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The Public Health Implications of Religious Exemptions: A Balance Between Public Safety and Personal Choice, or Religion Gone Too Far?

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THE PUBLIC HEALTH IMPLICATIONS OF RELIGIOUS EXEMPTIONS: A BALANCE BETWEEN PUBLIC SAFETY AND PERSONAL CHOICE, OR RELIGION GONE TOO FAR?

Christopher Ogolla†

The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.¹

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1. Prince v. Massachusetts, 321 U.S. 158, 166 (1944).

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INTRODUCTION

Religion has historically influenced public health.² It has, and does continue to play, both a positive and a negative role in population health. On the positive side, the evidence suggests that religion, however assessed, is generally a protective factor for mental illness.³ In behavioral health, vegetarian diets required by many Hindu, Seventh Day Adventists, and Buddhist religions, among others, “have been found to be associated with decreased risk of heart disease.”⁴ Additionally, in religions where smoking and drinking are prohibited (such as among the Mormons of Utah), “epidemiological maps of the incidence of lung cancer and liver disease show markedly low rates of occurrence.”⁵

In many parts of the world, religious organizations and groups provide key public health functions including, but not limited to, provision of good nutrition, HIV treatment and counseling services, clean drinking water, childhood immunizations, and prenatal and neonatal health screening services. Here in the United States, faith-based organizations have always been very active in the public health arena. Indeed, the Department of Health and Human Services has established a Center for Faith-Based and Neighborhood Partnerships whose goal is to “lead the department’s efforts to build and support partnerships with faith-based and community organizations in order to better serve individuals, families and communities in need.”⁶ These positives do not conflict with any laws.

On the other hand, religion has had some significant negative influences on public health. For example, many religious groups’ opposition to the use of condoms in the developing world has been

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2. Peter H. Van Ness, *Religion and Public Health*, 38 J. RELIGION & HEALTH 15, 17 (1999).
 3. Jeff Levin, *Religion and Mental Health: Theory and Research*, INT’L J. APPL. PSYCHOANALYTIC STUDIES 1, 10 (2010).
 4. Van Ness, *supra* note 2, at 17.
 5. *Id.*
 6. *The Center for Faith-Based and Neighborhood Partnerships*, U.S. DEP’T. OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/partnerships> (last visited Jan. 27, 2014).

associated with the increased spread of HIV and AIDS.⁷ Other denominations like Christian Scientists and Jehovah's Witnesses restrict members' use of medical services.⁸ Between 2000 and 2002, New York City public health officials reported that a total of eleven newborn males had laboratory-confirmed herpes simplex virus (HSV) infections in the weeks following out-of-hospital Jewish ritual circumcision. Ten of the eleven newborns were hospitalized and two died.⁹

Thus, it can be argued that to a great extent, religion and public health activities are inextricably intertwined. However, the constitutional relationship between the two is inordinately complex. Several constitutional rights are relevant to public health practice. Most common are the First, Fourth, Fifth and Fourteenth Amendments. The First Amendment provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances."¹⁰ In the words of Justice Hugo Black:

The "establishment of religion" clause of the First Amendment means at least this: Neither a state nor the Federal Government can set up a church. Neither can pass laws which aid one religion, aid all religions, or prefer one religion over another. Neither can force nor influence a person to go to or to remain away from church against his will or force him to profess a belief or disbelief in any religion. No person can be punished for entertaining or professing religious beliefs or disbeliefs, for church attendance or non-attendance.¹¹

The first clause, or the Establishment Clause, "prohibits government actions that unduly favor one religion over another. It

7. *Burundi: Religious Leaders' Resistance to Condom Hurts HIV Fight*, IRINNEWS.ORG (May 26, 2011), <http://www.irinnews.org/report/92817/Burundi-religious-leaders-resistance-to-condoms-hurts-hiv-fight>.

8. Van Ness, *supra* note 2, at 18.

9. Susan Blank et al., *Neonatal Herpes Simplex Virus Infection Following Jewish Ritual Circumcisions that Included Direct Orogenital Suction – New York City, 2000–2011*, 61 MORBIDITY & MORTALITY WEEKLY REP. 405 (2012).

10. U.S. CONST. amend. I.

11. *Everson v. Bd. of Educ. of Ewing Twp.*, 330 U.S. 1, 15-16 (1947).

also prohibits the government from unduly preferring religion over non-religion, or non-religion over religion.”¹²

There are concerns in public health that “[e]xemptions—religious or otherwise—are dangerous and put individuals at risk for contracting potentially debilitating and deadly infectious diseases.”¹³ The availability of religious exemptions in public health has pitted public health practitioners against those opposed to public health mandates such as those in immunization, contraception, quarantine, and isolation. For example, those against religious exemptions in public health contend that the First Amendment neither requires that states provide a religious exemption from immunization nor does it require that states provide religious accommodations with respect to immunization statutes.¹⁴ Additionally, they argue that “statutory religious exemption improperly advances religion because its essential effect is to entitle those holding a religious belief against immunization to be exempted from immunization.”¹⁵ Alternatively, “application of the religious exemption requires excessive entanglement of state and church.”¹⁶ Essentially, these arguments boil down to the fact that the religious exemptions themselves violate the Establishment Clause. Another line of criticism decries the strong privileges the law grants to religion by observing that “[t]here has been an ongoing religious dialectic between religious entities, the law and the public good for centuries, and it has tended from strong privileges for religious entities towards the application of the rule of law to them.”¹⁷ In other words, religion seems to be singled out for special beneficial treatment.¹⁸

12. *Establishment Clause*, CORNELL UNIV. LAW SCH. LEGAL INFO. INST., http://www.law.cornell.edu/wex/establishment_clause (last visited Aug. 2, 2014).

13. EVERY CHILD BY TWO, RELIGIOUS EXEMPTIONS FACT SHEET, http://www.vaccinateyourbaby.org/pdfs/religion_exemptions_fact_sheet.pdf (last visited Apr. 4, 2015).

14. *Turner v. Liverpool Cent. Sch.*, 186 F. Supp. 2d 187, 190 (N.D.N.Y. 2002).

15. *Id.* at 192.

16. *Id.* at 191.

17. MARCI A. HAMILTON, *GOD VS. THE GAVEL: RELIGION AND THE RULE OF LAW* 238 (2005).

18. Professor Steven Smith, a supporter of religious accommodations writes that “the anti-accommodationist position increasingly finds favor with legal academics. Why should religion be singled out for special constitutional treatment? Or at least for special favorable treatment” Steven D. Smith & Caroline Marla Corbin, *Debate, The Contraception Mandate and Religious Freedom*, 161 U. PA. L. REV. 261, 266 (2013).

Proponents of religious exemptions in public health contend that “any state inquiry into the nature or sincerity of a proclaimed religious belief is not driven by a compelling state interest and is therefore a blatant violation of the Free Exercise Clause of the U.S. Constitution.”¹⁹ Others argue that the constitutional right to contraceptives, recognized by the U.S. Supreme Court in *Griswold v. Connecticut*²⁰ is a negative liberty, not a positive right.²¹ They maintain that the “right created in *Griswold* was not a positive right to demand that the government provide or pay for contraceptives, much less than a right to force healthcare providers to prescribe or employers to subsidize contraception.”²² By induction, this argument holds that since the contraception right is a not a positive right, it cannot be mandated and therefore those opposed to it on religious grounds should be exempted. Still, others point to the Religious Freedom Restoration Act (RFRA), “which explicitly commands affirmative accommodation of religion”²³ RFRA, in turn, came about after the U.S. Supreme Court’s ruling in *Employment Division, Department of Human Resources of Oregon. v. Smith*.

In *Employment Division v. Smith*,²⁴ the Court held that the Free Exercise Clause permitted Oregon to include religiously inspired peyote use within the reach of its general criminal prohibition on use of that drug, and therefore permitted the state to deny unemployment benefits to persons dismissed from their jobs because of such religiously inspired use.²⁵ In an oft-quoted phrase regarding the constitutionality of religious exemptions in public or state activities (read public health activities), the Court found, “[w]e have never held that an individual’s religious beliefs excuse him from compliance with an otherwise valid law prohibiting conduct that the State is free to regulate. On the contrary, the record of more than a century of our

19. *Hepatitis B Vaccinations and State Law*, RUTHERFORD INST. 4 (2002), http://www.vaclib.org/letters/B18-RE_1.PDF. The Rutherford Institute is a Charlottesville, VA, based group that provides legal services in the defense of religious and civil liberties; see David Hudson, *The Establishment Clause Is Still a Contentious Battle Among the Justices*, ABA J., Nov. 2013, at 16.

20. 381 U.S. 479, 485 (1965).

21. Maureen Bailey, *Contraceptive Insurance Mandates and Catholic Charities v. Superior Court of Sacramento: Towards a New Understanding of Women’s Health*, 9 TEX. REV. L. & POL’Y., 368, 371 (2005).

22. *Id.*

23. Smith & Corbin, *supra* note 18, at 266.

24. 494 U.S. 872 (1990).

25. *Smith*, 494 U.S. at 874.

free exercise jurisprudence contradicts that proposition.”²⁶ As noted by the Congressional Research Service, “[t]he Court’s decision lowered the constitutional baseline of protection, meaning that laws that do not specifically target religion are not subject to heightened review under the First Amendment.”²⁷

In response to *Smith*, Congress passed RFRA in 1993.²⁸ RFRA provides in pertinent part:

[The g]overnment shall not substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability, except only . . . if [the government] demonstrates that application of the burden to the person is in furtherance of a compelling governmental interest; and is the least restrictive means of furthering that compelling governmental interest.²⁹

RFRA “essentially reinstated the heightened standard of protection applied to government actions that interfered with the free exercise of religion.”³⁰ However, because of *Smith*, courts have generally held that there is no First Amendment free exercise right to religious exemptions from mandatory public health activities. Yet, despite this consensus among the courts, forty-eight states statutorily provide for religious exemptions for school vaccination laws,³¹ while twenty-one states offer exemptions from contraceptive coverage

26. *Id.* at 878.

27. CYNTHIA BROUGHER, CONG. RESEARCH SERV., R43329, FREE EXERCISE OF RELIGION BY SECULAR ORGANIZATIONS AND THEIR OWNERS: IMPLICATIONS FOR THE AFFORDABLE CARE ACT (ACA) 2 (2014), available at <http://fas.org/sgp/crs/misc/R43329.pdf>.

28. 42 U.S.C. § 2000bb et seq. Congress responded to *Smith* by enacting the *Religious Freedom Restoration Act of 1993*, Pub. L. No. 103-141, 107 Stat. 1488 (November 16, 1993), codified at 42 U.S.C. § 2000bb “to restore the compelling interest test for free-exercise cases that prevailed prior to *Smith* and to provide a claim or defense to persons whose religious exercise is substantially burdened by government.” *Autocam Corp. v. Sebelius*, 730 F.3d 618, 625 (6th Cir. 2013) (citations omitted).

29. 42 U.S.C. § 2000bb-1 (1993).

30. BROUGHER, *supra* note 27.

31. See NAT’L CONF. OF ST. LEGISLATURES, STATES WITH RELIGIOUS AND PHILOSOPHICAL EXEMPTIONS FROM SCHOOL IMMUNIZATION REQUIREMENTS (Dec. 2012), <http://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx>.

