blake, It's an ART Not a Science: State-Mandated Insurance Coverage of Assisted Reproductive Technologies and Legal Implications for Gay and Unmarried Persons, 12 Minn. J.L. Sci. & Tech. 651, 653 (2011) (noting that ART coverage has been mostly a private-payer issue, but states have begun mandating it to ensure broader access). To understand the debate surrounding mandatory coverage of these services, compare David B. Seifer, Ethan Wantman, Amy E. Sparks, Barbara Luke, Kevin J. Doody, James P. Toner, Bradley J. van Voorhis, Paul C. Lin & Richard H. Reindollar, National Survey of the

reproductive exceptionalism described in Part I have made these services optional in insurance, employers may choose to offer these benefits to make themselves more attractive to skilled workers in a competitive labor market—particularly highly educated women who may value the ability to delay childbearing for career advancement. High-tech companies like Apple, Facebook, and Google touted these benefits for salaried employees.[328] Similarly, some universities and other white-collar industries have begun offering coverage.[329]

But the interest convergence evident in optional extension of fertility benefits still undermines reproductive justice in at least two respects. First, it serves the employers' interests in avoiding pregnancy in their workforce by encouraging the delay of pregnancy, contributing to the gestalt of antinatalism.[330] Second, it widens the economic status and racial divide in access to fertility treatments[331] because companies most often offer this benefit to the high-wage, highly educated workforce and rarely to lower-skilled and lower-wage or part-time workers most in need of resources and least able to exert clout in the labor market.[332] Class, race, and gender biases intersect in these employer motivations to provide fertility and family leave benefits because "for high-wage workers" who are disproportionately white and male, "having children is viewed very positively," whereas "for low-wage workers, and poor Black and Latina women" in particular, having children "is seen as a sign of irresponsible

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Society for Assisted Reproductive Technology Membership Regarding Insurance Coverage for Assisted Reproductive Technologies, 110 Fertility & Sterility 1081, 1081 (2018) (summarizing survey results showing that the majority of respondents want insurance to cover fertility treatments for specific segments of vulnerable populations), with Katie Falloon & Philip M. Rosoff, Who Pays? Mandated Insurance Coverage for Assisted Reproductive Technology, 16 AMA J. Ethics 63, 65–66 (2014) (arguing that mandated insurance coverage for infertility treatments is inadvisable policy for "a variety of troubling reasons").

328. See Dara Kerr, Egg Freezing, So Hot Right Now, CNET (May 22, 2017), https://www.cnet.com/tech/tech-industry/egg-freezing-so-hot-right-now/ [https://perma.cc/9EAT-ZLV3] (noting that various tech companies are offering egg-freezing benefits for female employees).

329. See Karen Gilchrist, Egg Freezing, IVF and Surrogacy: Fertility Benefits Have Evolved to Become the Ultimate Workplace Perk, CNBC (Mar. 14, 2022), https://www.cnbc.com/2022/03/14/egg-freezing-ivf-surrogacy-fertility-benefits-are-the-new-work-perk.html [https://perma.cc/NB7J-A2FN] (last updated Oct. 4, 2022); , Rise in Fertility Benefits From U.S. Employers, CBS: MoneyWatch, at 00:26 (Apr. 19, 2022), https://www.cbsnews.com/video/moneywatch-fertility-benefits-us-employers/#x [https://perma.cc/4KRY-AE39].

330. See Joya Misra, This "Perk" Masks the Larger Issue of Wage Penalties for Motherhood, N.Y. Times (Oct. 16, 2014), https://www.nytimes.com/roomfordebate/2014/10/15/freezing-plans-for-motherhood-and-staying-on-the-job/this-perk-masks-the-larger-issue-of-wage-penalties-for-motherhood (on file with the *Columbia Law Review*) ("[P]olicies that encourage women to freeze their eggs supposedly to delay parenthood[] may actually discourage women from becoming mothers altogether.").

331. See, e.g., Jamie M. Merkison, Anisha R. Chada, Audrey M. Marsidi & Jessica B. Spencer, Racial and Ethnic Disparities in Assisted Reproductive Technology: A Systematic Review, 119 Fertility & Sterility 341, 346 (2023).

332. See Jones, A Different Class, supra note 10, at 693–95.

behavior."[333] While it may give a public boost to a company's image, the selective extension of these benefits perpetuates biases.

This is also an era of increased consumer appreciation of socially conscious branding. Having captured the public's attention, *Dobbs* shines a spotlight on employers' coverage of abortion care. Companies may capitalize on popular opinion, given that most Americans oppose *Dobbs* and believe abortion should be legal in all or many circumstances.[334] Employees and customers alike may appreciate an employer who sides with health care access,[335] prompting companies to position themselves as champions of reproductive freedom and equal rights for women in the workforce.[336] Vox Media's CEO said, "[*Dobbs*] puts families, communities, and the economy at risk, threatening the gains that women have made in the workplace over the past 50 years."[337] Other reproductive services like prenatal care, pregnancy, and delivery, however, do not exert the same pressure on employers to state on the record their viewpoints and practices.

Expansions of benefits that enable and support reproduction have historically had to be mandated by law. When undertaken voluntarily without regulatory intervention, these expansions of employer benefits represent a fragile interest convergence that follows employers' perceptions of their interests and does not typically extend to low-wage workers. In short, interest convergence reinforces the power dynamic that places employers as gatekeepers to care for conception, pregnancy, birth, and childrearing.

2. *Contraception and Abortion.* — While employers' economic and actuarial interests undercut one dimension of reproductive justice, that of procreation, these very same forces would seem to motivate employers to support the dimension of reproductive justice that involves avoiding procreation. Yet the history and variety of employers' objections to covering contraception and abortion demonstrate irresolvable tensions here, too.

Coverage for contraception was nearly nonexistent in group health plans at the beginning of the ERISA era of employer-sponsored insurance

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333. Id. at 738–43.

334. See Pew Rsch. Ctr., Majority of Public Disapproves of Supreme Court's Decision to Overturn *Roe v. Wade* 4 (2022), https://www.pewresearch.org/politics/wp-content/uploads/sites/4/2022/07/PP_2022.07.06_Roe-v-Wade_REPORT.pdf [https://perma.cc/SN3N-8SHE].

335. See Emma Goldberg, These Companies Will Cover Travel Expenses for Employee Abortions, N.Y. Times (Aug. 19, 2022), https://www.nytimes.com/article/abortion-companies-travel-expenses.html (on file with the *Columbia Law Review*) (detailing the companies that have affirmed their commitment to helping employees have access to health care).

336. See id. (relaying a statement from Levi Strauss & Co. saying that "[p]rotection of reproductive rights is a critical business issue impacting our work force, our economy and progress toward gender and racial equity").

337. A Note from Vox Media CEO Jim Bankoff on the Supreme Court Decision Overturning *Roe v. Wade*, Vox Media (June 24, 2022), https://www.voxmedia.com/2022/6/24/23181817/a-note-from-vox-media-ceo-jim-bankoff-on-the-supreme-court-decision-overturning-roe-v-wade [https://perma.cc/G2QQ-DCQX].

in 1978, and plans at that time covered sterilization and abortion at higher rates than contraception.[338] Some plans justified the exclusion as avoiding the cost of covering contraception, despite the actuarial logic and evidence that covering contraception saves plans the costs of unintended pregnancies and births.[339] By the time that President Bill Clinton proposed a sweeping health reform plan in 1993, this was still the case in the vast majority of plans.[340] After the comprehensive Clinton health plan failed to pass, members of Congress introduced some individual bills that would have required plans to cover contraception.[341] When those too failed to pass, states enacted their own contraceptive coverage mandates.[342] As Professor Sylvia Law posed in 1998, "[T]he [continued] exclusion and limitation of coverage for contraceptive services in employment-based insurance programs violates the PDA,"[343] and litigation has sought to force particular employers to add coverage.[344]

These decades of wrangling over contraception (which continues to the present day) illustrate how most employers have resisted covering contraception in their plans until political will or labor power forced them to do so.[345] The ACA, at long last, indirectly required group plans to

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338. See Charlotte F. Mueller, Insurance Coverage for Contraception, 10 Fam. Plan. & Persps. 71, 77 (1978) (finding in a survey of group plans that, as of 1978, "[c]ontraceptive coverage, in contrast to abortion[] and . . . sterilization coverage, is almost nonexistent" and that only "one company's basic contract cover[ed] all contraceptive services").

339. See id. at 75 (noting that covering "[c]ontraceptive services [is] cost-effective because without them either abortions or deliveries would ensue, both of [which are] more expensive than family planning"). Other plans "sometimes justif[ied] limited maternity benefits on the grounds that pregnancy is planned and is not outside personal control, [even though] the reasoning is weakened by the failure of carriers to cover adequately both the prevention and the termination of unplanned pregnancies." Id. at 77; see also Cynthia Dailard, The Cost of Contraceptive Insurance Coverage 12–13 (2003), https://www.guttmacher.org/sites/default/files/article_files/gr060112.pdf [https://perma.cc/WUG9-4LBS] (highlighting that covering contraceptives has long been cost effective).

340. See Dailard, Contraceptive Coverage, supra note 148, at 6.

341. See id. (noting that the demise of Clinton's Health Security Act "harkened an era of incremental reform").

342. Id. at 7 (describing states' efforts, including California's 1994 bill that linked contraceptive and prescription drug coverage). For a more current overview of state actions to expand contraceptive coverage, see Beyond the Beltway, State Actions to Expand Contraceptive Coverage 2 (2023), https://powertodecide.org/sites/default/files/2023-06/State%20Action%20to%20Protect%20Access%20to%20Contraceptive%20Coverage.pdf [https://perma.cc/GC27-N4YY].

343. Law, supra note 42, at 363–64.

344. See Dailard, Contraceptive Coverage, supra note 148, at 8 (noting how contraceptive coverage advocates used litigation as a tool to apply pressure on individual employers).

345. See B. Jessie Hill, Symposium: The Contraceptives Coverage Controversy—What's Old Is New Again, SCOTUSBlog (Feb. 21, 2014), https://www.scotusblog.com/2014/02/symposium-the-contraceptives-coverage-controversy-whats-old-is-new-again/ [https://perma.cc/K842-7KT5] (summarizing the historical controversy over contraceptive coverage).

cover contraception but still with major exemptions for religious organizations.[346]

Employers, too, continue to seek validation of their owners' religious beliefs through denial of contraceptive coverage for employees and dependents.[347] Organizations that identify as being religiously "pro-life" are not coherently so in their health plans: Most employers who object to covering contraception and pregnancy termination also fail to provide benefits that support reproduction, such as fertility treatment, paid family leave, and childcare.[348]

Consider the example of Hobby Lobby, a private for-profit employer. The craft store owned by evangelical Christians, the Green family, made national news when its challenge to the ACA's contraception mandate went to the Supreme Court.[349] The Greens ultimately won their case, thus establishing that a closely held for-profit company can have religious beliefs that exempt it from providing its employees with contraception.[350]

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346. See supra section I.A.3.

347. See generally Holly Fernandez Lynch & Gregory Curfman, Bosses in the Bedroom: Religious Employers and the Future of Employer-Sponsored Health Care, *in* Law, Religion, Health in the United States 154–68 (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017) (assessing the implications of an employer's religion for an employee's health care coverage).

348. See, e.g., Sofia Resnick, Hobby Lobby Allegedly Fired Employee Due to Pregnancy, Rewire News Grp. (July 29, 2014), https://rewirenewsgroup.com/2014/07/29/hobby-lobby-allegedly-fired-employee-due-pregnancy/ [https://perma.cc/T9JX-C8A9] (alleging that Hobby Lobby both denies contraceptive coverage and fails to show concern for its pregnant employees). In an informal survey on Hobby Lobby employees' satisfaction with Hobby Lobby's maternity policies, respondents' comments included:

> "They refuse to accommodate pregnant workers." (2020).
>
> "They deny certain types of birth control, but won't hold your position and do not have maternity leave. Do NOT get pregnant while working there. And if you do, don't expect to be able to nurse your child or spend time with them. Company first, family last." (2019).
>
> "[M]aternity leave [policy] sucks. Hope you don't plan on having any kids because when you get back you're definitely expected to be working back at 100% on day one. Mentally, emotionally physically or not (man or woman) hope you're ready." (2017).

Maternity and Adoptive Leave at Hobby Lobby, InHerSight.com, https://www.inhersight.com/company/hobby-lobby/maternity-leave [https://perma.cc/T9JX-C8A9] (last visited Oct. 26, 2023); see also Doe v. Catholic Relief Servs., 429 F. Supp. 3d 440, 443–45 (D. Md. 2021) (involving a claim by an employee that his religious employer engaged in unlawful discrimination by removing the employee's same-sex spouse from the employer-sponsored health plan); cf. Anne Branigin, Who Can Access IVF Benefits? A Gay Couple's Complaint Seeks an Answer, Wash. Post (Apr. 13, 2022), https://www.washingtonpost.com/business/2022/04/13/gay-couple-ivf-benefits-discrimination-complaint/ (on file with the *Columbia Law Review*) (reporting on an EEOC class action against the City of New York as an employer alleging that the denial of IVF coverage to same-sex couples is unlawful discrimination).

349. See, e.g., Adam Liptak, Supreme Court Rejects Contraceptives Mandate for Some Companies, N.Y. Times (June 30, 2014), https://www.nytimes.com/2014/07/01/us/hobby-lobby-case-supreme-court-contraception.html (on file with the *Columbia Law Review*).

350. See Burwell v. Hobby Lobby, 573 U.S. 682, 688–93 (2014).

(HHS had already exempted religious nonprofits from the ACA mandate in accordance with the Religious Freedom Restoration Act (RFRA).[351]) The crux of the Greens' objection was their Christian beliefs "that life begins at conception and that it would violate their religion to facilitate access to contraceptive drugs or devices that operate after that point."[352] Hobby Lobby provided evidence that it sometimes loses money in the name of its owners' religious beliefs, pointing to the loss of millions of dollars in revenue annually from being closed on Sundays to observe the Sabbath.[353]

But the case also illuminates some other interests at play. If the company elected to purchase insurance that did not cover these services, they would be fined $100 per day per employee, or roughly $475 million per year for Hobby Lobby.[354] If, instead, it dropped insurance altogether, Hobby Lobby faced substantial penalties of $26 million per year.[355] Dropping insurance altogether would also put companies like Hobby Lobby at a competitive disadvantage in attracting and retaining employees:

> The companies could attempt to make up for the elimination of a group health plan by increasing wages, but this would be costly. Group health insurance is generally less expensive than comparable individual coverage, so the amount of the salary increase needed to fully compensate for the termination of insurance coverage may well exceed the cost to the companies of providing the insurance. In addition, any salary increase would have to take into account the fact that employees must pay income taxes on wages but not on the value of employer-provided health insurance. . . . Likewise, employers can deduct the cost of providing health insurance, . . . but apparently cannot deduct the amount of the penalty that they must pay if insurance is not provided . . . . Given these economic incentives, it is far from clear that it would be financially advantageous for an employer to drop coverage and pay the penalty.[356]

The solution posed by the Court was a double win for Hobby Lobby and other religious objectors. These companies could provide insurance to their employees *and* leave out objected-to contraception without any penalty. The cost of providing the mandatory contraception coverage would instead fall on the third-party insurers, who, in turn, push that cost back onto other employers and their employees.[357] Despite having a solution that kept the

351. See id. at 698–99 (describing how HHS had exempted some religious organizations from the ACA contraception mandate); see also 45 C.F.R. § 147.132 (2023) (listing the religious exemption).

352. *Hobby Lobby*, 573 U.S. at 703.

353. Brief for Respondents at *8, *Hobby Lobby*, 573 U.S. 682 (No. 13-354), 2014 WL 546899.

354. *Hobby Lobby*, 573 U.S. at 720.

355. Id.

356. Id. at 722.

357. See supra section I.B.2.

cost in the private domain, the Court majority could not help sniping at the government: "If, as HHS tells us, providing all women with cost-free access to all FDA-approved methods of contraception is a Government interest of the highest order, it is hard to understand HHS's argument that it cannot be required . . . to pay *anything* in order to achieve this important goal."[358]

The economic interests in exemptions for Hobby Lobby and other religious for-profit employers are opaque but worth interrogating. First, religious organizations may reap savings by shifting some portion of the cost of contraceptive health care for their employees onto other organizations. The additional hurdles created by this shift deter many people from accessing these forms of contraception.[359] While the companies' health plans save money on the objected-to forms of contraception, they are likely to incur greater costs from at least some unwanted pregnancies that the lack of access to those contraceptives may produce.[360]

For Hobby Lobby, however, this short-term cost can be viewed as a potential long-term gain in reputation among powerful religious constituencies and in political influence from the notoriety of their decision.[361] Taking a high-profile political stance of this nature may also appear as a form of corporate social responsibility (CSR), or virtue signaling, branding, and profit seeking.[362] Business owners with credibly conservative evangelical beliefs have parlayed this into access to Supreme Court justices through donations to the Historical Society.[363] Likewise, even when a company does

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358. *Hobby Lobby*, 573 U.S. at 729.

359. See supra sections I.B.1–.2.

360. See supra note 339 and accompanying text.

361. Cf. Interview with Kristin Madison, Professor L. & Health Scis., Northeastern Univ. Sch. of L., in Bos., Mass. (Jan. 18, 2023) (explaining this possibility); Jodi Kantor & Jo Becker, Former Anti-Abortion Leader Alleges Another Supreme Court Breach, N.Y. Times (Nov. 19, 2022), https://www.nytimes.com/2022/11/19/us/supreme-court-leak-abortion-roe-wade.html (on file with the *Columbia Law Review*) (reporting on how antiabortion leaders received advance news of the *Hobby Lobby* Supreme Court opinion).

362. See, e.g., Elizabeth Sepper & James D. Nelson, The Religious Conversion of Corporate Social Responsibility, 71 Emory L.J. 217, 220–21 (2021) (noting that "CSR enthusiasts continue to define religious exemptions as socially responsible behavior"); Christopher Beem, Why Virtue Signaling Isn't the Same as Virtue—It Actually Furthers the Partisan Divide, The Conversation (Aug. 29, 2022), https://theconversation.com/why-virtue-signaling-isnt-the-same-as-virtue-it-actually-furthers-the-partisan-divide-189195 [https://perma.cc/SL6T-4VUB] (defining and providing examples of virtue signaling).

363. See Robert Barnes & Ann Marimow, Justice Alito Denies Disclosing 2014 Hobby Lobby Opinion in Advance, Wash. Post (Nov. 19, 2022), https://www.washingtonpost.com/politics/2022/11/19/alito-hobby-lobby-supreme-court-nyt/ (on file with the *Columbia Law Review*); Jo Becker & Julie Tate, A Charity Tied to the Supreme Court Offers Donors Access to the Justices, N.Y. Times (Dec. 30, 2022), https://www.nytimes.com/2022/12/30/us/politics/supreme-court-historical-society-donors-justices.html (on file with the *Columbia Law Review*) (last updated Jan. 1, 2023); cf. Emma Green, Evangelical Mega-Donors Are Rethinking Money in Politics, The Atlantic (Jan. 2, 2019), https://www.theatlantic.com/politics/archive/2019/01/evangelical-mega-donors/578563/ (on file with the *Columbia Law Review*).

not seem particularly religiously oriented, the owners of that business may have individual fame and notoriety in mind.[364]

Yet, as Professors Elizabeth Sepper and James Nelson have pointed out, there exists a "foundational divergence between the political economies of CSR and corporate religious exemptions."[365] While CSR "looks to the democratic state" for direction and "involves doing more than state or federal laws require, . . . corporate religious exemptions lower the regulatory bar" and "def[y] the[] core commitments" of the democratic state.[366]

Viewed in context, an ostensibly natalist employer policy to discourage contraception more accurately fits this model of defiance and deregulation. The result is that, as Professor Sepper has argued elsewhere, the "underlying premises" of many instances in which businesses seek "religious exemption reflect a tradition of market libertarianism, rather than religious liberty."[367] The use of religious objections, rather than primarily ratifying an employer's natalist values, enables the firm to avoid regulations both requiring coverage and, possibly, prohibiting sex discrimination.[368]

From a reproductive justice vantage, employers who deny coverage for contraception and abortion are as problematic as those who discourage child birthing. Reproductive justice demands control equally over options to reproduce or not. Employers again place their own interests above the reproductive autonomy of individual employees. And while employees can certainly seek to match their own values and preferences over reproductive matters with common-minded employers,

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364. Consider, for example, the conservative activist Steven Hotze, who owns the health care services management firm, Braidwood Management Inc., which is at the helm of the pending Supreme Court litigation, *Braidwood Management Inc. v. Becerra*. See Laurie Sobel, Usha Ranji, Kaye Pestaina, Lindsey Dawson & Juliette Cubanski, Explaining Litigation Challenging the ACA's Preventive Services Requirements: *Braidwood Management Inc. v. Becerra*, KFF (May 15, 2023), https://www.kff.org/womens-health-policy/issue-brief/explaining-litigation-challenging-the-acas-preventive-services-requirements-braidwood-management-inc-v-becerra/ [https://perma.cc/36BC-B8BD]. Braidwood Management is not engaged in any religious activity, but Hotze himself attracts media attention and has taken many high-profile political positions. See, e.g., Zach Despart, GOP Megadonor Steven Hotze Charged After a Bogus Election Fraud Scheme Led a Former Cop to Threaten a Repairman, Tex. Trib. (Apr. 20, 2022), https://www.texastribune.org/2022/04/20/steve-hotze-houston-indicted-voter-fraud/ [https://perma.cc/AY6B-RZ3H] (describing the criminal charges brought against Hotze after he hired over a dozen private investigators to look for voter fraud ahead of the 2020 presidential election).

365. Sepper & Nelson, supra note 362, at 220.

366. Id.

367. Elizabeth Sepper, Free Exercise Lochnerism, 115 Colum. L. Rev. 1453, 1457 (2015).

368. Related issues are being raised in cases challenging coverage for HIV prevention medications. See Braidwood Mgmt. Inc. v. Becerra, 627 F. Supp. 3d 624, 637 n.3 (N.D. Tex. 2022) ("Plaintiffs' . . . complaint asserted [Religious Freedom Restoration Act] claims against compulsory coverage of . . . PrEP drugs . . . ."); Sobel et al., supra note 364 (summarizing the *Braidwood* litigation and its stakes).

this becomes ever more difficult with the proliferation of safeguards for employer conscience for religious and nonreligious organizations alike.

Whether antinatalist or not, an employer acts on its own interests in choosing which medical services it will cover. Under most any motivation, the employer acts as a source of control over employees' sexual and reproductive choices within the confines of health insurance coverage. Reliance on employers' preferences subjects reproductive access to the whims of interest convergence, which critical theory posits will move dominant players to support the interests of subordinated groups if and only to the extent that doing so also furthers the dominant group's interest.[369] Given the economic interests in employers of controlling employees' reproductive decisions, and the divergence of employers' year-over-year outlook from the individual employee's lifetime perspective, the likelihood of interest convergence and its duration for reproductive care appears even more fragile.

B. *Decoupling Reproductive-Care Access From Employment*

Employers from all viewpoints use the discretion given to them under a host of health care laws to make decisions about their health plans that match their actuarial, commercial, and personal interests. Rather than any one employer's values, the greater threat to reproductive justice comes from the system of employer-sponsored insurance itself, which subjects the reproductive options of over half of the population to the whims of employers' self-interests.

Reproduction, and the avoidance of it, carry profound consequences for individuals and their families—with the most profound consequences for women and other birthing people. In *Roe*, the right of women to be free to make decisions surrounding abortions was described as an individual right in part because of how much pregnancy affects the individual's life and opportunities:

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the

369. See Derrick A. Bell, Jr.,Comment, *Brown v. Board of Education* and the Interest-Convergence Dilemma, 93 Harv. L. Rev. 518, 524 (1980) (explaining how desegregation aligned with majority-white interests in 1954); see also Jennifer S. Hendricks, Converging Trajectories: Interest Convergence, Justice Kennedy, and Jeannie Suk's "The Trajectory of Trauma," 110 Colum. L. Rev. Sidebar 63, 67 (2010), https://columbialawreview.org/wp-content/uploads/2016/07/Hendricks.pdf [https://perma.cc/2W7W-UHLW] (exploring abortion rights advocacy and micro-interest convergence).

> problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.[370]

Planned Parenthood v. Casey, too, echoed how defining reproduction is for one's life in more intangible ways, characterizing reproductive decisionmaking as "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy."[371]

Reproductive justice and autonomy implicate bodily integrity and informed consent principles, too, or the idea that apart from certain exceptions, individuals ought to have freedom of self-determination over their own bodies.[372] So too, personal autonomy or the ability to chart one's life course according to one's own values and preferences. [373] And these interests implicate gender equality, as the burdens of birthing and rearing children on persons who can become pregnant implicate so many life opportunities.[374]

This broader sentiment—that individuals ought to be supported to make decisions about their own bodies and their reproductive lives—conflicts with the employer-sponsored benefits system in which employers can act as de facto gatekeepers of access to reproductive services. Delegating

370. Roe v. Wade, 410 U.S. 113, 153 (1973), overruled by Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); see also *Dobbs*, 142 S. Ct. at 2317 (Breyer, Sotomayor & Kagan, JJ., dissenting) ("*Roe* held, and *Casey* reaffirmed, that the Constitution safeguards a woman's right to decide for herself whether to bear a child.").

371. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992), overruled by *Dobbs*, 142 S. Ct. at 2228.

372. See Maya Manian, The Irrational Woman: Informed Consent and Abortion Decision-Making, 16 Duke J. Gender L. & Pol'y 223, 240 (2009) (discussing how informed-consent principles reflect values of bodily integrity and self-determination); see also B. Jessie Hill, Reproductive Rights as Health Care Rights, 18 Colum. J. Gender & L. 501, 502 (2009) (articulating a negative right to health encompassing abortion); Reva B. Siegel, Dignity and the Politics of Protection: Abortion Restrictions Under *Casey/Carhart*, 117 Yale L.J. 1694, 1740 n.132 (2008) [hereinafter Siegel, Politics of Protection] ("A clear articulation of dignity as autonomy or self-determination is echoed in Justice Stevens's concurrence [in *Casey*] . . . .").

373. Siegel, Politics of Protection, supra note 372, at 1753 ("[D]ignity-respecting regulation of women's decisions can neither manipulate nor coerce women: the intervention must leave women in substantial control of their decision, and free to act on it.").

374. See *Dobbs*, 142 S. Ct. at 2317 (Breyer, Sotomayor & Kagan, JJ., dissenting) ("Respecting a woman as an autonomous being, and granting her full equality, meant giving her substantial choice over this most personal and most consequential of all life decisions."); Reva B. Siegel, Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression, 56 Emory L.J. 815, 818–19 (2007) (discussing a multitude of ways in which control over when to give birth implicates important life decisions and opportunities); Lavanya Vijayasingham, Veloshnee Govender, Sophie Witter & Michelle Remme, Employment Based Health Financing Does Not Support Gender Equity in Universal Health Coverage, BMJ 1–2 (2020), https://www.bmj.com/content/bmj/371/bmj.m3384.full.pdf [https://perma.cc/JXJ2-VZGC] (noting how employer-sponsored insurance threatens women's access to health care because "women face more employment insecurity and transitions across their work lives, including for reproduction and unpaid care work").

these highly consequential policy decisions to employers establishes the power dynamic that thwarts reproductive justice as it sublimates individuals' access to institutions' and owners' preferences.[375]

Of course, employers through their benefit decisions do not exert complete control over the reproductive lives of their employees, unlike political bodies that can make procedures illegal and thus totally inaccessible. Employers cannot ban their employees from seeking available reproductive care and are constrained by the Pregnancy Discrimination Act from discriminating against employees based on their reproductive care decisions, including seeking, obtaining, or forgoing abortions.[376]

Still, when employers choose not to cover a full range of reproductive services from contraception and abortion to comprehensive prenatal care and delivery to fertility therapies, they act as a very real barrier to access to care for employees. Eleven percent of Americans say they lack enough cash, savings, credit card balances, or other means to pay a $400 bill.[377] Twenty-four percent of Americans struggle to pay their bills each month.[378] Compare these financials to the out-of-pocket burden of various reproductive treatments: contraception (between $20 and $50 monthly),[379] a Plan

375. Professor B. Jessie Hill has posited that laws giving private entities complete control over employees' health care benefits may be an unconstitutional delegation, considering that those employees would otherwise be entitled to subsidized coverage under the ACA. See B. Jessie Hill, Religious Nondelegation, 54 Loy. U. Chi. L.J. 511, 530–32 (2022).

376. See 42 U.S.C. § 2000e(k) (2018) (noting that an employer does not need to "pay for health insurance benefits for abortion" but cannot discriminate on the basis of childbirth and related medical conditions); 29 C.F.R. pt. 1604 app. (2023) ("An employer cannot discriminate in its employment practices against a woman who has had an abortion."); see also Doe v. C.A.R.S. Prot. Plus, Inc., 527 F.3d 358, 364 (3d Cir. 2008) (holding that the PDA prohibits employers from discriminating against a female employee because she had an abortion); Turic v. Holland Hosp., Inc., 85 F.3d 1211, 1214 (6th Cir. 1996) (holding that firing a pregnant employee because she contemplated having an abortion violated the PDA); EEOC PDA Guidance, supra note 149 ("Title VII protects women from being fired for having [or contemplating] an abortion.").

377. Bd. of Governors of the Fed. Rsrv. Sys., Economic Well-Being of U.S. Households in 2021, at 36 fig.20 (2022), https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf [https://perma.cc/V83U-LPCR].

378. See id. at 36 (providing a breakdown of households not able to fully pay their current monthly bills).

379. See How Do I Get Birth Control Pills?, Planned Parenthood, https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-do-i-get-birth-control-pills [https://perma.cc/3VN9-2QVH] (last visited Oct. 24, 2023) (stating that one month of birth control "start[s] at $20/pack" and can cost "up to $50"). The Biden administration considers out-of-pocket costs for contraception worrisome enough to prompt it to propose a rule that makes contraception entirely free to individuals with plans under the ACA. See Press Release, Ctrs. for Medicare & Medicaid Servs., Biden–Harris Administration Proposes New Rules to Expand Access to Birth Control Coverage Under the Affordable Care Act (Jan. 30, 2023), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-proposes-new-rules-expand-access-birth-control-coverage-under-affordable [https://perma.cc/NT39-D9EX] (noting that the rule proposes an independent pathway to access contraceptive services "through a willing contraceptive provider" at no cost).

B dosage (between $40 and $50),[380] prenatal/childbirth/postpartum care ($18,865),[381] and one cycle of in vitro fertilization ($12,500).[382] Most people need third-party financing to have meaningful access to reproductive care.

The United States' reliance on employer-sponsored insurance gives commercial entities great sway in which reproductive services will receive funding and does so in a regressive way, benefitting high-income workers at the expense of low-income ones and conferring outsized benefits on white men with economic status at the expense of people of color.[383] Beyond racial inequality and regressivity, the enshrined preference for employer-sponsored insurance gives dominion over reproductive care access to the very same private entities whose economic interests often conflict with reproductive justice.[384] Thus, reforms that aim to justly distribute health care resources almost all propose the decoupling of health care financing from employment status.[385] In the more discrete language of political economy, progressive health care funding strategies shift away from private market direction and toward public control.[386]

Decoupling reproductive care funding from employment represents a net positive for reproductive autonomy for several reasons. First, employers' expansion of reproductive care coverage is exceedingly fragile, secured only by the whims of corporate managers and their perceived economic and other interests. Walmart was, until the passage of the ACA, the

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380. Plan B Morning-After Pill, Planned Parenthood Mass., https://www.plannedparenthood.org/planned-parenthood-massachusetts/online-health-center/planned-parenthood-services-birth-control-abortion-std-hiv-pregnancy-health-care/emergency-contraception-plan-b [https://perma.cc/CKP6-2FPR] (last visited Oct. 24, 2023).

381. Rae et al., supra note 201 (finding health costs associated with pregnancy, childbirth, and postpartum care to average $18,865).

382. Weigel et al., supra note 31 (citing Georgina M. Chambers, Elizabeth A. Sullivan, Osamu Ishihara, Michael G. Chapman & G. David Adamson, The Economic Impact of Assisted Reproductive Technology: A Review of Selected Developed Countries, 91 Fertility & Sterility 2281, 2288 (2009)).

383. See Clark C. Havighurst & Barak D. Richman, Distributive Injustice(s) in American Health Care, 69 Law & Contemp. Probs. 7, 8 (2006) (arguing that the United States health care system regressively distributed health care costs on the basis of class and wealth); Jonathan Oberlander, The Political Economy of Unfairness in U.S. Health Policy, 69 Law & Contemp. Probs. 245, 250–51 (2006) (same); Wiley et al., Health Reform Reconstruction, supra note 49, at 723–24 (describing how employer-sponsored insurance benefited white people given few Black people had jobs with employer-sponsored benefits).

384. See supra section II.A.

385. See, e.g., Nancy S. Jecker, Can an Employer-Based Health Insurance System Be Just?, 18 J. Health Pol. Pol'y & L. 657, 671 (1993); Lindsay Wiley, From Patient Rights to Health Justice, 37 Cardozo L. Rev. 833, 837 (2016) [hereinafter Wiley, From Patient Rights].

386. See, e.g., Oberlander, supra note 383, at 262–64 (explaining why markets cannot ensure progressive health financing); Anja Rudiger, Human Rights and the Political Economy of Universal Health Care: Designing Equitable Financing, 18 Health & Hum. Rts. 67, 68 (2016).

paradigm of corporate resistance to benefits expansion.[387] And it was, until *Dobbs*, no vocal supporter of reproductive choice.[388] Changes in corporate control or strategy can immediately retrench its expansion of abortion access through its health plan.[389] Similarly, the creeping availability of exemptions to reproductive care coverage mandates for employers with religious objections give employers a lever to pull at their discretion to alter the coverage for their employees.[390] More types of employers are emboldened to assert that challenge to more and more aspects of reproductive and sexual health care coverage. Expansions of coverage from employer choice are not durable.

The control over employee behavior that employers' choices exert is itself a source of subordination.[391] Withdrawing employers from the decision over what reproductive care to fund removes this source of control—and of current and historic discrimination—from the equation.[392] The subordinating effects are most apparent for people of color, who are the most likely to be in low-wage jobs with the least generous

387. See, e.g., Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180, 183 (4th Cir. 2007) (noting the "nationwide campaign to force Wal-Mart Stores, Inc., to increase health insurance benefits for its 16,000 Maryland employees").

388. See supra notes 7–9 and accompanying text.

389. Cf. Siddharth Cavale & Arriana McLymore, Walmart Shareholder Proposal for Report on Abortion Ban Impact Fails, Reuters (June 1, 2022), https://www.reuters.com/world/us/walmart-shareholder-proposal-abortion-ban-impact-fails-2022-06-01/ (on file with the *Columbia Law Review*) (reporting that Walmart shareholders rejected an investor-led proposal for a "report assessing the impact on its employees if the U.S. Supreme Court rolls back abortion rights").

390. Timothy S. Jost, Supreme Court Excuses Organizations With Religious or Moral Objections From Covering Workers' Birth Control, Commonwealth Fund Blog (July 9, 2020), https://www.commonwealthfund.org/blog/2020/supreme-court-excuses-organizations-religious-or-moral-objections-covering-workers-birth [https://perma.cc/E4N8-23L5] (describing two Supreme Court cases upholding Trump-era regulations that exempted objecting organizations from mandatory contraceptive coverage); Amy Myrick & Sabrina Merold, Religious Liberty and Access to Reproductive Health Care, Am. Bar Ass'n (July 5, 2022), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/intersection-of-lgbtq-rights-and-religious-freedom/religious-liberty-and-access-to-reproductive-health-care/ (on file with the *Columbia Law Review*) (explaining how rules promulgated under Donald Trump, relying in part on the Religious Freedom Restoration Act, have expanded the scope of religious exemptions).

391. Cf. Mahmoud F. Fathala, The Impact of Reproductive Subordination on Women's Health & Family Planning, 44 Am. U. L. Rev. 1179, 1181–82 (1995) (describing subordination by "[p]atriarchal societies" as flowing from the reasoning "that if women had control over their reproduction, they would also have the *unthinkable*—control over their own sexuality"); Maher, Employment-Based Anything, supra note 55, at 1296–98 (describing the long-recognized "imbalance in power between management and workers in real world markets" and the lack of constraints on exploitation in the context of health-insurance benefits).

392. See, e.g., Yearby et al., supra note 59, at 188–89 (describing how health policies during the Jim Crow era allowed unions and employers to discriminate against racial-minority workers—a tactic that persists in the structure of modern health care).

and most restrictive benefits.[393] Further, employers' actuarial interests may exacerbate the impulse toward surveilling these groups of employees,[394] many of whom come from marginalized communities that are already heavily surveilled. Removing reproductive care from the grasp of employers removes these subordinating influences of employers over individual reproductive autonomy and wider reproductive justice.

III. INSURANCE REFORMS FOR REPRODUCTIVE JUSTICE

Examples of how and why employers seek to control employee reproduction to serve commercial ends reveal the conflict at the core of employers' dominant role in directing access to reproductive care. This conflict represents a net loss for reproductive justice. If proponents of reproductive justice worry about governmental intrusion in individuals' intimate decisions about reproduction,[395] they also must scrutinize employers' intrusions, which subordinate individuals' reproductive autonomy to the myriad moral *and* economic preferences of commercial entities and their owners. Decoupling reproductive health care access from the discretion of employers ought to be a central aim of health reform in support of the meaningful reproductive autonomy contemplated by the reproductive justice framework.