(usually for religious reasons) for insurers or employers in their policies.³²

The questions then arise; first, do religious exemptions in public health activities allow the government to unduly prefer religion over non-religion?³³ Second, is immunizing religious conduct consistent with public welfare, health, and safety?³⁴ Third, are the overwhelming number of states that provide statutory religious exemptions for immunizations (forty-eight) and religious exemptions for contraception (approximately half) tipping the balance heavily in favor of religion? Put otherwise, are these jurisdictions running on Scylla, wishing to avoid Charybdis?³⁵

This paper attempts to answer these questions by analyzing the historical, legal, and policy arguments for and against religious exemptions in public health functions, specifically in vaccination, contraception, and quarantine and isolation. This article notes that, although a number of states and localities have statutes, rules, and regulations mandating immunizations and provision of contraception, a majority of states have enacted religious refusal clauses essentially weakening the overall public health goals of the mandates. Part I reviews the positive and negative roles that religion plays in public health and argues that exemptions—religious or otherwise—are dangerous and put individuals at risk for contracting potentially debilitating and deadly infectious diseases.

Part II describes the history of religious exemptions in public health noting that (1) they have been around since the early part of the nineteenth century; (2) that the exemptions are generally offered for medical, religious, and philosophical grounds; and (3) that there

32. NAT'L CONF. OF ST. LEGISLATURES, INSURANCE COVERAGE FOR CONTRACEPTION LAWS (Feb. 2012), <http://www.ncsl.org/research/health/insurance-coverage-for-contraception-state-laws.aspx>.

33. See KENT GREENWALT, 1 RELIGION AND THE CONSTITUTION: FREE EXERCISE AND FAIRNESS, 2 (2006) (“[T]he crucial issue then becomes whether legislatures or courts should create privileged exceptions that are based directly on a person’s religious convictions or rest on some standard, such as “conscience” that includes religious convictions but does not distinguish between them and similar nonreligious convictions.”).

34. HAMILTON, *supra* note 17, at 8.

35. Scylla and Charybdis are two monsters in Greek mythology. Scylla attacked sailors and Charybdis was a dangerous whirlpool at the mouth of the cave of the sea monster Scylla. To be stuck in between Scylla and Charybdis forces States between two equally unpleasant options: Granting religious exemptions hurts public health activities, but denying those exemptions may trigger free exercise and establishment clause challenges. Either way, the States are interfering with religion.

has been strong opposition to both vaccination and contraception. Nevertheless, great strides have been made in the provision of contraceptives despite several states having religious exclusions for their contraceptive equity laws.

Part III discusses contraceptive equity laws in both state and federal courts and analyzes several cases challenging contraceptive mandates—in particular, *Hobby Lobby Stores Inc. et al. v. Sebelius*,³⁶ and *Conestoga Wood Specialties Corp. v. HHS*³⁷—and their disparate impacts on public health. Part IV discusses the U.S. Supreme Court's decision in *Burwell v. Hobby Lobby Stores Inc.*,³⁸ and notes that its holding—that for-profit religious corporations can be considered persons exercising religion for purposes of the RFRA—does not bode well for public health. For example, this article argues in this section that the majority's view that the government can simply accommodate for-profit corporations' religious beliefs by paying for the contraceptives is unworkable, as argued by Justice Ginsburg in her dissent.

Part IV discusses isolation and quarantine, noting that a significant problem with religious exemptions in quarantine and isolation is that they seem antithetical to science.

Part V addresses the question of whether religious accommodation is a balance between public safety and personal choice, or religion gone too far. It avers that overwhelming number of states providing statutory religious exemptions for immunizations, and those that provide religious exemptions for contraception, quarantine, and isolation are tipping the balance heavily in favor of religion.

Part VI offers some recommendations, specifically three individuals, who though not necessarily addressing religious exemptions, have done more to advance the goals of public health, individual rights, and personal autonomy notwithstanding. The paper concludes by arguing that religious exemptions in public health activities allow the government to unduly prefer religion over non-religion, that immunizing religious conduct is not consistent with public welfare, health, and safety and, finally, that the overwhelming number of states (forty-eight) providing statutory religious exemptions for immunizations and the nearly half that provide exemptions for contraception, are tipping the balance heavily in favor of religion.

36. 723 F.3d 1114 (10th Cir. 2013).

37. 724 F.3d 377 (3rd Cir. 2013), *rev'd by* *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

38. 134 S.Ct. 2751 (2014).

I. HISTORY OF RELIGIOUS EXEMPTIONS IN PUBLIC HEALTH ACTIVITIES

A. Vaccinations

Religious exemptions have been around since the early part of the nineteenth century. In public health, exemptions are generally offered for medical, religious, or philosophical reasons.³⁹ A religious exemption is a statutory provision that allows parents to exempt their children from vaccination if vaccination contradicts their sincere religious beliefs.⁴⁰ It can also mean exemption from any public health activity based on one's religious beliefs. A medical exemption exempts a child who is susceptible to adverse effects from the vaccine.⁴¹ Exemptions based on philosophical beliefs refer to the statutory language that does not restrict the exemption to purely religious or spiritual beliefs,⁴² but allows objections based on personal, moral, or other beliefs.⁴³

Most public health exemptions have been in the area of immunization. State immunization laws have a history dating back to the middle of the nineteenth century.⁴⁴ Local municipalities, counties, cities, and boards of education were among the first to attempt to enact school vaccination laws and policies. Boston became the first U.S. city to require all public school children to show proof of vaccination in 1827.⁴⁵ Next came the states. Within thirty years, Massachusetts would become the first state to enact a vaccination requirement for school children in order to prevent the transmission of smallpox.⁴⁶ New York soon followed in 1862. Other states that passed similar laws included Connecticut in 1872, Indiana in 1881,

39. Daniel A. Salmon et al., *Health Consequences of Religious and Philosophical Exemptions from Immunization Laws: Individual and Societal Risk of Measles*, 282 JAMA 47 (1999).

40. James G. Hodge & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, 90 KY. L. J. 831, 873 (2002).

41. PUBLIC HEALTH LAW AND ETHICS: A READER, 379 (Lawrence O. Gostin ed., 2002).

42. Hodge & Gostin, *supra* note 40.

43. See NAT'L CONF. OF ST. LEGISLATURES, *supra* note 31.

44. Jean M. Santoli & Alan Hinman, *Nonmedical Exemptions to State Immunization Laws*, 92 AM. J. PUB. HEALTH 8 (2002).

45. Hodge & Gostin, *supra* note 40, at 851.

46. Kevin M. Malone & Alan Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights*, in LAW IN PUBLIC HEALTH PRACTICE 262, 269 (Richard A. Goodman et al., eds., 2d ed. 2007).

Arkansas, Illinois, Wisconsin, and Virginia in 1882, California in 1888, Iowa in 1889, and Pennsylvania in 1895.⁴⁷

Although vaccinations were being used increasingly in schools, opposition to vaccination laws also arose in many quarters.⁴⁸ Indeed, “[s]ome opponents expressed valid scientific objections about effectiveness; some worried that vaccination transmitted other diseases . . . or caused harmful effects; and others objected on grounds of religious or philosophical principles.”⁴⁹ In the seminal public health case of *Jacobson v. Massachusetts*,⁵⁰ Reverend Henning Jacobson refused the vaccination, citing concerns over the vaccination’s safety and claiming that he and his son had previously experienced adverse reactions to vaccinations.⁵¹ In rejecting Jacobson’s contention and upholding the Massachusetts statute, the Supreme Court noted that:

The authority of the state to enact this statute is to be referred to what is commonly called the police power,—a power which the state did not surrender when becoming a member of the Union under the Constitution. Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a state to enact quarantine laws and ‘health laws of every description;’ indeed, all laws that relate to matters completely within its territory and which do not by their necessary operation affect the people

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47. Hodge & Gostin, *supra* note 40, at 851.
48. See, e.g., The Coll. of Physicians of Phila., *History of the Anti Vaccination Movements*, HIST. OF VACCINES, <http://historyofvaccines.org/content/articles/history-anti-vaccination-movements> (last updated Dec. 18, 2014) (referring to the British Vaccination Acts of 1853 and 1867 and noting that “[t]he Vaccination Act of 1853 ordered mandatory vaccination for infants up to 3 months old, and the Act of 1867 extended this age requirement to 14 years, adding penalties for vaccine refusal. The laws were met with immediate resistance from citizens who demanded the right to control their bodies and those of their children.”); Allison M. Kennedy et al., *Vaccine Beliefs of Parents Who Oppose Compulsory Vaccination*, 120 PUB. HEALTH REP. 252, 257 (2005) (noting that “[o]pposition to compulsory vaccination is not a new phenomenon; it has been present in some form since the earliest compulsory vaccination laws.”); *Zucht v. King*, 260 U.S. 174, 175 (1922) (deciding the case of Rosalyn Zucht, a child excluded from the San Antonio Texas public school because she did not have the required certificate of vaccination and refused to submit to vaccination).
49. Hodge & Gostin, *supra* note 40, at 844.
50. 197 U.S. 11 (1905).
51. Ben Horowitz, *A Shot in the Arm: What a Modern Approach to Jacobson v. Massachusetts Means for Mandatory Vaccinations During a Public Health Emergency*, 60 AM. U. L. REV. 1716, 1719 (2011).

of other states. According to settled principles, the police power of a state must be held to embrace; at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.⁵²

Thus the court dismissed Jacobson's exemption argument on the basis that a "health regulation requiring small pox vaccination was a reasonable exercise of the state's police power that did not violate the liberty rights of individuals under the Fourteenth Amendment to the U.S. Constitution."⁵³ Although in *Jacobson*, "the question was whether the state had overstepped its own authority and whether the sphere of personal liberty protected by the Due Process Clause of the Fourteenth Amendment included the right to refuse vaccination,"⁵⁴ others have noted that Jacobson's brief was "riddled with religious rhetoric."⁵⁵

Hundreds of cases have followed *Jacobson's* reasoning.⁵⁶ For example, in *Wright v. Dewitt School District No.1 of Arkansas County*,⁵⁷ the Arkansas Supreme Court held that a state health regulation which required all students to be vaccinated against smallpox as prerequisite to attending school was a reasonable regulation and a reasonable exercise of police power and as such did not violate the constitutional right to the free exercise of religion.⁵⁸ In that case, the appellants—adults and school age children—were members of a church known as the General Assembly and Church of the First Born.⁵⁹ The appellee, DeWitt School District #1 of Arkansas County, required all students to be vaccinated against smallpox as a prerequisite to attending school pursuant to a state health regulation. The appellants argued that this requirement violated their religious beliefs. They also contended that the school age appellants had been attending the schools operated by the Dewitt School District #1 for

52. *Jacobson*, 197 U.S. at 24-25.

53. Malone & Hinman, *supra* note 46, at 271.

54. Wendy K. Mariner, et al., *Jacobson v. Massachusetts: It's Not Your Great-Great Grandfather's Public Health Law*, 95 AM. J. PUB. HEALTH 581, 582 (2005).

55. See Horowitz, *supra* note 51, at 1719 n.29 (citing Mariner, *supra* note 54, at 582 and noting that "while the brief filed by Jacobson was riddled with religious rhetoric, the Court only addressed the health concern advanced by Jacobson.").

56. Using Westlaw's KeyCite citing references, 3,038 citations for the case were shown as of August 2014.

57. *Wright v. De Witt Sch. Dist.*, 385 S.W.2d 644 (Ark.1965).

58. *Id.*

59. *Id.* at 645.

many years without being vaccinated, and as a result no one had suffered any adverse effect; that there had been no smallpox in Arkansas County for more than fifty years; and that no immediate, grave, or present danger existed which justified any infringement upon their constitutional right to freely exercise their religious views.⁶⁰ In dismissing their appeal, the Court noted that the appellants did not have the legal right to resist on religious grounds the enforcement of the health regulation requiring the vaccination of all children as a prerequisite to attendance of the schools operated by the School District.⁶¹

Here, the Court relied on the language from *Jacobson v. Massachusetts*⁶² for the principle that “the police power of a state must be held to embrace; at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety.”⁶³

1. Recent Religious Exemption Challenges

Courts have consistently upheld immunization laws that mandate vaccinations even when challenged on religious belief grounds.⁶⁴ For example, in *Brown v. Stone*,⁶⁵ the Mississippi Supreme Court struck down as unconstitutional a part of a statute that provided an exemption to vaccination on religious grounds. The statute provided, in relevant part that “[a] certificate of religious exemption may be offered on behalf of a child by an officer of a church of a recognized denomination. This certificate shall certify that parents or guardians of the child are bona fide members of a recognized denomination whose religious teachings require reliance on prayer or spiritual means

60. *Id.*

61. *Id.*

62. 197 U.S. 11 (1905).

63. *Wright*, 385 S.W.2d at 647.

64. See Daniel Salmon & Andrew Siegel, *Religious and Philosophical Exemptions from Vaccination Requirements and Lessons Learned from Conscientious Objectors from Conscriptation*, 116 PUB. HEALTH REP. 289 (2001) (noting that “[t]he jurisprudence the U.S. Supreme Court has developed in cases in which religious beliefs conflict with public or state interests suggests that mandatory immunization against dangerous diseases does not violate the First Amendment right to free exercise of religion”); *Brown v. Stone*, 378 So.2d 218, 221 (Miss. 1979) (noting that “[t]he courts have weighed the interest of the state in protecting its citizenry as against the desirability of religious freedom devoid of unnecessary governmental intrusion and have generally concluded that the state interest was paramount.”).

65. *Brown*, 378 So.2d at 223.

of healing.⁶⁶ In *Brown*, a father filed a suit seeking an injunction to compel a school district to admit his son as a student even though his son had not complied with the statute requiring immunization of all students.⁶⁷ The father argued that he did not permit his son to be vaccinated because of strong and sincere religious beliefs, and that he sought a religious exemption from vaccination for his son but was denied because the certificate did not comply with the statute.⁶⁸ Consequently, he contended that the religious exemption provisions of the statute were invalid insofar as they forced complainants to join a religious organization in order to practice their religious beliefs freely.⁶⁹

The Mississippi Court agreed with the father. In striking down the exemption, the Mississippi Supreme Court found that

[t]he exception, which would provide for the exemption of children of parents whose religious beliefs conflict with the immunization requirements, would discriminate against the great majority of children whose parents have no such religious convictions. To give it effect would result in a violation of the Fourteenth Amendment to the United States Constitution which provides that no state shall make any law denying to any person within its jurisdiction the equal protection of the laws, in that it would require the great body of school children to be vaccinated and at the same time expose them to the hazard of associating in school with children exempted under the religious exemption who had not been immunized as required by the statute.⁷⁰

Critics might contend that *Brown v. Stone* is an example of a case that overrides individual autonomy in favor of the police powers of the state. For example, the *Brown* Court relies on *Prince v. Commonwealth of Massachusetts*,⁷¹ *Jacobson v. Massachusetts*,⁷² and *Zucht v. King*,⁷³ for the principle that the U.S. Supreme Court has long held that it is within the police power of the state to provide for compulsory vaccination. This is only partially true. The U.S. Supreme

66. *Id.* at 219.

67. *Id.*

68. *Id.* at 221.

69. *Id.*

70. *Id.* at 223.

71. 321 U.S. 158 (1944).

72. 197 U.S. 11 (1905).

73. 260 U.S. at 176.

Court cases did not specifically hold that exemption from immunizations violated the Fourteenth Amendment's Equal Protection Clause. Indeed, in *Jacobson*, Justice Harlan noted that the courts may strike down legislation designed to protect the general welfare when it has no real or substantial relation to the public health, morals, or safety, or if the legislation is "a plain, palpable invasion of rights" secured by the constitution.⁷⁴ In his view, "the police power of a state, whether exercised directly by the legislature, or by local body acting under its authority, may be exerted in such circumstances, or by regulations so arbitrary and oppressive in particular cases, as to justify the interference of the courts to prevent wrong and oppression."⁷⁵

However, there is a long line of cases, dating from 1830 to 2001 where courts have held that vaccination laws do not discriminate against school children to the exclusion of others in violation of the Equal Protection Clause.⁷⁶ In that sense, the *Brown* court was right in striking the religious exemption.

A different line of religious exemption cases inquires whether the challenger's beliefs are religious and whether they are sincere. One such case is *Mason v. General Brown Central School District*.⁷⁷ In that case, parents who advocated "a natural existence"⁷⁸ challenged a district court's ruling dismissing their complaint which sought to compel the school district to permit their son, based on his own religious beliefs, and his parents' beliefs, to attend public school without being immunized as required by New York law.⁷⁹ The law required that all children be immunized before starting school but provided an exemption to those who opposed immunization on religious grounds.⁸⁰ The plaintiffs belonged to a church group that had no membership requirements, no worship or other services, and no traditional doctrine.⁸¹ The district court found that as regards the

74. 197 U.S. at 31.

75. *Id.* at 38.

76. See PUBLIC HEALTH LAW AND ETHICS: A READER, *supra* note 41, at 387.

77. *Mason v. Gen. Brown Cent. Sch. Dist.*, 851 F.2d 47, 50 (2d Cir. 1988).

78. *Id.* at 49 (finding that "the [Plaintiffs] believe that the human body possesses the means of healing itself without medical intervention and that therefore, immunizations are unnecessary and indeed contrary to the 'genetic blueprint' intended by nature.").

79. *Id.* at 48.

80. *Id.* at 49.

81. *Id.*

plaintiffs' beliefs, "they were not essentially religious but were a mere embodiment of chiropractic ethics."⁸²

In affirming the district court's decision, the Court of Appeals for the Second Circuit analyzed whether the appellants' beliefs were religious. It agreed with the district court that the appellants' beliefs were not religious. The appellate court then analyzed whether the organization to which the appellants belonged, possessed an indicia of a religious group or order.⁸³ In a telling analysis of the group, the court stated:

The [group] has no rites of membership, no requirement of active participation, no regular religious meetings, no system of providing guidance to its members, no regular contact between members and leaders, and no indication that it provides any religious services, *i.e.*, marriages, burials, or community and humanitarian aid Significantly, anyone with the money can 'buy' into the church and obtain any desired ecclesiastical title (including bishop, priest, archbishop, friar, reverend, or rabbi) by doing no more than filling out an application and then writing out a check.⁸⁴

Thus the religious exemption claim in *Mason* failed because the courts deemed their beliefs primarily scientific in nature, non-religious based, and that the group with which they were affiliated was not a bona fide religious order.

A contrary outcome occurred in *Turner v. Liverpool Central School*.⁸⁵ In *Turner*, the plaintiff contended that the school district violated her constitutional rights and those of her minor daughter by failing to provide a religious exemption from the state's immunization requirement.⁸⁶ Before registering her daughter for kindergarten, the plaintiff notified the school district that she was religiously opposed to the introduction of any foreign material into the human body and, therefore, sought a religious exemption from New York State's immunization requirement. The plaintiff believed in universal life force.⁸⁷ After questioning the plaintiff, the district determined that the

82. *Id.* at 50.

83. *Id.* at 53.

84. *Id.*

85. 186 F. Supp. 2d at 187.

86. *Id.* at 187.

87. The court noted that "Plaintiff believes in a Universal Life Force, which is the manifestation of God in all things According to Plaintiff, immunization interferes with the transmission of the life force and disrupts one's natural balance and, therefore, one's ability to receive the

congregation was not a genuine religion and that although the plaintiff's beliefs regarding immunization were sincere, they were founded upon a personal philosophy rather than a legitimate religion.⁸⁸ In denying the district's motion for dismissal, the court found that the religious views that the plaintiff espoused appeared to be religious in nature as opposed to merely philosophical or scientific.⁸⁹ In that case, the court found for the plaintiff noting that the secular purpose of the exemption is to allow children whose parents have a "genuine and sincere religious belief" that prohibits them from having their children inoculated, to attend school.⁹⁰

Why the disparate result between the plaintiff in *Mason v. General Brown Central School District* advocating a natural existence and the plaintiff in *Turner v. Liverpool Central School District* belonging to universal life force that saw immunization as interfering with the transmission of the life force and therefore disrupting one's natural balance? Is there sincerity in the latter and none in the former? Perhaps the distinction rests on the fraudulent nature of the church group in *Mason*. There, the court noted that "[w]hile it has sometimes been difficult for us to establish precise standards by which the *bona fides* of a religion may be judged, these difficulties have not hindered us in denying protected status to organizations which are 'obviously shams and absurdities' and whose leaders 'are patently devoid of religious sincerity' The [Universal Life Church] and more specifically for purposes of this case, the [Davenport Universal Life Church] is such an organization."⁹¹

The problem with the sincerity analysis is three-fold. First, it is a probing interference in religion, historically considered unconstitutional by the U.S. Supreme Court.⁹² Second, at the administrative level, it allows the school district to determine what religious belief is and what it is not. This can be a slippery slope. Third, because sincerity of beliefs is a fact specific endeavor, courts risks being bogged down by collateral issues by putting the plaintiff through a trial of his asserted beliefs, including, arguably, unorthodox ones. However, the flip side of the argument against the sincerity analysis is that "[w]hile courts must avoid determining the validity of religious beliefs, at times it may be necessary to determine whether

life force In addition, Plaintiff believes that immunization violates the sanctity of the body." *Id.* at 189 n.2.

88. *Id.* at 189.

89. *Id.* at 189-90.

90. *Id.* at 192.

91. *Mason v. Gen. Brown Cent. Sch. Dist.*, 851 F.2d 47, 53 (2d Cir. 1988)

92. BROUGHER, *supra* note 27, at 3.

beliefs would qualify as religious for certain purposes, including religious exemptions for statutory requirements.”⁹³

2. Implications for Public Health Practice

Although “[i]n practice, legal exemptions for vaccination constitute only a small percentage of total school entrants[,] . . . disease outbreaks in religious communities that have not been vaccinated do occur” as shown by epidemiological evidence.⁹⁴ Among the most cited epidemiological studies include a study that reported outbreaks of measles that occurred in two groups of Christian Scientists in 1985. Thomas Novotny noted that “[t]hese outbreaks resulted in 187 cases . . . [accounting] for 6.7 percent of 2,813 total cases reported to CDC in 1985.”⁹⁵ The authors attributed the outbreak to state immunization laws that exempt religious groups.⁹⁶

Another study quantified the risk of contracting measles among individuals who claimed religious or philosophical exemptions from immunization (exemptors) and compared the result with vaccinated persons. The study also examined the risk that exemptors pose to the nonexempt population. The study found that “[o]n average, exemptors were [thirty-five] times more likely to contract measles than were vaccinated persons.”⁹⁷ Additionally, an increase or decrease in the number of exemptors would affect the incidence of measles in non-exempt populations. As Daniel Salmon found, “[i]f the number of exemptors doubled, the incidence of measles infection in nonexempt individuals would increase by 5.5 percent, 18.6 percent, and 30.8 percent, respectively, for intergroup mixing ratios of 20 percent, 40 percent, and 60 percent.”⁹⁸ Similar findings were obtained by Daniel Feikin and colleagues who “conducted a population-based

93. *Id.*

94. According to CDC’s report on vaccination coverage among children in kindergarten for the 2012-2013 school year, “an estimated 91,453 exemptions were reported among a total estimated population of 4,242,558 kindergarteners. Overall, among the 49 states and DC that reported 2012-13 school vaccination exemptions, the percentage of kindergarteners with an exemption ranged from 0.1% in Mississippi to 6.5% in Oregon, with a median of 1.8%.” Ctrs. for Disease Control & Prevention, *Vaccination Coverage Among Children in Kindergarten – United States, 2012–13 School Year*, 62 MORBIDITY & MORTALITY WEEKLY REP. 607, 607-609 (2013); PUBLIC HEALTH LAW AND ETHICS: A READER, *supra* note 41.