This Article concludes by considering how health reform may achieve this decoupling. Doing so raises tough questions about reproductive care in universal health reform that the existing policy literature has yet to fully

393. See, e.g., Heeju Sohn, Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage Over the Life-Course, 36 Population Rsch. Pol'y Rev. 181, 182 (2017) ("[L]ow income and propensity to work in jobs with no health benefits [are] the primary causes for high uninsurance rates among African Americans." (citation omitted)); Rosemarie Day & Deb Gordon, Employer-Sponsored Health Insurance Contributes to Structural Racism, The Hill (Sept. 5, 2020), https://thehill.com/opinion/healthcare/515184-employer-sponsored-health-insurance-contributes-to-structural-racism/ [https://perma.cc/FD8Z-VN42] ("Having to rely on a job for health insurance significantly disadvantages Black and brown people because they are less likely to be working in jobs that offer [employer-sponsored insurance] benefits.").

394. See Matthew Brodie, Beyond Privacy: Changing the Data Power Dynamics in the Workplace, Law & Pol. Econ. Project (Feb. 7, 2023), https://lpeproject.org/blog/beyond-privacy-changing-the-data-power-dynamics-in-the-workplace/ [https://perma.cc/9JL7-67KZ] (noting the value of employee surveillance, which provides employers with "huge data sets to feed increasingly sophisticated algorithms" about their employees' habits and rhythms).

395. See, e.g., Barbara Hewson, Reproductive Autonomy and the Ethics of Abortion, 27 J. Med. Ethics ii10, ii11 (2001) ("If people are to be free, that freedom must include freedom to make these difficult and extremely personal choices."); Keeanga-Yamahtta Taylor, Abortion Is About Freedom, Not Just Privacy, New Yorker (July 6, 2022), https://www.newyorker.com/news/our-columnists/abortion-is-about-freedom-not-just-privacy (on file with the *Columbia Law Review*) (noting that the "right to privacy" includes both protection from state interference with personal decisions and "the more fundamental freedom of women to control their own bodies").

confront:[396] namely the control over reproductive options inherent in any third-party funding system and the special danger to reproductive freedom in relocating third-party funding control to American governmental units.

The most effective mode of removing employers from their gatekeeping function over reproductive care is to shift from an employer-dependent, multipayer funding system to a universal, single-payer system. Yet, while a single-payer system would release the hold of private employers over reproductive autonomy to a great extent, it also shifts that same power to

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396. See, e.g., David DeGrazia, Single Payer Meets Managed Competition: The Case for Public Funding and Private Delivery, 38 Hastings Ctr. Rep. 23, 24 (2008) (making no reference to contraception or abortion). Many analyses assume universality means coverage for all reproductive services. See, e.g., Nat'l Network of Abortion Funds, Abortion Funding: A Matter of Justice 19 (2005), https://clacaidigital.info/bitstream/handle/123456789/206/Abortion.Funding.pdf [https://perma.cc/54S9-92RX] (calling on Congress to "[i]nclude abortion in all government health programs"); Nat'l P'ship for Women & Fams., A Framework for Making Universal Coverage Meaningful for Women 7 (2019), https://nationalpartnership.org/wp-content/uploads/2023/02/universal-health-coverage.pdf [https://perma.cc/H7V9-VALX] [hereinafter Nat'l P'ship for Women & Fams., Universal Coverage] ("[U]niversal coverage proposals must include comprehensive coverage for abortion care for all enrollees."); Vidya Visvabharathy, Don't Call It Universal Without Including Abortion Coverage, Physicians for a Nat'l Health Program (Sept. 4, 2017), https://pnhp.org/news/dont-call-it-universal-without-including-abortion-coverage/ [https://perma.cc/NWF9-QUV2] ("[S]ingle-payer groups must explicitly advocate for coverage of abortion services . . . ."); Erica West & Emma Wilde Botta, Why Single Payer Is a Feminist Issue, SocialistWorker.org (Jan. 18, 2018), https://socialistworker.org/2018/01/18/why-single-payer-is-a-feminist-issue [https://perma.cc/QCG2-SLTQ] ("Single-payer would significantly improve women's health by mandating coverage of all essential reproductive care and all LBGTQ health care[,] . . . preventive care[,] and . . . all forms of contraception."). Others note abortion as a political sticking point. See, e.g., Roger M. Battistella, Health Care Turning Point: Why Single Payer Won't Work 33, 37–42 (2010) (noting that disagreement over abortion will likely prevent the consensus necessary to pass federal single payer); Michael S. Sparer, States as Policy Laboratories: The Politics of State-Based Single-Payer Proposals, 109 Am. J. Pub. Health 1511, 1511–13 (2019) (noting Colorado's experience but otherwise not tackling reproductive care).

Some have considered workarounds for abortion. See, e.g., Robert M. Veatch, Single Payers and Multiple Lists: Must Everyone Get the Same Coverage in a Universal Health Plan?, 7 Kennedy Inst. Ethics J. 153, 161–62 (1997) (posing that a single-payer system in which individuals could buy into a series of different coverage "lists" could solve the abortion debate). Few consider the deeper problem for all reproductive services from reproductive exceptionalism. See Kaitlin Hunter & Gabe Horwitz, What Could Happen to Reproductive Health Care Under Single Payer?, Third Way (Sept. 13, 2019), https://www.thirdway.org/memo/what-could-happen-to-reproductive-health-care-under-single-payer [https://perma.cc/46MK-SDBN] (noting that a Republican-controlled federal government could exclude or defund contraception and abortion); Lab. Campaign for Single Payer, It's a Workers' Issue! Abortion Access and the Right to Health Care, YouTube, at 44:03 (Oct. 21, 2022), https://www.youtube.com/watch?v=lnEqCKsEDYc (on file with the *Columbia Law Review*) (describing the knock-on effects of abortion bans on other areas of reproductive care). And fewer still—if any—consider the inherent gatekeeping function of a third-party payment model.

lawmakers and bureaucrats.[397] In theory, a publicly funded system in a democratic society should reflect the political will of the governed and therefore enact coverage that reflects the broad public support that contraception and abortion access have had for decades.[398] In practice, however, contraception and abortion access have been leveraged by countermajoritarian political forces and have made reproductive care exceptional in other efforts at universal coverage, much to the detriment of reproductive autonomy.[399]

A variety of reform options exist. This Part examines the degree to which each option may further the aims of reproductive justice. While the political economy of health reform suggests that incremental reforms may be more politically feasible than transformative ones, this Article employs the broader framework of confrontational incrementalism to investigate whether feasible increments would confront or continue to accommodate the subordinating influences of the employer-sponsored insurance system detailed in the previous Parts. The United States' experience with employer funding of reproductive care suggests that systemic reforms ought to confront both the subordinating influences of third-party control over individual reproductive autonomy and the trend of reproductive exceptionalism that has diminished access to reproductive services. Ultimately, confrontational incrementalism suggests a path pursuing reproductive autonomy simultaneously with universal public benefits and a path on which state-level reforms may need to lead the way.

A. *Assessing Health-Reform Options*

At its most tangible, the problem of employer-sponsored reproduction is about the power to control the distribution of resources for reproductive care and its consequences. Working in tandem, America's decisions not to establish universal public health care and to cobble together a porous legal infrastructure of reproductive exceptionalism

397. Cf. Deborah Stone, Single Payer—Good Metaphor, Bad Politics, 34 J. Health Pol. Pol'y & L. 531, 534 (2009) ("The countries that [implement] single-payer [don't] hav[e] one payer, but *one rule maker*.").

398. See, e.g., Public Attitudes About Birth Control, Roper Ctr. for Pub. Op. Rsch. (July 27, 2015), https://ropercenter.cornell.edu/public-attitudes-about-birth-control [https://perma.cc/ZKF9-6ZTP] (recounting a 1998 poll finding that seventy-five percent of the country would approve of a national bill requiring coverage for prescription birth control); Public Opinion on Abortion, Pew Rsch. Ctr. (May 17, 2022), https://www.pewresearch.org/religion/fact-sheet/public-opinion-on-abortion/ [https://perma.cc/K675-MBXC] (charting public opinion on abortion between 1995 and 2022).

399. See, e.g., Courtney Megan Cahill, The New Maternity, 133 Harv. L. Rev. 2221, 2223–25 (2020) (analyzing how "[c]onstitutional law's assumptions about obvious maternity and complicated paternity" work to validate sex discrimination); Metzger, supra note 276, at 898 ("[A]dvocates need to convince courts that abortion's uniqueness does not necessarily justify abortion-specific regulation but on the contrary may necessitate subjecting some abortion-specific measures to greater scrutiny.").

hand employers significant power over this distribution with relatively little constraint or responsibility to the individuals who depend on it. Reforms that would alter this power dynamic range from incremental constraints on employer discretion (e.g., coverage mandates for specific services) to systemic reforms (e.g., establishing universal public funding).

In the parlance of political economy, smaller incremental reforms may offer greater *feasibility* of enactment and implementation, with the trade-off of less impact.[400] Systemic reforms may have greater policy impact, but they have slim chances of enactment.[401] Concerns over feasibility manifested in the two most recent debates over system-wide health reforms during the Clinton and Obama Administrations. Both began with big ideas but ultimately pursued more modest changes that relied on the continued availability of employer-sponsored insurance, with the ACA marking the "apotheosis" of this incrementalism trend by building other insurance reforms around a mandate for large employers to provide insurance.[402] While a few states in recent years have pursued public options that would create alternatives to employer-sponsored insurance, Congress and most state legislators have instead taken pains to protect the connection between health care coverage and employment.[403]

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400. See Federico Sturzenegger & Mariano Tommasi, Introduction, *in* The Political Economy of Reform 1, 3 (Federico Sturzenegger & Mariano Tommasi eds., 1998) (describing various academic models of political reform); Michael R. Reich, Political Economy Analysis for Health, 97 Bull. WHO 514, 514 (2019) (advocating for applying to health care reform political economy's focus on the power to distribute resources and assessment of political feasibility for policy change).

401. See, e.g., Ashley M. Fox & Michael R. Reich, Political Economy of Reform, *in* Scaling Up Affordable Health Insurance: Staying the Course 395 (Alexander S. Preker, Marianne E. Lindner, Dov Chernichovsky & Onno P. Schellekens eds., 2013) (explaining why transforming health financing systems is popular and effective but has proven so difficult to pass).

402. See Dailard, Contraceptive Coverage, supra note 148 (recounting Clinton's "sweeping, controversial proposal to achieve universal health insurance" in 1993 that ultimately "harkened an era of incremental reform"); Wiley et al., Health Reform Reconstruction, supra note 49, at 671–72 (describing the view that the ACA is an "incremental step" toward the "bold[] aim" of universal coverage).

403. See Jaime S. King, Katherine L. Gudiksen & Erin C. Fuse Brown, Are State Public Option Health Plans Worth It?, 59 Harv. J. on Legis. 145, 191 (2022) (providing an overview of all state public-option bills, and demonstrating that even the most aggressive "[c]omprehensive public option" plans merely permit employers to opt-in); Christine Monahan, Justin Giovannelli & Kevin Lucia, Update on State Public Option-Style Laws: Getting to More Affordable Coverage, Commonwealth Fund: To The Point (Mar. 29, 2022), https://www.commonwealthfund.org/blog/2022/update-state-public-option-style-laws-getting-more-affordable-coverage [https://perma.cc/W9XJ-ZNGN] (describing the public-option-type laws adopted in three states); cf. Peter R. Orszag & Rahul Rekhi, Policy Design: Tensions and Tradeoffs, *in* The Trillion Dollar Revolution: How the Affordable Care Act Transformed Politics, Law, and Health Care in America 53 (Ezekiel J. Emanuel & Abbe Gluck eds., 2020) (recounting that the designers of the ACA worked with a directive to "do no harm" to employer-sponsored insurance while pursuing universal coverage strategies).

How, then, to measure progress? This Article sets its sights on assessing how large and small reforms to the employer-sponsored insurance default may advance or thwart reproductive justice. To assess the trade-offs involved in potential reforms, it employs the framework of confrontational incrementalism, which centers principles of justice as the desired ends for reform, while interrogating whether and to what extent proposed reforms confront or accommodate the sources of subordination that impede justice.[404] Put concretely, incremental reforms that use up political energy and resources to expand access without confronting the subordinating influence of employer-sponsored insurance, therefore, may lay stumbling blocks to reaching the goal of universal access to meaningful reproductive care rather than stepping stones toward achieving it.[405]

Consider examples of reforms that would merely constrain employer choice, such as a recent federal proposal for amending ERISA or the ACA to require all group plans to cover fertility treatment.[406] It would incrementally expand access to this portion of reproductive care for many people. But objections from religious employers[407] would likely limit some of its impact, just as such objections have done to similarly modest attempts to expand coverage for sexual and reproductive health care after the *Hobby Lobby* decision.[408] Among the fifteen states that have enacted some form of fertility coverage mandate, several already include exemptions for religious employers.[409] And, of course, ERISA preempts states from enforcing rules against self-funded plans,[410] further diluting the impact of these incremental reforms at the state level.