95. Thomas Novotny et al., *Measles Outbreaks in Religious Groups Exempt from Immunization Laws*, 103 PUB. HEALTH REP. 49, 50 (1988).

96. *Id.* at 52.

97. Salmon et al., *supra* note 39.

98. *Id.*

retrospective cohort study using data collected on standardized forms regarding all reported measles and pertussis cases among children aged three to eighteen years in Colorado during 1987-1998.”⁹⁹ They found that those who had religious or personal exemptions from vaccinations were on average twenty-two times more likely to acquire measles and six times more likely to acquire pertussis than vaccinated children.¹⁰⁰ They further found that “[i]n children of day care and primary school age, in whom contact rates and susceptibility are higher, these risks were approximately 62-fold and 16-fold greater among exemptors for measles and pertussis, respectively.”¹⁰¹ In 2000, the CDC reported that “the two most recent outbreaks of polio reported in the United States affected members of religious groups who object to vaccination (*i.e.*, outbreaks occurred in 1972 among Christian Scientists and in 1979 among members of an Amish community).”¹⁰² Between September 2004 and February 2005, the CDC further reported that there were 345 cases of pertussis affecting primarily preschool aged children among the Amish in Kent County, Delaware. The report noted that vaccine-preventable disease outbreaks continue to occur among under-vaccinated populations in the United States, including contained religious communities.¹⁰³ Jessica Atwell has noted that “[a]s recent as 2010, 9,120 cases of pertussis were reported in California, more than any year since 1947.”¹⁰⁴ Atwell similarly concluded that geographic areas with non-medical exemptions are associated with high rate of pertussis.¹⁰⁵ Finally, in September 2013, the *Texas Tribune* reported that “[i]n Tarrant County, an unvaccinated man contracted measles abroad and spread the disease to twenty people at Eagle Mountain International

99. Daniel Feikin, et al., *Individual and Community Risks of Measles and Pertussis Associated with Personal Exemptions to Immunization*, 284 JAMA 3145, 3145 (2000).

100. *Id.*

101. *Id.* at 1349.

102. D. Rebecca Prevots et al., *Poliomyelitis Prevention in the United States: Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP)*, 49 MORBIDITY & MORTALITY WEEKLY REP. 1, 9 (2000).

103. P. Eggers et al., *Pertussis Outbreak in Amish Community – Kent County Delaware, September 2004 - February 2005*, 55 MORBIDITY & MORTALITY WEEKLY REP. 817, 817 (2006).

104. Jessica Atwell et al., *Nonmedical Vaccine Exemptions and Pertussis in California, 2010*, 132 PEDIATRICS 624, 624 (2013).

105. *Id.* at 629.

Church who had not been vaccinated or had not received a second dose of the MMR vaccine, as recommended.”¹⁰⁶

These studies and reports tend to show that there is a link between religious exemption laws in vaccination and public health. The effects clearly place public health at risk. Consequently, personal and religious belief exemptions should be eliminated because they present a risk to the “herd immunity.”¹⁰⁷ For example, in a globalized world, with frequent travel, transmission of vaccine-preventable diseases is much easier and more widespread; therefore, those who choose not to be vaccinated based on religious beliefs endanger the health of not only the members of their immediate communities, but many other people in places that are easily reachable by travel.¹⁰⁸ Measured against this standard, a strong argument can be made for doing away with religious exemptions in vaccination and in public health altogether. In spite of the evidence, surprisingly, states have expanded religious exemptions in other public health areas, notably in contraception and in quarantine and isolation.

B. Contraception

Contraception plays a significant role in women’s health and public health in general. It is vital to preventing unintended

106. Becca Aaronson, *Outbreaks Make a Case for Vaccination*, TEX. TRIBUNE, Sept. 9, 2013, <http://www.texastribune.org/2013/09/09/outbreaks-make-case-vaccinations/>.

107. Herd immunity generally means that above a certain immunization percentage rate in a population, a disease cannot spread to enough people during its incubation period to sustain itself. Thus, the higher the immunization rate, the more immune the population would be to the disease. Professor Epstein points out that “[i]mportantly, the efficacy of a vaccine from a societal standpoint depends largely on how widespread the use of the vaccine is. A free-rider problem arises whenever someone decides not to take the vaccine, thinking that the targeted disease is near eradication because everyone else has taken the vaccine. Note that the public benefit of any vaccination program decreases as more people make this strategic choice.” Richard Epstein & Catherine Sharkey, *Products Liability*, CASES & MATERIALS ON TORTS 794 (10th ed., 2012).

108. For example, in 2014, the Centers for Disease Control and Prevention (CDC) reported that measles had infected 129 people in thirteen states, the most in the first four months of any year since 1996. Thirty-four of the cases were imported via travel to other countries, including seventeen from the Philippines where a huge outbreak had affected 20,000 people and caused sixty-nine deaths. Lenny Bernstein, *CDC Reports Biggest Measles Outbreak Since 1996*, WASH. POST, Apr. 24, 2014, <http://www.washingtonpost.com/news/to-your-health/wp/2014/04/24/cdc-reports-13-measles-outbreaks-in-the-u-s-most-cases-since-1996/>.

pregnancies, which account for half of all pregnancies among American women.¹⁰⁹ According to a 2011 Institute of Medicine study, approximately 49 percent of pregnancies in the United States were unintended.¹¹⁰ Contraception reduces unintended pregnancies, abortions, and may prevent the spread of sexually transmitted infections, such as HIV/AIDS.¹¹¹ The CDC lists family planning as one of the ten great public health achievements of the twentieth century.¹¹² Additionally, the CDC notes that “the most important determinant of declining fertility in developing countries is contraceptive use, which explains 92 percent of the variation in fertility among fifty countries.”¹¹³

While “various methods of contraception have been utilized since Roman times, contraceptive birth control information and contraceptive devices were once prohibited” by state and federal law in the United States.¹¹⁴ Contraceptives were considered obscene and immoral.¹¹⁵ The modern birth control movement began in 1912.¹¹⁶ In 1916, Margaret Sanger, a public health nurse concerned about the adverse health effects of frequent childbirth, challenged the laws that suppressed the distribution of birth control information by opening the first family planning clinic in Brooklyn, New York.¹¹⁷ Sanger challenged the “Comstock Act . . . which prohibited the importation and transmittal through the mails of any contraceptive devices or any

109. *Barriers to Contraceptive Access for Low-Income Women*, NAT’L INST. FOR REPROD. HEALTH http://www.nirhealth.org/sections/publications/documents/contraceptiv_eaccessquicksheetFINAL.pdf (last visited Nov. 1, 2014).

110. INST. OF MED., *CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS* 79, 102 (2011).

111. NAT’L INST. FOR REPROD. HEALTH, *supra* note 109.

112. Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Family Planning*, 48 MORBIDITY & MORTALITY WEEKLY REP. 1073, 1073 (1999).

113. *Id.* at 1076.

114. PETER N. SWISHER ET AL., *FAMILY LAW: THEORY, PRACTICE AND FORMS* § 5:11 (9th ed. 2014).

115. *See Note, Judicial Regulation of Birth Control Under Obscenity Laws*, 50 YALE L. J. 682, 682 (1941) (noting that “[r]egulation of contraceptives began in 1873 By forbidding the mailing, importation, and interstate transportation of indecent articles, obscene publications and ‘contraceptives,’ Congress hoped to check the moral degeneration that followed the Civil War.”).

116. Ctrs. for Disease Control & Prevention, *supra* note 112, at 1073.

117. *Id.*

writings describing contraceptive devices.”¹¹⁸ Although Sanger was threatened with a forty-five year jail term for violating the Act, and was later jailed for a month,¹¹⁹ she continued to challenge the law. These challenges established a legal precedent that allowed physicians to provide advice on contraception for health reasons.¹²⁰ During the 1920s and 1930s, Sanger continued to promote family planning by opening more clinics.¹²¹ As a result, physicians gained the right to counsel patients and to prescribe contraceptive methods. By the 1930s, a few state health departments and public hospitals had begun to provide family planning services.¹²²

In the 1960s, the contraceptive pill and the intrauterine device (IUD) were put on the American market, despite heated objections from various religious groups.¹²³ Among those opposing the pill was the Roman Catholic Church, which had officially banned any “artificial” means of birth control in 1930.¹²⁴

In 1961, Dr. C. Lee Buxton, the chairman of the Yale Medical School department of obstetrics and gynecology, and Estelle Griswold, the executive director of Connecticut Planned Parenthood, opened four Planned Parenthood clinics. They were arrested for defying a Connecticut law that made it a crime to use birth control.¹²⁵ Their prosecution led to the landmark case of *Griswold v. Connecticut* in which the U.S. Supreme Court held that the Connecticut statute forbidding use of contraceptives violated the right of marital privacy that is within the penumbra of specific guarantees of the Bill of Rights.¹²⁶ Seven years later, in *Eisenstadt v. Baird*, the U.S. Supreme Court held that a Massachusetts statute which prohibited the

118. SWISHER ET AL., *supra* note 114, at § 5.11 n. 1.

119. CHARLES ALAN WRIGHT ET AL., 30A FEDERAL PRACTICE AND PROCEDURE: FEDERAL RULES OF EVIDENCE § 6359 (2014).

120. Ctrs. for Disease Control & Prevention, *supra* note 112, at 1073.

121. *Id.* at 1073-74.

122. *Id.* at 1074.

123. SWISHER, *supra* note 114.

124. *The American Experience, People & Events: The Catholic Church and Birth Control*, PBS, http://www.pbs.org/wgbh/amex/pill/peopleevents/e_church.html (last visited Jan. 28, 2014).

125. *The American Experience, Timeline: The Pill 1951-1990*, at 3, PBS, <http://www.pbs.org/wgbh/amex/pill/timeline/timeline2.html> (last visited Jan. 28, 2014).