Assessed under the lens of confrontational incrementalism, a fertility coverage mandate might expand access yet not ultimately advance reproductive justice. A federal coverage mandate for group insurance would give

404. See Wiley et al., Health Reform Reconstruction, supra note 49, at 733–41 (presenting the confrontational incrementalism framework and applying it to prepandemic and pandemic-era health care reforms); cf. Angela P. Harris & Aysha Pamucku, The Civil Rights of Health: A New Approach to Challenging Structural Inequality, 67 UCLA L. Rev. 758, 809 (2020) (comparing environmental justice and reproductive justice movements); Gabriel Scheffler, Equality and Sufficiency in Health Care Reform, 81 Md. L. Rev. 144, 169–71 (2021) (finding points of comparison and convergence between conceptions of the right to health care as equality in access versus an acceptable minimum of care).

405. See Wiley et al., Health Reform Reconstruction, supra note 49, at 734–35.

406. See Access to Infertility Treatment and Care Act, S. 1461, 116th Cong. (2019) (proposing that all private and federal public-health plans cover fertility treatment).

407. See Cynthia Brougher, Cong. Rsch. Serv., RL34708, Religious Exemptions for Mandatory Health Care Programs: A Legal Analysis 5–6 (2012) (discussing religious-employer exemptions from mandatory coverage).

408. E.g., Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, 140 S. Ct. 2367 (2020); Zubik v. Burwell, 578 U.S. 420 (2016); DeOtte v. State, 20 F.4th 1055 (5th Cir. 2021); Braidwood Mgmt. Inc. v. Becerra, 666 F. Supp. 3d 613 (N.D. Tex. 2023).

409. Weigel et al., supra note 31 ("Many states [with laws requiring coverage of at least some infertility treatments] provide exemptions for . . . religious employers.").

410. See id.

more people the financial means for fertility treatment, enabling more people who wish to have a child to do so. But such a mandate would maintain the tether between access and employment, excluding the low-wage and part-time workers and uninsured nonworkers for whom fertility treatment already is farthest out of financial reach. Unless the coverage mandate were paired with the enactment of fertility coverage requirements for individual market plans and public programs (Medicare and Medicaid), it would likely entrench the existing socioeconomic and racial disparities in access.[411] Even under a mandate, plans' narrow definitions of infertility may exclude LGBTQ enrollees from getting that coverage.[412] When enacted at the state level, mandates contribute to the already profound geographic disparities in access and resources,[413] which follow historical trends of racial exclusion.[414] And neither federal nor state fertility coverage mandates deal with employers' failure to support (or worse, the hostility to) pregnancy, childbirth, and child-rearing that fertility treatments aim to produce.[415]

Proposals to tweak the existing regulatory infrastructure are instances of the cat-and-mouse of reproductive exceptionalism in insurance: Employers are reluctant to cover reproductive care and proponents must gather

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411. Katharine F.B. Correia, Katherine Kraschel & David B. Seifer, State Insurance Mandates for In Vitro Fertilization Are Not Associated With Improving Racial and Ethnic Disparities in Utilization and Treatment Outcomes, 228 Am. J. Obstetrics & Gyn. 313.3l, 313.e7 (2023) (finding that state insurance mandates alone "do not seem to be sufficient in their present form to result in narrowing or creating equal access to or outcomes from IVF"); see also Katherine Kraschel, Going Public—The Future of ART Access Post-*Dobbs*, Harv. L. Petrie–Flom Ctr.: Bill of Health (May 23, 2023), https://blog.petrieflom.law.harvard.edu/2023/05/23/going-public-the-future-of-art-access-post-dobbs/ [https://perma.cc/9F4J-EFH9] ("[S]tate insurance mandates that require only private insurers to cover infertility treatment disproportionately exclude BIPOC . . . and may, in fact, exacerbate racial disparities in access to care." (citing Katharine F.B. Correia, Katherine Kraschel & David B. Seifer, State Insurance Mandates for In Vitro Fertilization Are Not Associated With Improving Racial and Ethnic Disparities in Utilization and Treatment Outcomes, 228 Am. J. Obsetrics & Gynecology 331 (2023))).

412. See Janet Choi & Cynthia McEwen, In Their Rush to Offer Fertility Benefits, Employers Could Be Unwittingly Creating a New Inequity for LGTBQIA+ Employees, Fortune (July 12, 2023), https://fortune.com/2023/07/21/in-their-rush-to-offer-fertility-benefits-employers-could-be-unwittingly-creating-a-new-inequity-for-lgtbqia-employees/ [https://perma.cc/F2X5-YC7K] (noting how policies that define "infertility" as "six to 12 months of unprotected, heterosexual sex without successful conception" exclude same-sex couples from fertility-care coverage); Weigel et al., supra note 31 ("LGBTQ individuals also face heightened barriers to accessing fertility care, as they often do not meet definitions of 'infertility' that would qualify them for covered services.").

413. See Weigel et al., supra note 31 (highlighting that most of the poorest states have no fertility mandate).

414. See Wiley et al., Health Reform Reconstruction, supra note 49, at 719 (explaining the historical trend of "continued exclusion [and] subordination of Black and Brown people from the health care system").

415. See supra section II.B.

either the labor-market clout to convince them[416] or the political will to require them to do so.[417] When advocates do muster the political will to pass requirements for reproductive coverage, the enactments frequently have concessions and exemptions for religious employers or small businesses and carveouts for abortion.[418] To the extent that the passage of these tweaks have consumed the political energy needed for reforms that more fully engage the dimensions of reproductive justice and establish alternatives to employer-sponsored insurance, they could pose stumbling blocks to the realization of reproductive justice.[419]

Other reforms focus on establishing alternative sources of insurance in the multipayer system—usually referred to as public options. Establishing a source of public insurance that *individuals* could choose to buy (the individual public option) could give people an alternative to their employer plans.[420] The public option's effect on reproductive choice, however, would depend on whether the public option covers those aspects of reproductive care the employer plan restricts, as well as the relative affordability of the public plan.

Establishing a source of public insurance that *employers* could offer their employees (the employer public option)[421] could "simultaneously offer an out for employers who want" to release their involvement in health care financing and "start to build the foundation for a simpler, more equitable financing system down the road."[422] Because they establish alternatives to employer-

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416. For instance, DOJ employees formed the Gender Equality Network (DOJ GEN) to advocate for various policy changes in their employment, including for coverage of fertility benefits in their federal employees' health-benefit plan. See Pay Equity and FEHB Coverage for Fertility Treatments, DOJ GEN Blog (Nov. 18, 2022), https://dojgen.org/blog/updates-on-pay-equity-and-fehb-coverage-for-fertility-treatments [https://perma.cc/S62T-KTJL].

417. Cf. Brown, supra note 58, at 41 (observing that "[s]ome of the push for regulation" of employer-sponsored insurance "comes from organizations that applaud more government steering of the system . . . , but no small amount derives from groups that opportunistically insist that government make regulations on behalf of their worthy ends and then go away").

418. This pattern is exemplified by the ACA's exclusion of abortion in subsidized exchange plans and religious-employer exemptions in state fertility-coverage mandates. See supra notes 163–171 and accompanying text.

419. See Wiley et al., Health Reform Reconstruction, supra note 49, at 733–35 (discussing how "incremental reforms" can be "stumbling blocks" if they accommodate, rather than dismantle, problematic structures).

420. See Monahan et al., supra note 403 (describing public-option-style laws in Colorado, Nevada, and Washington).

421. See Allison K. Hoffman, Howell E. Jackson & Amy Monahan, A Public Option for Employer Health Plans 21–41 (Feb. 17, 2021) (unpublished manuscript), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3265&context=faculty_scholarship [https://perma.cc/69PK-R85W] (introducing the concept of an employer public option and reviewing the policy, regulatory, fiscal, and business arguments in favor of it).

422. Alison K. Hoffman, A Long View on Health Insurance Reform: The Case for an Employer Public Option, Harv. L. Petrie–Flom Ctr.: Bill of Health (May 18, 2021), https://

sponsored insurance, both styles of public option present incremental reforms that would more meaningfully confront employers' influence on coverage.

Single-payer reform offers the most effective and complete decoupling, placing the primary responsibility for health care finance in a "public" system.[423] The complication for reproductive care in this mode stems from the Hyde Amendment and accumulated public laws exempting pregnancy termination from public funding. Under an unflinching inquiry, the benefits of decoupling health care from employment by establishing universal public insurance must confront the forces of reproductive exceptionalism and political control over reproduction that pervade American law and discourse.

B. *Single-Payer: Promise and Perils*

Single-payer systems in other countries score higher across affordability, equity, health outcomes, and administrative efficiency measures than the U.S. healthcare system.[424] There exists considerable heterogeneity in the systems categorized as "single-payer," but most share the features of collecting revenue through taxation, pooling the money in a publicly controlled fund, making all residents eligible to receive health care payment from that fund, setting broad criteria for the services covered by the fund, and negotiating prices and requiring all providers to accept reimbursement from that fund.[425]

A single-payer model decouples employers from health care by defining public eligibility for the program and often by prohibiting employers from offering benefits that duplicate those offered by the single-payer program.[426] Individuals get access to health care based on residence rather than employment status.

But this does not fully resolve the "gatekeeping" aspects of reproductive care; instead, it shifts the gatekeeping function from

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blog.petrieflom.law.harvard.edu/2021/05/18/employer-public-option-health-insurance/ [http://perma.cc/U7UZ-TDBR/].

423. See Stone, supra note 397 (describing public health care as "a mechanism for implementing mutual aid").

424. Eric C. Schneider, Arnav Shah, Michelle M. Doty, Roosa Tikkanen, Katherine Fields & Regina D. Williams II, Mirror, Mirror 2021: Reflecting Poorly, Commonwealth Fund (Aug. 4, 2021), https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly [http://perma.cc/Q8EB-4TZA].

425. See, e.g., J.L. Liu & R.H. Brook, What Is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S., 32 J. Gen. Intern. Med. 822, 822–31 (2017) (highlighting common features of single-payer plans).

426. See Fuse Brown & McCuskey, supra note 8, at 438–39 (explaining how many state single-payer bills include nonduplication provisions that "remove commercial competitors to the single-payer plan benefits and permit insurers only to offer 'wraparound' services that supplement the single payer's coverage").

employers to the federal government. In single-payer systems, the government assumes primary responsibility for financing care. Employers are involved only to the extent of their tax contributions and, occasionally, their ability to offer supplementary benefits that the public system does not cover.[427] Would the federal government be a superior gatekeeper of reproductive care? Currently, the evidence is mixed. A federal single-payer program would likely mean many major reproductive services were covered universally for all people but leave open important questions about the scope of coverage. For instance, many people lack access to infertility treatments, like IVF, under the current model. Would the single-payer program uniformly cover these services and for all people, including LGBTQ persons? The Hyde Amendment currently forbids federal money from funding abortion care. Could single-payer reform endanger reproductive justice by making the Hyde Amendment restrictions universal?

1. *The Promise of Universal Benefits.* — A universal public system would offer at least three valuable gains for reproductive care: equality of access, (presumably adequate) benefits, and affordability. Currently, access to reproductive care varies greatly depending on whether one receives benefits on the exchange, through a public system, or through work, subject to all the variations discussed in Part I and the preferences and beliefs of one's employers at any given moment.

A single-payer health care plan removes this uncertainty, giving everyone access to the same benefits package. This may prove particularly important for communities of color, people with disabilities, lower-income individuals, and other groups who are frequently more likely to be uninsured, underinsured, or covered by public programs and who face significant disparities in reproductive health care,[428] maternal morbidity, and mortality.[429] Universal benefits could go some way in reducing these avoidable inequalities.[430]

Take, for example, uninsured people who qualify for health benefits only upon becoming pregnant. Medicaid and CHIP provide services to

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427. Id.

428. Madeline Sutton, Ngozi Anachebe, Regina Lee & Heather Skanes, Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020, Nat'l Libr. of Med. (Jan. 5, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7813444/ [https://perma.cc/VRW7-TPCP/].

429. Id.

430. See Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald & Laurie C. Zephyrin, Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries, Commonwealth Fund (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/QW24-AK2E/] (comparing the reproductive-health outcomes of citizens of the United States against countries with universal coverage).

pregnant people at certain income ranges, and until recently, these benefits terminated sixty days after a person delivered the baby. Under the American Rescue Plan Act, states have the option to use Medicaid funds to cover the person's health care needs up until one year postpartum.[431] Universal care, by contrast, would provide people guaranteed access to a basic minimum of reproductive services (including pregnancy prevention) regardless of pregnancy status or financial need and not subject to the whims or business interests of employers.

Alternatively, consider a pregnant woman working a full-time job that provides benefits for her, her spouse, and two other children. Perhaps the job affords her very little parental leave, her wages pale in comparison to the costs of daycare for three in her area, and a high-risk pregnancy makes work dangerous. She would like to leave her job and seek work again when the kids are older, but doing so means giving up the security of benefits during her pregnancy and afterward for her, the baby, and all the other members of the family. Or perhaps she is offered a different job opportunity with greater pay but no health benefits or with less coverage of pregnancy care. Her pregnancy status makes job mobility impossible solely because of health benefits.[432] Under the universal-care model, this woman would be free to take that time out of the workforce or change jobs and still maintain health coverage for her and her family.

The draft House bill for Medicare for All (H.R. 1976) provides a concrete example of consistency in benefits. The bill agrees to pay for "[c]omprehensive reproductive, maternity, and newborn care" so long as it is "medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition."[433] These services would be available without any cost sharing.[434]

The bill offers no greater details about reproductive care than this blanket guarantee. Specifics would likely be addressed at the regulatory level, with an agency determination of what counts as "medically necessary

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431. Medicaid Postpartum Coverage Extension Tracker, KFF (Feb. 13, 2023), https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/ [http://perma.cc/A3JS-PYNG] (summarizing the relevant provision and tracking the states that have implemented the extended postpartum-care coverage).

432. See Katherine Elizabeth Ulrich, You Can't Take It With You: An Examination of Employee Benefit Portability and Its Relationship to Job Lock and the New Psychological Contract, 19 Hofstra Lab. & Emp. L.J. 173, 196–97 (2001) (noting that Americans remain at jobs longer than they otherwise would when they feel that their employee benefits are not "portable" between jobs). For more on how the employer market shapes people's job opportunities and other personal freedoms, see Valarie K. Blake, The Freedom Premium (draft manuscript on file with the *Columbia Law Review*). For an analysis of how the relative scarcity of fertility coverage drives labor market trends, see Valarie K. Blake & Elizabeth Y. McCuskey, The Infertility Shift, Harv. L. Petrie–Flom Ctr.: Bill of Health (May 12, 2023), https://blog.petrieflom.law.harvard.edu/2023/05/12/the-infertility-shift/ [https://perma.cc/R3V5-392N].

433. Medicare for All Act of 2021, H.R. 1976, 117th Cong. § 201(a) (2021).

434. Id. § 202.

or appropriate." Presumably, such broad language suggests an intent to be as comprehensive and inclusive as possible, initiating the coverage decisions with the individual's doctor and their determination of the patient's needs. But the debate referenced in Part I about medical necessity in termination of pregnancy likely will spill over into this aspect of single payer, too. Likewise, private insurance's exclusions of fertility treatment and assisted reproductive technologies from their necessity definitions pose a threat to access, especially for LGBTQ communities who are frequently implicitly excluded even when coverage is available.[435] Despite the universality in its wording, Medicare for All may still be subjected to the forces of reproductive exceptionalism.[436]

Medicare for All would cover all aspects of reproductive care on parity with other medical care, without any premium or form of cost sharing.[437] This stands in direct contrast to the thousands of dollars that most insured people pay out of pocket for childbirth or the devastating costs of birthing a premature child. For contraception, Medicare for All is a fully enforceable coverage mandate not subject to exemptions for religion and likely not subject to RFRA exclusions.[438] For fertility treatment, the medical necessity determination may be subject to agency rulemaking discretion, but nothing in Medicare for All prohibits employers from offering wraparound coverage for those items that may be excluded from the public plan.[439]

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435. See Blake, supra note 327, at 667–73 (noting that state regulations often use exclusionary language that makes it difficult, if not impossible, for LGBTQ individuals to access reproductive care).

436. Compare Nat'l P'ship for Women & Fams., Universal Coverage, supra note 396, at 7 (advocating that "universal coverage proposals must include comprehensive coverage for abortion"), with Kevin Pham, Supporting "Medicare for All" Isn't Pro-Life, Heritage Found. (Dec. 26, 2019), https://www.heritage.org/medicare/commentary/supporting-medicare-all-isnt-pro-life [https://perma.cc/FU6G-4JPM] (arguing that pro-life advocates cannot support Medicare for All unless the reproductive care guarantees that arguably cover abortion were removed). It is important to note, too, that Medicare in its current form does not cover many contraceptive services and treatments. See Gina Jiménez, For Young People on Medicare, a Hysterectomy Sometimes Is More Affordable Than Birth Control, KFF Health News (Mar. 7, 2023), https://kffhealthnews.org/news/article/medicare-birth-control-disabilities-coverage/ [https://perma.cc/R4LY-54GR].

437. H.R. 1976, 117th Cong. § 202 (2021) ("The Secretary shall ensure that no cost-sharing . . . is imposed on an individual for any benefits provided under this Act.").

438. Recall that Justice Alito in *Hobby Lobby* admonished the government for making private entities pay for mandated contraception, saying, "If, as HHS tells us, providing all women with cost-free access to all FDA-approved methods of contraception is a Government interest of the highest order, it is hard to understand HHS's argument that it cannot be required . . . to pay *anything* in order to achieve this important goal." Burwell v. Hobby Lobby, 573 U.S. 682, 729 (2014). A single-payer system removes the private payer as the agent of public policy.

439. See, e.g., Jonathan Foley, Taking Medicare for All Seriously, Health Affs. Forefront (June 11, 2019), https://www.healthaffairs.org/content/forefront/taking-medicare-all-seriously [https://perma.cc/9SG3-92Y9] (explaining that Medicare for All would eliminate private health insurance, "except for affinity benefits"). Medicare currently does not generally cover ART, though it may cover diagnostic testing for infertility. See Weigel et al., supra note 31.

Though rife with pitfalls, publicly funded universal health care aligns the interests of patients and the payer (their elected representatives) to a much greater extent than the current employer-sponsored insurance system does. Employers' motivations to exclude cost-effective preventative reproductive care stem at least in part from their short-term, year-over-year perspective of who is in their risk pool.[440] The employer who refuses to pay the modest cost of contraception does so on the hope that the employee who has an unintended pregnancy will be some other employer's (or public program's) responsibility by the time the condition manifests.[441] A single-payer system, by contrast, bears responsibility for the entire population over their lifetimes. As a funder, the single payer must consider both short and long-term risks for everyone, as well as the social costs of its funding decisions.[442]

This realignment of payer and patient interests better serves population-health and health-justice goals.[443] And it offers a counterweight to reproductive exceptionalism for contraception and abortion because it forces the funding institution to consider and bear the additional financial and social costs of denying these services.[444]

2. *Abortion Exceptionalism in Universal Care.* — Still, any single-payer plan, while promising equal and affordable access to reproductive care, must reckon with the reality that political pressure has long rendered the federal government unwilling to fund abortion.

In the wake of *Roe*, Congress responded almost immediately by passing the Hyde Amendment, prohibiting the use of federal funds to pay for abortions except in cases of rape, incest, or endangerment of the pregnant person's life.[445] The federal practice of denying payment for abortion care is persistent: Though not codified into law, the Hyde Amendment is a rider to the appropriations bill that is *renewed annually* by Congress,[446] suggesting the overall commitment of the governing body to this premise. It is also

440. See supra section I.B.2.

441. See supra section I.B.2.

442. See Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, Social Solidarity in Health Care, American-Style, 48 J.L. Med. & Ethics 411, 413 (2020) (noting that single-payer systems aim to improve population health, universal and equitable access to care, and manageable health care costs at both the country and household levels).

443. See Wiley, From Patient Rights, supra note 385, at 879 (emphasizing that health justice requires protection of collective and individual interests).

444. For fertility treatments, the actuarial picture is more complex because expensive fertility treatments, if successful, lead to additional expenses. See Dependent Health Coverage and Age for Healthcare Benefits, Nat'l Conf. of State Legislatures (Nov. 1, 2016), https://www.ncsl.org/health/dependent-health-coverage-and-age-for-health-care-benefits [https://perma.cc/8R6D-WATJ] (outlining the ACA and state law requirement that insurers must extend dependent coverage to children); Weigel et al., supra note 31 (analyzing the cost of fertility treatments).

445. Salganicoff et al., Hyde Amendment, supra note 44.

446. Id.

pervasive: Hyde-style prohibitions exist in all the major federal health care programs.[447]

The Hyde Amendment prohibits states from using federal money to fund abortions, but it does not prohibit the use of state money.[448] Thirty-two states and the District of Columbia have passed their own Hyde-style restrictions on the use of state funds for abortions.[449] One state, South Dakota, is more restrictive than Hyde, only allowing state funds in the case of endangerment to the pregnant person's life.[450] A minority, seventeen states, allow state money to pay for abortion care.[451] The Hyde Amendment has thus had a dramatic effect on who carries the fiscal burden of abortions in America. Low-income people and people of color are more likely to seek abortions and more likely to be on Medicaid and face a barrier to coverage.[452]

Lawmakers seeking to pass a single-payer plan would have to confront the Hyde Amendment, forcing three possible choices: override Hyde, permit Hyde to continue, or remain silent on the topic. Medicare for All legislation took the approach to override the Hyde Amendment.[453] Draft language states, "Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund."[454] Of course, such provisions may prove to be a sticking point in the passage of universal health care, raising the possibility that preserving Hyde may be a concession to attract consensus from more center-left or moderate politicians. Opposition to abortion (and to some extent to contraception, too) has consistently been a wedge issue, wielded for political purposes to stymie past health reform efforts and increase the transaction costs of their enactment.[455]

Single-payer plans have grown increasingly popular among voters: A recent poll reported that as many as 63% of Americans believe it is the government's responsibility to pay for health care.[456] Similarly, 61% of

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447. See id. (describing the range of federal programs impacted by the Hyde Amendment).

448. See id.

449. See State Funding of Abortion Under Medicaid, supra note 46 (explaining that these thirty-two states and the District of Columbia follow the federal standard).

450. See Salganicoff et al., Hyde Amendment, supra note 44.

451. See State Funding of Abortion Under Medicaid, supra note 46. Of the states permitting the use of state funds for abortion care, nine do so pursuant to a court order for payment. Id.

452. See Salganicoff et al., Hyde Amendment, supra note 44.

453. See Medicare for All Act of 2021, H.R. 1976, 117th Cong. § 701(b)(3) (2021).

454. Id.

455. See, e.g., Jeannie I. Rosoff, The Clinton Health Plan: What Does It Do for Reproductive Health Services?, 26 Fam. Plan. Persps. 39, 40 (1994) (noting that President Clinton's proposed health plan omitted the word "abortion" to avoid political backlash).

456. Bradley Jones, Increasing Share of Americans Favor a Single Government Program to Provide Health Care Coverage, Pew Rsch. Ctr. (Sept. 29, 2020), https://

Americans believe abortion should be legal in most or all cases.[457] But the idea that federal funds should go to paying for abortions enjoys less popularity, at least in the polls that predate *Dobbs.* A 2016 poll found that 55% of Americans supported the Hyde Amendment; within Democrats, as many as 41% supported Hyde compared with 44% who rejected it.[458] A Politico–Harvard poll in that same year showed similar figures. Fifty-eight percent of voters opposed allowing Medicaid to fund abortions, while that same percentage of voters supported ongoing federal funding for Planned Parenthood.[459]

A federal single-payer health care system that fails to address Hyde has the potential to decrease the demand for abortion while simultaneously diminishing abortion access. The expansion of access to coverage for contraception and family planning services in a universal public plan would further reduce the demand for abortion.[460] In a Hyde-restricted single-payer program, however, individuals would have one option for health benefits, and it would deny payment for abortion care except in those narrow categories of exceptions. Those who currently have private insurance that covers abortion care would be moved to the abortion-restricted single-payer plan, and the funds that private employers currently spend on health plans would be channeled through the federal government as tax revenue, subjected to Hyde. Although private plans might be able to offer supplemental coverage for abortion, that would be too costly for many to afford unless provided as a benefit from any employer.

Failure to expressly reject Hyde could mean that single-payer draft legislation fails to garner enough support from the political left, where its greatest champions would likely be. Senator Bernie Sanders has made plain that a repeal of the Hyde Amendment is part and parcel of the goal of a

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www.pewresearch.org/fact-tank/2020/09/29/increasing-share-of-americans-favor-a-single-government-program-to-provide-health-care-coverage/ [https://perma.cc/N5TQ-AEME].

457. Hannah Hartig, About Six-in-Ten Americans Say Abortion Should Be Legal in All or Most Cases, Pew Rsch. Ctr. (June 13, 2022), https://www.pewresearch.org/fact-tank/2022/06/13/about-six-in-ten-americans-say-abortion-should-be-legal-in-all-or-most-cases-2/ [https://perma.cc/BJ3X-EMWE].