126. 381 U.S. 479, 485, 486 (1965).

distribution of contraceptives to unmarried adults was also unconstitutional.¹²⁷

America has since evolved from its early history of prohibiting contraception to present-day practices where a substantial number of states are affirmatively providing state-supported family planning information and services for the benefit of their citizens. In 1978, Congress passed the Pregnancy Discrimination Act (PDA) which amended Title VII of the Civil Rights Act of 1964. The PDA prohibited employment discrimination against a person because of pregnancy or because of child/pregnancy-related medical issues.¹²⁸ In December 2000, the Equal Employment Opportunity Commission (EEOC) ruled that exclusion of prescription contraceptives from a health insurance plan violates Title VII of the Civil Rights Act of 1964.¹²⁹

Since 1998, several state legislatures have passed contraceptive equity laws which require that “[g]enerally, if an insurer or plan covers other prescription drugs and/or outpatient services, it must also cover contraceptives and contraceptive services—and it must do so on comparable terms.”¹³⁰ According to the Guttmacher Institute, “[twenty-eight] states [now] require insurers that cover prescription drugs to [also] provide coverage of the full range of FDA approved contraceptive drugs and devices.”¹³¹ Many of those states “do not allow religious hospitals to opt out. And nearly half do not allow religious universities to refuse, either.”¹³² Among the states that do not have religious refusal clauses include Colorado¹³³, Georgia¹³⁴,

127. 405 U.S. 438 (1972).

128. 42 U.S.C. § 2000e(k) (2012).

129. EQUAL EMP’T OPPORTUNITY COMM’N, *Decision on Coverage of Contraception* (Dec. 14, 2000), available at <http://www.eeoc.gov/policy/docs/decision-contraception.html>.

130. *Contraceptive Equity Laws in the States* CTR. FOR REPROD. RIGHTS, <http://reproductiverights.org/en/project/contraceptive-equity-laws-in-the-states> (last updated Jan. 4, 2006).

131. GUTTMACHER INST., *STATE POLICIES IN BRIEF: INSURANCE COVERAGE OF CONTRACEPTIVES* (Feb. 1, 2015), available at http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.

132. Star-Ledger Editorial Board, *Birth Control: A Matter of Public Health, Women’s Choice*, NJ.COM, Feb. 07, 2012, http://blog.nj.com/njv_editorial_page/2012/02/birth_control_a_matter_of_publ.html.

133. See COLO. REV. STAT. § 10-16-104 (West 2014) on maternity coverage stating that “[a]ll group sickness and accident insurance policies providing coverage within the state . . . shall insure against the expense of normal pregnancy and childbirth or provide coverage for maternity

Iowa¹³⁵, New Hampshire¹³⁶, Vermont¹³⁷, and Wisconsin.¹³⁸ California, New York, and Oregon provide limited religious exclusions. For example, the California Insurance Code on disability, insurance, and contraceptive coverage provides that “a religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer’s

care and provide coverage for contraception in the same manner as any other sickness, injury, disease”

134. See GA. CODE § 33-24-59.6 (2014) on coverage for prescription drugs and devices for contraception stating in pertinent part that “[e]very health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after July 1, 1999, which provides coverage for prescription drugs on an outpatient basis shall provide coverage for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.”
135. See IOWA CODE § 514C.19 (2014) (prohibiting various health insurance plans that provide benefits for outpatient prescription drugs, devices or services from denying or restricting benefits for FDA-approved prescription contraceptive drugs, devices or outpatient services).
136. See N.H. REV. STAT. ANN. § 415:18-I (2014) (requiring, among other things that “[e]ach insurer that issues or renews any group policy of accident or health insurance providing benefits for medical or hospital expenses, which provides coverage for outpatient services shall provide to each group, or to the portion of each group comprised of certificate holders of such insurance who are residents of this state, coverage for outpatient contraceptive services under the same terms and conditions as for other outpatient services.”).
137. See VT. STAT. ANN. tit. 8 § 4099c (2014) (stating that “[a] health insurance plan shall provide coverage for outpatient contraceptive services including sterilizations, and shall provide coverage for the purchase of all prescription contraceptives and prescription contraceptive devices approved by the federal Food and Drug Administration.” Additionally, “[a] health insurance plan . . . shall not establish any rate, term or condition that places a greater financial burden on an insured or beneficiary for access to contraceptive services, prescription contraceptives and prescription contraceptive devices than for access to treatment, prescriptions or devices for any other health condition.”).
138. WIS. STAT. § 609.805 and § 632.895(17) (2014) (requiring that, on coverage of contraceptives, insurance policies and self-insured health plans that provide coverage for outpatient health care services, preventive services or prescription drugs and devices also provide coverage for contraceptives prescribed by a health care provider). The law also requires that any outpatient services that are necessary to prescribe, administer, maintain or remove a contraceptive be provided if such services are covered for any other drug benefits. See also NAT’L CONF. OF ST. LEGISLATURES, *supra* note 32.

religious tenets.”¹³⁹ Similarly, the Health and Safety Code on religious employer exemption provides, in pertinent part, that “a religious employer may request a health care service plan contract without coverage for federal Food and Drug Administration approved contraceptive methods that are contrary to the religious employer’s religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods.”¹⁴⁰

Despite several states having religious exclusions for their contraceptive equity laws, great strides have been made in provision of contraceptives since the early 1900s. This has indeed been good for public health. The Georgia statute, for example, notes that

maternal and infant health are greatly improved when women have access to contraceptive supplies to prevent unintended pregnancies, that the absence of prescription contraceptive coverage is largely responsible for the fact that women spend 68 percent more in out-of-pocket expenses for health care than men; and requiring insurance coverage for prescription drugs and devices for contraception is in the public interest in improving the health of mothers, children, and families and in providing for health insurance coverage which is fairer and more equitable.¹⁴¹

Nevertheless, in spite of these great strides in availability and access to contraceptives, the debate between access to and use of contraceptives vis-à-vis one’s religious convictions still rages on, both in state courts and increasingly in federal courts.¹⁴² The U.S. Supreme Court, in *Burwell v Hobby Lobby Stores Inc.*,¹⁴³ shed some light on this issue, though it still left some questions unanswered.¹⁴⁴ In order to help the reader understand the legal battles leading to the *Hobby Lobby* decision, this article now provides a brief account of the state and federal cases where plaintiffs challenged contraception laws.

139. CAL. INS. CODE § 10123.196 (West 2014).

140. CAL. HEALTH & SAFETY CODE § 1367.25 (West 2014).

141. GA. CODE ANN. § 33-24-59.6 (West 2014).

142. This increase is attributable to the passage of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010), which required certain preventive health services and screenings to be covered in all new health insurance, plans without cost sharing.

143. 134 S.Ct. at 2751.

144. For example, because Hobby Lobby challenged forms of contraception that prevent uterine implantation, but did not object to those that prevent conception, it is unclear what will happen to cases where plaintiffs are challenging all the contraceptives.

II. CONTRACEPTIVE EQUITY LAWS AND RELIGIOUS REFUSAL CLAUSES¹⁴⁵

A. State Precedents

In *Catholic Charities v. Superior Court of Sacramento*, Catholic Charities, a social service organization, challenged the provisions of the Women's Contraception Equity Act (WCEA)¹⁴⁶ requiring those employers that provided group health care and disability insurance prescription coverage for their employees to include coverage for prescription contraceptives.¹⁴⁷ The WCEA provides an exemption that "permits a religious employer to request a policy that includes drug coverage but excludes coverage for contraceptive methods that are contrary to the religious employer's religious tenets."¹⁴⁸ The law describes a "religious employer" as "an entity for which each of the following is true:"

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(2)(A) i or iii, of the Internal Revenue Code of 1986, as amended.¹⁴⁹

The charity "challenged the exemption as involving an impermissible distinction between religious and secular activities of a religious institution."¹⁵⁰ Additionally, it argued that the law violates the Free Exercise Clauses of the U.S. and California Constitutions by coercing the organization to violate its religious beliefs, in that the law, by regulating the content of insurance policies, in effect requires

145. As of the time of writing this article, there are several court cases that have made their way through state supreme courts and in the federal circuits challenging laws that require religious organization charities to cover birth control for their employees.

146. 32 Cal.4th 527, 85 P.3d 67 (Ca. 2004); CAL. HEALTH & SAFETY CODE § 1367.25(a) (West 2000).

147. *Catholic Charities*, 85 P.3d at 73.

148. *Id.* at 74.

149. § 1367.25(b)(1).

150. Bailey, *supra* note 21, at 376.

employers who offer their workers' insurance for prescription drugs to offer coverage for prescription contraceptives.¹⁵¹ In upholding the exemption against this challenge, the California Supreme Court first noted that Catholic Charities did not qualify as a "religious employer" under the Women's Contraception Equity Act because it did not meet any of the definition's four criteria.¹⁵² The court further noted that Catholic Charities did not primarily employ persons who share its Roman Catholic religious beliefs, but rather employed a diverse group of persons of many religious backgrounds, all of whom shared its Gospel-based commitment to promote a just, compassionate society that supports the dignity of individuals and families.¹⁵³ Additionally, the court found that "Catholic Charities [served] people of all faith backgrounds, a significant majority of [whom] did not share [its] Roman Catholic faith Consequently, . . . [it was] not entitled to an exemption from the mandate imposed by the [law]."¹⁵⁴

Second, regarding the violation of the Free Exercise Clause, the court, citing *Employment Division. v. Smith*, stated that the U.S. Supreme Court "articulated the general rule that religious beliefs do not excuse compliance with otherwise valid laws regulating matters the state is free to regulate [T]he right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes).'"¹⁵⁵

One commentator has argued that the California Supreme Court interpreted the "religious employer" distinction wrongly, stating:

The question is once the legislature has decided to grant an exemption to a religious employer, may it further define 'religious employer' in such a radical way that some employers that one would ordinarily think of as religious (Catholic Charities) do not qualify because the legislature has deemed them 'secular' . . . ? Catholic Charities argued that the parsing of the religious organization into secular components was problematic but the court failed to address the argument altogether.¹⁵⁶

151. *Catholic Charities*, 85 P.3d at 81.

152. *Id.* at 75.

153. *Id.* at 77.

154. *Id.* at 75.

155. *Id.* at 81.

156. Bailey, *supra* note 21, at 377.

The California Supreme Court correctly upheld the Act's narrow religious exemption. First the court rightly noted that the law's requirements apply neutrally and generally to all employers, regardless of religious affiliation, except to those few who satisfy the statute's strict requirements for exemption on religious grounds.¹⁵⁷ Catholic Charities did not. Second, in terms of public health, the court makes the following compelling argument:

The Legislature enacted the WCEA in 1999 to eliminate gender discrimination in health care benefits and to improve access to prescription contraceptives. Evidence before the Legislature showed that women during their reproductive years spent as much as 68 percent more than men in out-of-pocket health care costs, due in large part to the cost of prescription contraceptives and the various costs of unintended pregnancies, including health risks, premature deliveries and increased neonatal care. Evidence also showed that, while most health maintenance organizations (HMO's) covered prescription contraceptives, not all preferred provider organization (PPO) and indemnity plans did. As a result, approximately 10 percent of commercially insured Californians did not have coverage for prescription contraceptives.¹⁵⁸

The above statement offers a justification as to why the California legislature passed the law as a way of eliminating gender discrimination. In essence, "a failure to provide contraceptive coverage when a plan does include prescriptive drug benefits amounts to sex discrimination."¹⁵⁹

A similar constitutional challenge was mounted in New York, in *Catholic Charities of Albany v. Serio*.¹⁶⁰ In that case, Catholic Charities challenged the validity of legislation requiring health insurance policies that provide coverage for prescription drugs to include coverage for contraception.¹⁶¹ The court found that the "Women's Health and Wellness Act (WHWA) [mandated] expanded health insurance coverage for a variety of services needed by women, including mammography, cervical cytology, and bone density screening."¹⁶² The WHWA contained provisions requiring that an employer health insurance contract "which provides coverage for

157. *Catholic Charities*, 85 P.3d at 82.