458. Peter Moore, Most Americans Back Federal Abortion Funding Ban, YouGov (Aug. 12, 2016), https://today.yougov.com/topics/politics/articles-reports/2016/08/12/taxation-and-morality [https://perma.cc/H3KY-DFAA].

459. Politico & Harv. T.H. Chan Sch. Pub. Health, The 2016 Election: Clinton vs. Trump Voters on American Health Care 16–17 (2016), https://www.politico.com/f/?id=00000158-039b-d881-adda-77db04b70000 [https://perma.cc/JCW2-HZA9].

460. Abortion rates declined in Massachusetts after the adoption of "RomneyCare" in 2006, which was the blueprint for the ACA. Patrick Whelan, Abortion Rates and Universal Health Care, 362 New Eng. J. Med. e45(1), e45(2) (2010) (reporting a decrease in abortion rates of 1.5% generally and 7.4% in teenagers). The same happened nationwide after implementation of the ACA. Joelle Abramowitz, Planning Parenthood: The Affordable Care Act Young Adult Provision and Pathways to Fertility, 31 J. Population Econ. 1097, 1108 (2018) (reporting that the ACA's passage was associated with a disproportionate decrease in abortion rates for people aged twenty to twenty-four).

single-payer health plan,[461] while more centrist democratic leaders like President Joe Biden have also recently come out in opposition to the Hyde Amendment.[462] This could make it politically difficult for Democrats to rally around any proposal that did not outright reject Hyde.

Colorado's attempt to adopt a state single-payer model in 2017 provides an illuminating example of the clash between single-payer health reform and reproductive rights when Hyde-style restrictions remain in place.

In 2017, after six years of effort, a Democratic politician finally got enough votes to put a state-based universal health care plan on the ballot. Amendment 69 would have amended the Colorado Constitution to create a state-based single-payer plan, funded through a 10% payroll tax that would effectively end private insurance in the state.[463] An overwhelming 78% of voters rejected the amendment.[464] One reason the amendment did not pass was that it may have effectively removed all abortion care coverage options because, in 1984, Colorado amended its constitution to ban the use of public funds for abortions.[465]

The National Association for the Repeal of Abortion Laws (NARAL), an abortion rights organization, opposed Amendment 69 on grounds that the state plan might not be able to fund abortions and private insurance would also no longer be an option, leaving people in the state without any financial support for abortion care.[466] Because the Colorado single-payer bill did not expressly confront the state's constitutional ban on abortion spending, it jeopardized abortion access to a degree that reproductive justice advocates found unacceptable.[467] Note that at the federal level, the Hyde Amendment gets passed annually as an appropriations bill, so a federal single-payer statute that was *silent* on Hyde would still be subject to its funding restrictions that year—but Congress could remove the Hyde restrictions by simply not

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461. See Claire Landsbaum, Bernie Sanders's Medicare-for-All Bill Covers All Women's Health Services, Including Abortion, The Cut (Sept. 13, 2017), https://www.thecut.com/2017/09/bernie-sanders-medicare-for-all-bill-covers-abortion.html [https://perma.cc/Q6NG-SX8P].

462. William Saletan, Abortion Funding Isn't as Popular as Democrats Think, Slate (June 12, 2019), https://slate.com/news-and-politics/2019/06/joe-biden-hyde-amendment-democratic-support.html [https://perma.cc/KZ78-4762].

463. Colorado Creation of ColoradoCare System, Amendment 69 (2016), Ballotpedia, https://ballotpedia.org/Colorado_Creation_of_ColoradoCare_System,_Amendment_69_(2016) [https://perma.cc/AQS5-P4HK] (last visited Oct. 25, 2023).

464. Id.

465. Dylan Matthews, Single-Payer Health Care Failed Miserably in Colorado Last Year. Here's Why., Vox (Sept. 14, 2017), https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure [https://perma.cc/92ZG-Z3YA]; see also Colo. Const. art. V, § 50 (prohibiting the use of public funds to pay for abortions).

466. See Becca Andrews, Here's Why Abortion Advocates Won't Vote for Universal Health Care in Colorado, Mother Jones (Sept. 12, 2016), https://www.motherjones.com/politics/2016/09/colorado-ballot-measure-universal-health-care-abortion/ [https://perma.cc/F3HK-N2XM].

467. See id.

including the amendment in the next year's appropriation for HHS or exempting the single-payer trust from that restriction.[468]

Conservatives will not support Medicare for All in its current form because it ostensibly covers the full range of reproductive services.[469] The progressives who drafted and support it do so in part *because* the bill comprehensively covers reproductive care, including abortion. So, abortion exceptionalism undermines the political consensus required to pass single-payer reforms.

3. *State-Level Single-Payer.* — Despite the challenges observed in Colorado, state-level single-payer plans remain potentially more politically feasible than a federal one.[470] Two aspects of state-level single-payer may more effectively confront the reproductive exceptionalism and political hurdles of enacting federal single-payer.

First, the political economy of health reform suggests that the states most likely to enact single-payer reforms are those in which the populace has elected progressive representatives to the legislative and executive branches. While multiple states—including California, Iowa, Massachusetts, and Ohio—have had single-payer bills *introduced* in their legislatures, only Vermont has passed a bill.[471] The states who have taken more meaningful steps toward single payer tend to have progressive politics. Colorado, Nevada, and Washington recently enacted state-level public option programs.[472] And, for example, Oregon's Legislative Task Force on Universal Health Care submitted a detailed proposal for a statewide single-payer system in September 2022.[473]

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468. See James V. Saturno, Megan S. Lynch & Bill Heniff, Jr., Cong. Rsch. Serv., R42388, The Congressional Appropriations Process: An Introduction (2016), https://crsreports.congress.gov/product/pdf/R/R42388 [https://perma.cc/3Y8T-SH7H] (detailing aspects of the congressional appropriations process); Matthew B. Lawrence, Congress's Domain: Appropriations, Time, and *Chevron*, 70 Duke L.J. 1057, 1059–61 (2021) (explaining the difference between annual and permanent appropriations).

469. See, e.g., Louis Brown, Health Care: The Greatest Pro-Life Political Battle of Our Time, Pub. Discourse (Dec. 2, 2019), https://www.thepublicdiscourse.com/2019/12/58579/ [https://perma.cc/R8MC-3WSP] ("The right to life would not survive a single-payer health care system."); Pham, supra note 436 ("But in reality there is only one single-payer plan currently up for debate, 'Medicare for All,' and there is unequivocally no pro-life argument for that bill.").

470. See Fuse Brown & McCuskey, supra note 8, at 400–01 ("[T]here is a nontrivial possibility that some state or states could thread the political, administrative, financial, and legal needles necessary to pass a single-payer plan in the coming years.").

471. Jean Yi, More States Are Proposing Single-Payer Health Care. Why Aren't They Succeeding?, FiveThirtyEight (Mar. 9, 2022), https://fivethirtyeight.com/features/more-states-are-proposing-single-payer-health-care-why-arent-they-succeeding/ [https://perma.cc/XZ7Y-DZHZ].

472. Monahan et al., supra note 403.

473. See Ore. Legis. Pol'y & Rsch. Off., Joint Task Force on Universal Health Care: Final Report & Recommendations, at v–vi (2022), https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20

The states most likely to enact single payer are thus also the states whose majority constituencies are most likely to demand full coverage for reproductive services, including abortion. The experience with Colorado's Amendment 69 again is instructive. The referendum failed among voters not due to lack of support for the concept of a single-payer system but because the proposal could not accommodate abortion funding as drafted without also changing the state's constitution. At the state-by-state level, attracting sufficient political support for single-payer might *require* that a plan also dismantle some facets of abortion exceptionalism. In Oregon, for example, the Task Force's single-payer plan contemplates coverage without reproductive exceptions, and public commentary raised the concern that all reproductive services should be part of the coverage to gain public support.[474]

Second, the experience of states as payers (both as administrators of Medicaid plans and as civilian public employers) also suggests that exceptions to the funding streams for abortion care may play less prominent roles in any single-payer experiment. While thirty-three states have enacted their own Hyde-style restrictions on coverage for abortion in their employee health plans,[475] those states are also the ones politically less likely to pursue single-payer seriously. The sixteen states who already cover abortion and a fuller range of reproductive and sexual health care in their employee plans are more likely to pursue single-payer options. Thus, state funding restrictions are less likely to factor into state single-payer coverage. And some states whose politics have leaned conservative in recent years saw voter referenda come out in support of abortion rights in the election cycle immediately after *Dobbs*.[476] The referenda in Kentucky, Michigan, North Carolina, and Ohio imply that even some purple states may have voter-level support for expanding access to reproductive care—or at least no further appetite for curtailing it.[477]

Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf [https://perma.cc/BB5B-PHJB].

474. Id. at 20, 69.

475. See Salganicoff et al., Hyde Amendment, supra note 44 (noting that thirty-three states have elected to extend Hyde to their state coffer, while only sixteen states permit use the of state funds for abortions).

476. See, e.g., Spencer Kimball, Abortion Rights Keep Winning on the Ballot in Conservative States—Florida and Arizona Could Be Next, CNBC (Aug. 9, 2023), https://www.cnbc.com/2023/08/09/abortion-rights-keep-winning-on-the-ballot-in-conservative-states.html [https://perma.cc/G5MD-3J5L] (describing the abortion-related votes in Kansas and Kentucky in the immediate aftermath of *Dobbs*).

477. See Rachel Rebouché & Mary Ziegler, Why Direct Democracy Is Proving So Powerful for Protecting Abortion Rights, The Atlantic (Nov. 11, 2022), https://www.theatlantic.com/ideas/archive/2022/11/abortion-rights-midterm-election-ballot-initiatives/672071/ (on file with the *Columbia Law Review*); Billy Wynne, Alyssa Llamas, Erin Slifer & Audrey McClurg, What Recent State Elections Mean for Health Care, Health Affs. Forefront (Nov. 16, 2022), https://www.healthaffairs.org/content/forefront/recent-state-

State single-payer systems do, however, require the receipt of federal funding streams to fully fund their plans.[478] Getting waivers to "pass-through" federal money from Medicaid, Medicare, and the ACA exchanges will be essential to the feasibility of any state single-payer.[479] Unless Congress abandons the Hyde Amendment, that federal funding will still come with abortion restrictions on its use. States would thus need to use separate state funds to pay for abortion services, as a few already do in their Medicaid programs.[480]

Pursuing single payer at the state level dilutes the universality of these reforms, and it likely leaves unaided those marginalized groups already most subordinated by the political system. But in the framework of confrontational incrementalism, it represents a step forward, despite its limited jurisdictional reach.[481] Pragmatically, pursuing single-payer to decouple health care access from employment appears as a net positive if pursued in states with durable support for reproductive choice. From an interest convergence perspective, government funding comes out ahead of employer funding due to its direct accountability to the populace and its broader, longer-term view of health care costs.

C. *Whose Choice? Vigilance About Third-Party Funding*

These seemingly intractable trade-offs in the pursuit of reproductive justice through health reform point to a more fundamental obstruction in the design of health care: the reliance on third-party funding. Situating these consequential decisions about the availability of medical care in *any* "third party" beyond the patient (and their doctor) invites the mechanisms of subordination and control into the realm of individual reproductive autonomy. The analyses above have illustrated the subordinating influences of placing employers' personal and commercial interests in this role. The implications of shifting third-party funding control to governments may not be better because many of those governments have themselves acted as

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elections-mean-health-care [https://perma.cc/8KEQ-XTZN]; see also Adam Edelman, In a Win for Abortion-Rights Supporters, Ohio Voters Reject Issue 1, NBC News (Aug. 8, 2023), https://www.nbcnews.com/politics/elections/ohio-issue-one-reject-loss-abortion-rights-ballot-measure-rcna98842# [https://perma.cc/KR3G-VA7H] (reporting on the failure of a ballot measure in Ohio that would have made it more difficult to pass a future amendment to the constitution to protect abortion rights).

478. See Fuse Brown & McCuskey, supra note 8, at 398 & n.39.

479. Id.

480. Lindsay F. Wiley, Medicaid for All? State-Level Single-Payer Health Care, 79 Ohio St. L.J. 843, 868–69 (2018).

481. See Wiley et al., Health Reform Reconstruction, supra note 49, at 739–41. A focus on state-level reform may present some serious limitations, however, that deserve critical evaluation for whether they meet the standards for confrontational incrementalism. Some states will never progress, and too great a focus on state-level reform could leave those states (and their residents) with less appetite for national reform behind.

subordinating influences both historically and currently. Whether a private entity or a governmental unit wields the power of the purse in relatively more or less subordinating ways becomes a central issue in health reform aimed at expanding reproductive justice.

The insurance model of third-party funding also relies heavily on the concept of "medical necessity" in distributing plan resources. As explained above,[482] the determination of whether a covered service is "medically necessary" hands additional power to employers, insurers, and lawmakers to exclude reproductive care. Even when an insurance plan has committed to covering abortion, contraception, or fertility, its administrators may deny coverage for such care under a determination that the patient does not meet the medical-necessity standard.[483] This insurance-based coverage carveout is a highly discretionary and contestable standard that patients rarely have the wherewithal to contest.[484] This determination is exceptionally punishing for reproductive care and for LGBTQ enrollees trying to access fertility benefits.[485]

Health-reform efforts should therefore approach any third-party funding mechanism with greater vigilance to its influence over reproductive justice. As Professor Matthew Lawrence has explained in the context of government appropriations, "The subordination question ('who pays?') should be as familiar to institutional analysis of separation-of-powers questions as is the legal-process question ('who decides?')."[486] To be antisubordinative, a government funding mechanism must also confront exceptionalism and situate the decisionmaking in a segment of government that is as accountable to the affected stakeholders as possible.[487] The questions of *who pays* and *who decides* are bound together. And, as Dean Rachel Rebouché predicted, the focus of abortion access efforts post-*Roe* must turn "from rights to resources."[488]

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482. See supra section I.A.3.

483. Cf. Hill, Essentially Elective, supra note 176, at 100 (discussing limits on abortions when they are classified as "'non-essential,' 'non-urgent,' or 'elective'" procedures).

484. See Karen Pollitz, Justin Lo, Rayna Wallace & Salem Mengistu, Claims Denials and Appeals in ACA Marketplace Plans in 2021, KFF (Feb. 9, 2023), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/ [https://perma.cc/H6RK-58NE] ("In 2021, HealthCare.gov consumers appealed less than two-tenths of 1% of denied in-network claims.").

485. See Blake, supra note 327, at 663–65.

486. Matthew B. Lawrence, Subordination and Separation of Powers, 131 Yale L.J. 78, 89 (2022).

487. See id. at 153–54 ("Exercises of power that threaten harm to the country as a whole pose less risk of subordination and avoid the institutional and operational concerns . . . [because] once costs are particularized, it is often logistically and politically difficult to prevent them from being targeted at marginalized groups.").

488. Rebouché, supra note 19, at 1416.

In health care terminology, an alternative to the ordinary insurance model of third-party finance of care is "direct care,"[489] in which a program directly funds providers from whom patients may receive care without the involvement of an insurer to arrange payment. Examples of direct care internationally include the U.K.'s National Health System[490] and domestically include the Veterans' Health Administration (VHA)[491] and Indian Health Service (IHS),[492] which operate health care facilities that treat patients in their respective populations: veterans and members of federally recognized tribes. Providing reproductive services through direct-care organizations would diminish the control that third parties have over access to these services and may mitigate the medical-necessity determination problem too. But it would not entirely avoid the influence of funding, as some entity must determine how to fund the providers themselves. The experiences thus far with direct care in the VHA and IHS have not been positive for a host of reasons,[493] many of which stem from the vulnerability of the defined populations they serve.[494] Notably, the VHA began offering abortion care in September 2022, even in states where abortion is banned or restricted.[495]

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489. See, e.g., Andis Robeznieks, Pondering Direct Care? 13 Potential Benefits and Drawbacks, Am. Med. Ass'n (Oct. 10, 2018), https://www.ama-assn.org/practice-management/payment-delivery-models/pondering-direct-care-13-potential-benefits-and [https://perma.cc/T8F9-UCF2] (defining "direct care" and assessing its benefits and drawbacks).

490. See The NHS Constitution for England, Gov.UK, https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england [https://perma.cc/QZ9H-KY7G] (last updated Aug. 17, 2023) (describing England's National Health Service).

491. See Veterans Health Administration, VA, https://www.va.gov/health/ [https://perma.cc/E22U-5CJG] (last updated Oct. 24, 2023).

492. See About IHS, Indian Health Serv., https://www.ihs.gov/aboutihs/ [https://perma.cc/ZT6B-83FP] (last visited Oct. 26, 2023) ("The IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states.").

493. See Associated Press, Veterans Share Stories of Bad Experiences With VA Medical Care, GulfLive (May 31, 2014), https://www.gulflive.com/mississippi-press-news/2014/05/veterans_share_stories_of_bad.html [https://perma.cc/THH2-S9CT] (reporting on issues at several VA facilities that have prompted investigations and calls for criminal probes); Mark Walker, Pandemic Highlights Deep-Rooted Problems in Indian Health Service, N.Y. Times (Sept. 29, 2020), https://www.nytimes.com/020/09/29/us/politics/coronavirus-indian-health-service.html (on file with the *Columbia Law Review*) (last updated Oct. 8, 2021) (explaining how the IHS has been "plagued by shortages of funding and supplies, a lack of doctors and nurses, too few hospital beds and aging facilities").

494. See Disparities, Indian Health Serv. (Oct. 2019), https://www.ihs.gov/newsroom/factsheets/disparities/ [https://perma.cc/CAP6-K4JT] (detailing the poor health, economic, and social conditions of Native Americans); Social Justice and Health Care for Veterans, Duq. Univ., https://guides.library.duq.edu/veterans [https://perma.cc/5HER-T8CH] (last updated Aug. 30, 2023) (acknowledging that the physical, mental, and social issues that veterans face make them a "vulnerable population").

495. See Abigail Abrams, Veterans Affairs' New Policy to Provide Abortions Sets Off Battle With Conservative States, Time (Sept. 15, 2022), https://time.com/6214024/veterans-affairs-

Yet the full consideration of reform demands more attention to the possibilities of moving further toward direct care provision for reproductive services, whether publicly funded, privately funded, or both. In 1970, Congress established the Title X federal grant program to ensure that financial considerations did not prevent people from accessing family-planning services,[496] a tenet of reproductive justice.[497] Title X funding for family planning thus serves as an existing model of how Hyde-restricted public funding for direct care works and does not work. Title X–funded clinics provide much more effective access to contraception than clinics that do not receive Title X funding and play a major role in securing access to contraception for adolescents.[498] But political pressures and the Hyde Amendment mean that Title X–supported clinics cannot use federal funds for abortion and are at the whim of executive branch maneuvering, including gag rules for abortion referrals and parental-notification policies that diminish their impact.[499] As a recent study concludes, political changes in "[s]tate and federal policies that shift how and to whom publicly supported family planning care is delivered have real-time effects on providers attempting to serve patients."[500]

The reproductive exceptionalism that has carved reproductive care (and especially abortion) out of each piece of the multipayer system in the United States has driven the proliferation of separate, independent, and predominately privately funded reproductive care clinics.[501] Thus, this mode of providing reproductive care serves patients who fall into the large gaps in the current system and supplies the care that political moves have carved out of public programs. Independent, privately funded clinics have come to be the predominant providers of abortion services,[502] including the surgical and

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abortion-fight/ (on file with the *Columbia Law Review*) (explaining that the VA is exempt from the Hyde Amendment); see also Shaye Beverly Arnold, Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American Women Using Indian Health Service Facilities, 104 Am. J. Pub. Health 1892, 1893 (2014) (explaining how the Hyde Amendment leads to discriminatory restrictions on Native Americans).

496. See Diana J. Mason & Lisa David, Title X: Moving Forward or Backward on Women's Health?, 321 JAMA 236, 237 (2019).

497. See supra text accompanying note 19.

498. See Blair G. Darney, Frances M. Biel, Megan Hoopes, Maria I. Rodriguez, Brigit Hatch, Miguel Marino, Anna Templeton, Jee Oakley, Teresa Schmidt & Erika K. Cottrell, Title X Improved Access to Most Effective and Moderately Effective Contraception in US Safety-Net Clinics, 2016–18, 41 Health Affs. 497, 500–02 (2022).

499. See id. at 498.

500. Alicia VandeVusse, Jennifer Mueller, Marielle Kirstein, Philicia W. Castillo & Megan L. Kavanaugh, The Impact of Policy Changes From the Perspective of Providers of Family Planning Care in the US: Results From a Qualitative Study, 30 Sexual & Reprod. Health Matters 1, 12 (2022).

501. See supra section I.B.2; see also Abortion Care Network, supra note 48, at 3.

502. See Abortion Care Network, supra note 48, at 3.

medication abortion care that has been the most exceptionalized.[503] (And the cycle of exceptionalism means that the proliferation of these clinics to fill these gaps may also *enable* those gaps to persist.) So the model of privately funded direct-care clinics has precedent in providing the full range of reproductive care outside of the insurance-based, third-party payment system; this infrastructure could be a place to direct private funding to expand its impact.

In considering direct-care clinics as an alternative to insurance-style, third-party funding, it is important to differentiate between direct-care clinics, which provide the services outlined in section I.A.3 as "reproductive care," and "crisis pregnancy centers," which counsel against abortion and typically do not provide medical care.[504] The proliferation of crisis pregnancy centers is also a byproduct of the exceptionalism that has forced reproductive care outside of the current funding system.[505] Trump-era regulations extending Title X federal funding to crisis pregnancy centers, repealed by the subsequent administration, illustrate the political maneuvering that public funding for privately established entities invites when it comes to abortion.[506]

Still, direct care might be a more desirable place to invite private funding for reproductive care rather than entrenching it at the employer level. For instance, private organizations that serve patient interests and advocate for universal care and reproductive choice have interests aligned with individuals' autonomy. In this mode, channeling private funding to direct-care organizations may offer a small step forward in access, though it necessarily works within the confines of reproductive exceptionalism. A private–public partnership might even be possible for direct-care providers located on federal lands within restrictive states.[507]

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503. See David S. Cohen, Greer Donley & Rachel Rebouché, Abortion Pills, 76 Stan. L. Rev. (forthcoming 2024) (manuscript at 73) (noting how fear of enforcement may cause abortion providers to change their habits); see also Donley, supra note 101, at 703 ("The REMS has segregated medication abortion outside of traditional healthcare settings into abortion and family planning clinics.").

504. See Am. Coll. of Obstetricians & Gynecologists, Issue Brief: Crisis Pregnancy Centers 1 (Oct. 2022), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/issue-briefs/crisis-pregnancy-centers.pdf [https://perma.cc/3CD5-E7PD]; Off. of Sexual Health & Youth Dev., Warning About Crisis Pregnancy Centers, Mass.gov (July 12, 2022), https://www.mass.gov/news/warning-about-crisis-pregnancy-centers [https://perma.cc/A22K-K2GR].

505. See Oriana González, Anti-Abortion Pregnancy Centers Are Expanding in the Post-*Roe* Era, Axios (Aug. 19, 2022), https://www.axios.com/2022/08/19/crisis-pregnancy-centers-abortion-roe-health-care (on file with the *Columbia Law Review*).

506. See 42 C.F.R. § 59.5(b)(3)(iii) (2023) (repealing the 2019 policy change by "ensur[ing] access to equitable, affordable, client-centered, quality family planning services").

507. See Kevin J. Hickey & Whitney K. Novak, Cong. Rsch. Serv., Congressional Authority to Regulate Abortion 4 (2022), https://crsreports.congress.gov/product/pdf/LSB/LSB10787 [https://perma.cc/MRD3-N2GT] ("Pursuant to its powers under the

Of course, the exceptionally high prices of medical and reproductive care in the United States prompt these funding conundrums and power dynamics in the first place. Therefore, policies that would decrease the prices of care would support reproductive justice, too. This Article leaves it to other scholars and researchers to press forward on that front, noting that direct care provided by the government at least removes the profit motivations from the provision of care by private entities.

CONCLUSION

As the battle for reproductive autonomy rages in America, many have never truly been free from third-party control. For generations, the legal and regulatory system has entrenched employer-sponsored insurance, placing employers in the role of gatekeepers of reproductive care and therefore reproductive freedom. In this relationship, individuals' interests in reproductive self-determination are subordinate to employers' actuarial, economic, and selfish interests. Those concerned about governmental control over their reproductive lives ought to be no more tolerant of commercial intrusion into that private space.

Single-payer health care, either state or federal, might unbind health care payment from employers' grip but could hand it over to some of the same political forces that have long restricted access to reproductive care. Thus, health reform that expands access to care requires extra vigilance to ensure that it confronts, rather than perpetuates, reproductive exceptionalism and makes meaningful progress for reproductive autonomy. This project implores those committed to universal health care to meaningfully center reproductive justice in their efforts. As challenging as that endeavor may be, incorporating reproductive justice is essential to the durability and promise of universal health care—and *Dobbs* has made that effort both imperative and urgent.

Spending Clause, Congress could leverage federal funds to restrict or expand access to abortion, either directly or indirectly."); David S. Cohen, Greer Donley & Rachel Rebouché, The New Abortion Battleground, 123 Colum. L. Rev. 1, 80 (2023) ("State abortion bans might be inapplicable on [federal] lands.").