158. *Id.* at 74.

159. Bailey, *supra* note 21, at 380.

160. 859 N.E.2d 459 (2006).

161. *Id.* at 461.

162. *Id.*

prescription drugs shall include coverage for the cost of contraceptive drugs or devices.”¹⁶³ Catholic Charities argued that the provisions “[violated] their rights under the religion clauses of the federal and state constitutions.”¹⁶⁴ They objected to the contraceptive coverage mandated in the WHWA.¹⁶⁵

Just like in *Catholic Charities v. Superior Court of Sacramento*, discussed above, the New York court found as a threshold matter that none of the plaintiffs qualified as a “religious employer” under the WHWA,¹⁶⁶ because the “plaintiffs are not, or are not only, churches ministering to the faithful, but are providers of social and educational services.”¹⁶⁷ Additionally, most of the plaintiffs acknowledged that they employ many people not of their faith, and that they serve people not only of their faith.¹⁶⁸

Turning to the Free Exercise Clause argument, the New York court rejected the plaintiffs’ contention that WHWA burdened their First Amendment rights and instead held that the Act is a generally applicable and neutral statute. The court found that “[t]he fact that some religious organizations—in general, churches and religious orders that limit their activities to inculcating religious values in people of their own faith—are exempt from the WHWA’s provisions on contraception does not, as plaintiffs claim, demonstrate that these provisions are not ‘neutral.’”¹⁶⁹ More important to this discussion is the New York court’s reliance on public health grounds to explain the passage of the law. The court observed:

The Legislature debated the scope of the ‘religious employer’ exemption intensely before the WHWA was passed. A broader exemption was proposed, one that would have been available to any ‘group or entity . . . supervised or controlled by or in connection with a religious organization or denominational group or entity’ Supporters of this version of the exemption argued, as do plaintiffs here, that religious organizations should not be forced to violate the commands of their faith. Those favoring a narrower exemption asserted that the broader one would deprive tens of thousands of women

163. *Id.*

164. *Id.*

165. *Id.* at 463.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.* at 464.

employed by church-affiliated organizations of contraceptive coverage. Their view prevailed.¹⁷⁰

Most significantly, both the California and the New York courts emphasized the public health importance of the narrow religious exemptions. Whereas the plaintiffs in both cases would have liked for the courts to not have distinguished between “religious employers” and “secular activities of religious organizations,”¹⁷¹ the courts read the statutes narrowly, thereby ensuring that tens of thousands of women employed by church-affiliated organizations would receive contraceptive coverage. This is a victory for public health for two principal reasons: First, both the legislatures and respective supreme courts acknowledged the importance of contraceptives to public health. Second, the rulings are a victory because many public health practitioners see these religious exemptions as aiding or advancing religion.¹⁷² For public health practitioners, a public health law that does not provide for a religious exemption, such as the one in Mississippi, or a narrower religious exemption, such as the ones in New York and California, are preferable to the broader exemptions advocated by the plaintiffs in these cases. Of course, public health practitioners recognize that these are two competing trends. Putting aside constitutional arguments, a no-religious exemption trend is better than the other because elimination of the religious exemptions will reduce the danger of putting individuals at risk for contracting diseases.

In sum, whereas state courts have consistently upheld laws mandating vaccination and contraception against religious exemption and constitutional challenges, in the federal courts, the results have been mixed.

B. Federal Precedents

The distinction between federal and state precedents is that federal court precedents have involved challenges from both religious entities and for-profit corporations.¹⁷³ These challenges have been

170. *Id.* at 462.

171. *See Catholic Charities v. Superior Court of Sacramento*, 85 P.3d 67, 79 (Ca. 2004).

172. *Turner v. Liverpool Cent. Sch.*, 186 F. Supp. 2d 187, 191 (N.D.N.Y. 2002).

173. According to a report by the National Women’s Law Center, “90 lawsuits have been filed in federal courts challenging the Affordable Care Act’s no cost-sharing provisions . . . [forty-five] of the cases have been filed by for profit companies ranging from a crafts store chain to an HVAC company.” NAT’L. WOMEN’S LAW CTR., OVERVIEW OF THE LAWSUITS CHALLENGING THE AFFORDABLE CARE ACT’S NO COST-

premised on the Free Exercise Clause, the Establishment Clause, and the Religious Freedom Restoration Act of 1993 (RFRA).¹⁷⁴ The challenges have been fueled largely by the Patient Protection and Affordable Care Act (ACA).

1. The Affordable Care Act and the Contraception Mandate

Congress passed the ACA in 2010.¹⁷⁵ The centerpiece of the ACA was its focus on preventive services in health. During the legislative process, an amendment to the ACA (known as the Women's Health Amendment) required coverage for recommended preventive services for women without cost sharing.¹⁷⁶ The "U.S. Department of Health and Human Services (HHS) charged the Institute of Medicine (IOM) with reviewing what preventive services are important to women's health and well-being and then recommending which of these should be considered in the development of comprehensive guidelines."¹⁷⁷ The IOM made several recommendations regarding women's reproductive health including, but not limited to, "a [full] range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes."¹⁷⁸ HHS adopted these recommendations as part of the ACA guidelines. In response to the request for comments on the interim final regulations, "most commenters, including some religious organizations, recommended that the [Department's] guidelines include contraceptive services for all women and that this requirement be binding on all group health plans and health insurance issuers with no religious exemption."¹⁷⁹

SHARING CONTRACEPTIVE COVERAGE BENEFIT 1 (Nov. 2013), *available at* http://www.nwlc.org/sites/default/files/contraceptive_coverage_litigation_overview_11-11-13_v2_vf.pdf.

174. 42 U.S.C. § 2000bb (2012).

175. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2713, 124 Stat. 119 (2010).

176. David Herszenhorn & Robert Pear, *Senate Passes Women's Health Amendment*, N.Y. TIMES, Dec. 3, 2009, *available at* http://prescriptions.blogs.nytimes.com/2009/12/03/senate-passes-womens-health-amendment/?_r=0.

177. INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS: REPORT BRIEF, 1 (2011) http://www.iom.edu/~media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf/.

178. *Id.* at 2.

179. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable

Others asserted that “requiring group health plans sponsored by religious employers to cover contraceptive services that their faith deems contrary to its religious tenets would impinge upon their religious freedom.”¹⁸⁰ HHS amended its rules to provide for religious exemption where contraceptive services are involved.¹⁸¹ For purposes of the exemption, a religious employer is one that: “(1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Code.”¹⁸² The religious employer exemption was modeled after the method of religious accommodation used in several states that already required health insurance issuers to provide coverage for contraception.¹⁸³

Plaintiffs have since brought several actions in federal courts challenging the lawfulness of the preventive services coverage regulations.¹⁸⁴ Two cases, *Hobby Lobby Stores Inc. et al. v. Sebelius*¹⁸⁵ and *Conestoga Wood Specialties Corp. v. HHS*,¹⁸⁶ are germane to this article.¹⁸⁷ In the former, appellants, two for-profit corporations—Hobby Lobby Stores, Inc. and Mardel, Inc.—and the corporations’ owners, challenged the district court’s denial of their motion for preliminary injunction, contending that the requirement that Hobby Lobby’s group health plan cover all forms of FDA-approved contraceptives violates RFRA, the Free Exercise Clause, and the Administrative Procedure Act.¹⁸⁸ *Hobby Lobby et al.*, emphasized

Care Act, 76 Fed. Reg. 46,621, 46,623 (Aug. 3, 2011) (to be codified at 45 C.F.R. § 147).

180. *Id.*

181. *Id.*

182. *Id.* (“Sections 6033(a)(3)(A)(i) and (iii) [of the Internal Revenue Code of 1986 as amended], refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.”).

183. *Id.*

184. For a list of cases then challenging the Contraceptive Mandate, see *Conestoga Wood Specialties Corp. v. Sec’y of the United States HHS*, 724 F.3d 377, 396 n. 10 (3d Cir. 2013) (Jordan, J., dissenting).

185. 723 F.3d 1114 (10th Cir. 2013).

186. 724 F.3d 377.

187. The U.S. Supreme Court subsequently upheld *Hobby Lobby Stores Inc. et al., v. Sebelius*, and reversed *Conestoga Wood Specialties v. HHS* (now *Conestoga Wood Specialties v. Burwell*). See *Burwell v. Hobby Lobby Stores Inc.*, 134 S.Ct. 2751 (2014).

188. *Hobby Lobby*, 723 F.3d at 1125.

that they objected to forms of contraception that prevent uterine implantation, but did not object to those that prevent conception.¹⁸⁹ The questions for consideration at the court of appeals were as follows: “(1) whether Hobby Lobby and Mardel are ‘persons’ exercising religion for purposes of RFRA; (2) if so, whether the corporations’ religious exercise is substantially burdened; and (3) if there is a substantial burden, whether the government can demonstrate a narrowly tailored compelling government interest.”¹⁹⁰ The court answered the first two questions in the affirmative noting that individuals may incorporate for religious purposes and keep their free exercise rights, and unincorporated individuals may pursue profit while keeping their free exercise rights.¹⁹¹ In addressing the contraceptive mandate, the court found that the contraceptive-coverage requirement was invalid as applied to Hobby Lobby because that requirement is not “the least restrictive means of advancing a compelling interest.”¹⁹²

2. Implications for Public Health Practice

From a public health standpoint, there are several problems with the Tenth Circuit Court of Appeals’ holding in *Hobby Lobby*. First, the decision encroaches on the doctor-patient relationship. In other words, certain decisions, such as which contraception to use or which medicine or form of treatment an employee should pursue should be left for the employee and his or her doctor.¹⁹³ As Judge Rovner noted in the dissent in *Grote v. Sebelius*:

Any given medical decision, depending on the nature of the patient’s condition, the available treatments, and the circumstances confronted by doctor and patient, might be inconsistent with the religious beliefs of one or more owners of the company that sponsors the patient’s workplace insurance. Holding that a company shareholder’s religious beliefs and practices are implicated by the autonomous health care decisions of company employees, such that the obligation to insure those decisions, when objected to by a shareholder, represents a substantial burden on that shareholder’s religious

189. *Id.* at 1126. Essentially, Hobby Lobby objected to drugs and devices with known post-fertilization mechanism of action, *i.e.*, those drugs and devices that could cause abortions.

190. *Id.* at 1126.

191. *Id.* at 1143.

192. *Id.* at 1143-44.

193. *Grote v. Sebelius*, 708 F.3d 850, 858 (7th Cir. 2013) (Rovner, J., dissenting).

liberties, strikes me as an unusually expansive understanding of what acts in the commercial sphere meaningfully interfere with an individual's religious beliefs and practices.¹⁹⁴

One can therefore argue that “[a]llowing religious doctrine to prevail over the need for competent [medical] care and a woman's right to complete and accurate information about her condition and treatment choices violates [not only] medical ethics [but also] existing law.”¹⁹⁵ To this point, one commentator has noted that “[f]or almost a half-century, the Supreme Court has held that people have the fundamental right to control their reproductive autonomy, which includes the right to purchase and use contraceptives. The government has a compelling interest in helping to facilitate the ability of people, and especially women, to exercise this basic right of reproductive autonomy.”¹⁹⁶

Second, allowing employers to refuse to cover certain services, based on their (employers) personal religious beliefs will likely create major structural and logistical problems in the U.S. healthcare system, where the employer sponsored healthcare plans play a significant role.¹⁹⁷ “The system of employer-sponsored health insurance has long provided coverage to the vast majority of America's workers and their dependents.”¹⁹⁸ Indeed, “in the first half of 2003, the U.S. employer-based health insurance market provided insurance to over 159 million Americans who constitute nearly two-thirds (63.4 percent) of the population under 65.”¹⁹⁹ Generally, the employer pays the insurance premium subsidy to the health insurer, which in turn pays for the medical costs of the employee. In this instance, the insurance company decides what to pay and what not to pay for. Should insurance companies decline, for example, to pay for certain contraceptives based on the employers' religious beliefs? And since

194. *Id.* at 866.

195. Editorial, *When Bishops Direct Medical Care*, N.Y. TIMES, Dec. 18, 2013, http://www.nytimes.com/2013/12/09/opinion/when-bishops-direct-medical-care.html?_r=0.

196. Erwin Chemerinsky, *God, Birth Control and Corporate America: Claiming Religious Freedom to Avoid Providing Insurance for Contraceptives Runs Afoul of the Law*, NAT'L. L. J., Dec. 9, 2013, at 38.

197. *See, e.g.*, I. Glenn Cohen et al., *When Religious Freedom Clashes with Access to Care*, 371 NEJM 596, 596-98 (2014) (noting that “Hobby Lobby's outcome is of concern to U.S. health care professionals because our health insurance system is still largely dependent on employers.”).

198. Mark Stanton, U.S. Dept. of Health & Human Servs., *Employer-Sponsored Health Insurance Trends in Cost and Access*, 17 AGENCY FOR HEALTHCARE RES. & QUALITY: RES. IN ACTION 1, 2 (2004).

199. *Id.*

insurance companies tend to have large pools of subscribers, how would they distinguish payments for those using contraceptives and those not using contraceptives? As some commentators have so aptly noted, “[e]mployers and employees may have fundamentally different perspectives on which medical interventions are acceptable, particularly when the employer’s fundamental mission is not to advance specific religious beliefs and its employees are therefore unlikely to be drawn exclusively from its own religious group.”²⁰⁰

Third, the protection of women’s health is a compelling governmental interest. For example, in 2001, an IOM report found that 42 percent of unintended pregnancies in the United States ended in abortion.²⁰¹ The report also found that “[t]he risk factors for unintended pregnancy are female gender and reproductive capacity.”²⁰² Additionally, “[w]omen suffer disproportionate rates of chronic disease and disability from some conditions, and often have high out-of-pocket health care costs.”²⁰³ And “[e]ven though slightly over half of the U.S. population is female, apart from reproductive concerns, medical research historically has neglected the health needs of women.”²⁰⁴ The government has and often does address these needs through legislation such as the contraceptive mandate.

Another compelling governmental interest is in reducing health disparities. Significant racial and ethnic disparities exist in women’s health. For example, non-Hispanic black and some Hispanic populations have preterm births at rates 60 percent and 27 percent higher, respectively, than the rate for non-Hispanic white women.²⁰⁵ In terms of teen pregnancy, teenagers who give birth are much more likely than older women to deliver a low birth weight or preterm infant, and their babies are at higher risk for dying in infancy. Additionally, the annual public costs associated with births among

200. Cohen et al., *supra* note 197, at 598.

201. See INST. OF MED, *supra* note 110, at 102.

202. *Id.* at 103.

203. *Clinical Preventive Services for Women: Closing the Gaps*, NAT’L ACAD. PRESS <http://www.nap.edu/catalog/13181/clinical-preventive-services-for-women-closing-the-gaps> (last visited Feb. 7, 2015).

204. INST. OF MED., *WOMEN’S HEALTH RESEARCH: PROGRESS, PITFALLS AND PROMISE 1* (2010).

205. *Committee Opinion Number 317: Racial and Ethnic Disparities in Women’s Health*, 106 AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS 889, 890 (Oct. 2005), available at <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co317.pdf?dmc=1&ts=20141026T1033161790>.

teenage girls are an estimated \$10.9 billion.²⁰⁶ Making contraceptives accessible to women thus serves the twin public health functions of addressing health disparities among women and preventing unwanted pregnancies. The editorial board of the *New England Journal of Medicine* underscored this point, writing:

If the full panel of FDA-approved contraceptive services is made available to American women, the public health of the country will benefit. If a woman's religious beliefs compel her to decline such services, she has the right to do so. But to deny coverage for these vital public health services to women who want them but cannot afford them outside their employer-sponsored insurance would be a personal and public health tragedy.²⁰⁷

The court in *Conestoga Wood Specialties Corp. v. HHS*²⁰⁸ arrived at the opposite conclusion from the court in *Hobby Lobby Stores Inc. et al. v. Sebelius*. In *Conestoga Wood Specialties Corp.*, appellants Conestoga Wood Specialties Corporation, a secular, for-profit corporation, and five of its shareholders, the Hahns, contended that providing the mandated coverage would violate their religious beliefs under the Free Exercise Clause and RFRA.²⁰⁹ In rejecting the appellants contention, the court first noted, as a threshold matter, that a for-profit, secular corporation cannot engage in religious exercise.²¹⁰ The court based its reasoning on the U.S. Supreme Court's reasoning in *First National Bank of Boston v. Bellotti* that "certain guarantees are held by corporations and that certain guarantees are 'purely personal' because 'the historic function of the particular guarantee has been limited to the protection of individuals.'" ²¹¹ The Free Exercise Clause, noted the court of appeals, is one such guarantee.²¹²

The *Conestoga* decision squared with the Sixth Circuit's ruling in *Autocam Corp. v. Sebelius*, which also held that secular, profit-seeking corporate employers are not a person capable of "religious exercise" as

206. Stephanie Ventura et al., *Pregnancy and Childbirth Among Females Aged 10–19 Years – United States, 2007–2010*, 62 MORBIDITY & MORTALITY WEEKLY REP. 71, 71 (2013).

207. Editorial, *Contraception at Risk*, 370 NEJM 77, 78 (2013).

208. 724 F.3d 377 (3d. Cir. 2013).

209. *Id.* at 380.

210. *Id.* at 388.

211. *Id.* at 383 (quoting *First Nat'l Bank of Boston v. Bellotti*, 435 U.S. 765, 778 n. 14 (1978)).

212. *Id.* at 388.

intended by RFRA.²¹³ More recently, the same Sixth Circuit Court in *Michigan Catholic Conference v. Burwell*,²¹⁴ held that that nonprofit entities affiliated with the Catholic Church that have religious objections to certain preventive care standards under the ACA failed to demonstrate a strong likelihood of success on the merits of its claim that the ACA's contraceptive-coverage requirement violated RFRA, the Administrative Procedure Act, and the Establishment Clause.²¹⁵

On the other hand, several federal circuit courts, including the District of Columbia and both the Seventh and Tenth Circuit Courts of Appeals, have held that for-profit corporations can be considered "persons" exercising religion for purposes of RFRA, and that the for-profit corporations' religious exercise is substantially burdened by the contraceptive mandate.²¹⁶ This circuit split was finally resolved by the U.S. Supreme Court.

III. THE U.S. SUPREME COURT BRINGS THE CURTAIN DOWN, "LET THE GOVERNMENT PAY": IMPLICATIONS FOR PUBLIC HEALTH PRACTICE

In June 2014, the U.S. Supreme Court settled the circuit split above by affirming the judgment of the Tenth Circuit²¹⁷ and reversing the judgment of the Third Circuit.²¹⁸ In a 5-4 decision, the Court ruled in a consolidated opinion in *Burwell v. Hobby Lobby Stores Inc.*,²¹⁹ that the contraception mandate is unlawful, noting that as applied to closely held corporations, the HHS's regulations imposing the contraceptive mandate violated RFRA because it is not the least restrictive means of furthering a compelling governmental interest.²²⁰ The Court first determined that Congress included corporations within RFRA's definition of "persons."²²¹ Second, it found that for-

213. *Autocam Corp.*, 730 F.3d at 626.

214. *Michigan Catholic Conference & Catholic Family Serv. v. Burwell*, 755 F.3d 372 (6th Cir. 2014).

215. *Id.* at 398.

216. *See Korte v. Sebelius*, 735 F.3d 654, 655 (7th Cir. 2013); *Grote v. Sebelius*, 708 F.3d 850, 866 (7th Cir. 2013); *Gilardi v. U.S. Dep't of Health & Human Servs.*, 733 F.3d 1208 (D.C. Cir. 2013).

217. *Hobby Lobby Stores, Inc., et al. v. Sebelius*, 723 F.3d 1114 (10th Cir. 2013).

218. *Conestoga Wood Specialties Corp. v. Sec'y of the U.S. Dept. of Health & Human Servs.*, 724 F.3d 377 (3d Cir. 2013).

219. 134 S.Ct. 2751, 2751 (2014).

220. *Id.*

221. *Id.* at 2769.

profit corporations can exercise religion under RFRA.²²² Third, the Court noted that the mandate placed a substantial burden on the corporation's exercise of religion. The court assumed that the HHS had shown a compelling interest for the mandate, but failed the second prong of the test—that is, whether the contraceptive mandate is the least restrictive means of furthering that compelling governmental interest.²²³

Notably, the Court seemed to endorse, and even encourage, the idea that the government could simply accommodate for-profit corporations' religious beliefs by paying for the contraceptive. In his concurring opinion, Justice Kennedy remarked:

The parties who were the plaintiffs in the District Courts argue that the Government could pay for the methods that are found objectionable In discussing this alternative, the Court does not address whether the proper response to a legitimate claim for freedom in the health care arena is for the Government to create an additional program The Court properly does not resolve whether one freedom should be protected by creating incentives for additional government constraints. In these cases, it is the Court's understanding that an accommodation may be made to the employers without imposition of a whole new program or burden on the Government. As the Court makes clear, this is not a case where it can be established that it is difficult to accommodate the government's interest, and in fact the mechanism for doing so is already in place.²²⁴

Here, the Court seemed to have been shifting the focus from contraceptive access for women to determining who should pay for contraceptives. Indeed, in the dissent, Justice Ginsburg, joined by Justices Breyer, Kagan, and Sotomayor, termed the “let the government pay” solution as unworkable. Ginsburg poses the following questions:

And where is the stopping point to the ‘let the government pay’ alternative? Suppose an employer's sincerely held religious belief is offended by health coverage of vaccines, or paying the minimum wage . . . or according women equal pay for sub-

222. *Id.* at 2769-72.

223. *Id.* at 2780 (“We will assume that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA, and we will proceed to consider the final prong of the RFRA test, i.e., whether HHS has shown that the contraceptive mandate is ‘the least restrictive means of furthering that compelling governmental interest.’”) (citation omitted).

224. *Id.* at 2786 (Kennedy, J., concurring).

stantially similar work Does it rank as a less restrictive alternative to require the government to provide the money or benefit to which the employer has a religion-based objection?²²⁵

Whether the Court's decision is pragmatic or unprincipled will be analyzed and debated for years to come. For the public health community, there are several points to ponder.

First, although this case involved small, closely held corporations, the impact on public health policy carries national implications. For example, it is unclear how this ruling will affect the contraception needs of female employees of large publicly held corporations. Justice Ginsburg in her dissent notes that “[t]he Court’s determination that RFRA extends to for profit corporations is bound to have untoward effects. Although the Court attempts to cabin its language to closely held corporations, its logic extends to corporations of any size, public or private.”²²⁶ In responding to this argument initially raised by HHS, the Court glosses over this point by simply stating that, “[t]hese cases, however, do not involve publicly traded corporations, and it seems unlikely that the sort of corporate giants to which HHS refers will often assert RFRA claims. HHS has not pointed to any example of a publicly traded corporation asserting RFRA rights, and numerous practical restraints would likely prevent that from occurring”²²⁷

However, just because corporate giants have not asserted RFRA claims against public health mandates, does not necessarily mean that they are unlikely to, or even will not assert the claims. As Chief Justice Roberts noted while upholding the ACA in 2012, “[l]egislative novelty is not necessarily fatal; there is a first time for everything.”²²⁸

Second, and most important to public health, the Court went to great lengths to limit its ruling to the mandate while apparently shielding other public health activities from similar RFRA challenges. In perhaps one of the few safe harbors for public health, the Court notes:

Our decision in these cases is concerned solely with the contraceptive mandate. Our decision should not be understood to hold that an insurance coverage mandate must necessarily fall if it conflicts with an employer’s religious beliefs. Other coverage requirements, such as immunizations, may be supported by different interests (for example, the need to combat the spread of infectious diseases) and may involve

225. *Id.* at 2802 (Ginsburg J., dissenting).

226. *Id.* at 2797 (Ginsburg J., dissenting).

227. *Id.* at 2774.

228. *Nat’l Fed’n of Ind. Bus. v. Sebelius*, 132 S.Ct. 2566, 2586 (2012).

different arguments about the least restrictive means of providing them.²²⁹

But this may be of little comfort to the public health community. Some commentators have remarked that “in the wake of [*Burwell*] v. *Hobby Lobby*, we may anticipate challenges to other medical services that some religions find objectionable, such as vaccinations, infertility treatments, blood transfusions, certain psychiatric treatments, and even hospice care.”²³⁰

Finally, public health practitioners will take comfort from the fact that the Court’s decision was purely a statutory interpretation and did not reach any First Amendment claims.²³¹ But this comfort may be short lived since it is likely that the same reasoning can be extended to the First Amendment.

The broader public policy implications of the *Hobby Lobby* decision on other areas of public health and healthcare in general, still remain to be seen. For example, although Justice Alito noted that the decision “[c]oncerns only the contraceptive mandate and should not be understood to hold that all insurance-coverage mandates, *e.g.*, for vaccinations or blood transfusions, must necessarily fall if they conflict with an employer’s religious beliefs. Nor does it provide a shield for employers who might cloak illegal discrimination as a religious practice,”²³² one may wonder if this means that vaccination programs are safe from RFRA challenges for now. Additionally, how many other employers would test and indeed implement the newly declared religious rights? Finally, would the newly declared religious rights have any impacts on the exemptions for isolation and quarantine?

IV. ISOLATION AND QUARANTINE: IMPLICATIONS FOR PUBLIC HEALTH PRACTICE

Isolation refers to the separation of ill persons who have a communicable disease from those who are healthy,²³³ whereas

229. *Burwell*, 134 S.Ct. at 2783.

230. Cohen et al., *supra* note 297, at 598.

231. See *Burwell*, 134 S.Ct. at 2785 (noting that “[t]he contraceptive mandate, as applied to closely held corporations, violates RFRA. Our decision on that statutory question makes it unnecessary to reach the First Amendment claim raised by *Conestoga* and the *Hahns*.”).

232. *Id.* at 2758.

233. Christopher Ogolla, *Non-Criminal Habeas Corpus for Quarantine and Isolation Detainees: Serving the Private Right or Violating Public Policy?*, 14 DEPAUL J. HEALTH CARE L. 135, 139 (2011).

quarantine “is used to separate and restrict the movement of well persons who may have been exposed to a communicable disease to see if they become ill.”²³⁴ Generally, the literature is bereft of cases where states have applied religious exemptions to quarantine and isolation.²³⁵ This is largely due to the fact that “public health quarantine and isolation are legal authorities that may be, but rarely are, implemented to prevent the spread of communicable diseases.”²³⁶ Nevertheless, some state statutes contain language that appears to grant religious exemptions. For example, a North Dakota statute provides in relevant part that “to the extent possible, cultural and religious beliefs must be considered in addressing the needs of individuals and establishing and maintaining isolation and quarantine premises.”²³⁷ Similarly, the Oregon Revised Statutes provide that “cultural and religious beliefs should be considered to the extent practicable in addressing the needs of persons who are isolated or quarantined and in establishing and maintaining premises used for isolation or quarantine,”²³⁸ and that “[i]solation or quarantine shall not abridge the right of any person to rely exclusively on spiritual means to treat a communicable disease or possibly communicable disease in accordance with religious or other spiritual tenets and practices.”²³⁹ Similar language about sensitivity to one’s religious

234. *Id.*

235. See Jeffrey Addicott, *Bioterrorism: Examining American Legal and Policy Readiness*, NATO SCIENCE FOR PEACE AND SECURITY SERIES: MEDICAL RESPONSE TO TERROR THREATS 14 (A. Richman et al., eds., 2010) (noting that “[t]he case law regarding the quarantine of individuals is sparse because the United States has yet to face mass quarantine due to the spread of an epidemic, pandemic or bioterrorist attack.”).

236. NAT’L CONF. OF ST. LEGISLATURES, STATE QUARANTINE AND ISOLATION STATUTES, <http://www.ncsl.org/research/health/state-quarantine-and-isolation-statutes.aspx> (last visited August 26, 2014).

237. Communicable Disease Confinement Procedure, N.D. CENT. CODE § 23-07.6-02(h) (West 2013).

238. Conditions of and Principles for Isolation or Quarantine, OR. REV. STAT. § 433.128 (9) (West 2014).

239. *Id.* § 433.128 (10)(a). Additionally, sub section (b) of the statute provides that “[n]othing in Or. Rev. Stat. 433.126 to 433.138, 433.142 and 433.466 prohibits a person who relies exclusively on spiritual means to treat a communicable disease or possibly communicable disease and who is infected with a communicable disease or has been exposed to a toxic substance from being isolated or quarantined in a private place of the person’s own choice, provided the private place is approved by the Public Health Director or the local health administrator and the person who is isolated or quarantined complies with all laws, rules and regulations governing control, sanitation, isolation and quarantine.” *Id.* § 433.128 (10)(b).

beliefs in times of isolation and quarantine applies to Connecticut,²⁴⁰ Massachusetts,²⁴¹ Hawaii,²⁴² South Carolina,²⁴³ and Washington State,²⁴⁴ to mention but a few. California provides a religious exemption for examination or inspection of any person who depends exclusively on prayer for healing in accordance with the teachings of any recognized religious sect. The exemption does not cover compulsory reporting of communicable diseases and isolation and quarantine where there is probable cause to suspect that the person is infected with the disease in a communicable stage.²⁴⁵ Rhode Island offers quarantine and isolation as an alternative to those who may be opposed to or unwilling, for reasons of health, religion, and conscience, to undergo immunization or treatment.²⁴⁶ On the other hand, states like Colorado,²⁴⁷ New Jersey,²⁴⁸ and North Carolina,²⁴⁹ provide no religious exemptions for quarantine and isolation.

240. CONN. GEN. STAT. § 19a-131(b)(9) (2014) (providing that “to the extent possible, cultural and religious beliefs shall be considered in addressing the needs of individuals and establishing and maintaining premises used for quarantine and isolation.”).

241. 105 MASS. CODE. REGS. 300.210 (H)(1)(c) (2014) (noting that “[t]o the extent possible, cultural and religious beliefs and existing disabilities shall be considered in addressing the needs of individuals.”).

242. HAW. REV. STATS. § 325-8 (West 2014).

243. Emergency Health Powers, S.C. CODE ANN. § 44-4-530(B)(8) (2013) (stating that “to the extent possible, cultural and religious beliefs must be considered in addressing the needs of the individuals and establishing and maintaining isolation and quarantine premises.”).

244. Conditions and Principles for Isolation or Quarantine, WASH. ADMIN. CODE § 246-100-045 (9) (noting that “isolation or quarantine shall not abridge the right of any person to rely exclusively on spiritual means alone through prayer to treat a communicable or possibly communicable disease in accordance with religious tenets and practices, nor shall anything in this chapter be deemed to prohibit a person so relying who is infected with a contagious or communicable disease from being isolated or quarantined in a private place of his or her own choice, provided, it is approved by the local health officer, and all laws, rules and regulations governing control, sanitation, isolation and quarantine are complied with. At his or her sole discretion, the local health officer may isolate infected individuals declining treatment for the duration of their communicable infection.”).

245. CAL. HEALTH & SAFETY CODE § 121370 (West 2014).

246. R.I. GEN. LAWS ANN. § 23-8-4 (West 2014).

247. COLO. REV. STAT. § 25-4-506 (3) (2014) (providing that “[a]ny person who depends exclusively on prayer for healing in accordance with the teachings of any well-recognized religious sect, denomination, or organization, and claims exemptions on such grounds, shall nevertheless be subject to examination, and the provisions of this part 5 regarding compulsory reporting of communicable diseases and isolations shall

What these divergent state practices demonstrate is that the laws and regulations regarding religious exemptions in quarantine and isolation depend on whether a public health emergency has been declared. Whereas this is not necessarily a bad thing, these exemptions, I argue, do not bode well for public health.

A significant problem with religious exemptions in quarantine and isolation is that they seem antithetical to science. For example, both the laws of Oregon and Washington provide that isolation or quarantine shall not abridge the right of any person to rely exclusively *on spiritual means to treat a communicable disease* “from being isolated or quarantined in a private place of the person’s own choice, provided, it is approved by the local health officer, and all laws, rules and regulations governing control, sanitation, isolation and quarantine are complied with.”²⁵⁰ It is hard to envision, from a public health or a biomedical standpoint how a quarantinable communicable disease can be treated “exclusively” by spiritual means. This is not an attack on anyone’s religion or sincere belief on treatment, rather, it is an acknowledgment that treatment of quarantinable communicable diseases requires much more than spiritual means. For example, according to the Centers for Disease Control and Prevention, isolation and quarantine are authorized for cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers,

apply where there is probable cause to suspect that such person has active tuberculosis. Such person shall not be required to submit to any medical treatment or to go to or be confined in a hospital or other medical institution if the person can safely be isolated in the person’s own home or other suitable place of the person’s choice.”).

248. N.J. STAT. ANN. § 30:4A-12 (2014) (providing in pertinent part that “[a]ny person who indicates that he subscribes to the art of healing by prayer as practiced by any well recognized religious denomination, the principles of which are opposed to medical treatment, shall not be required to submit to medical treatment unless he, or his parent, guardian or person standing in loco parentis, consents Any such person, however, shall be subject to all rules and regulations with reference to quarantine and isolation in case of contagious or infectious diseases and subject to physical restraint in case of emergency or violence.”).
249. See N.C. GEN. STAT. § 166A-19.12 (3)(e) (2014) (providing in pertinent part that the Division of Emergency Management shall have the powers and duties as delegated by the Governor and Secretary of Public Safety to coordinate with the State Health Director to amend or revise the North Carolina Emergency Operations Plan regarding public health matters to provide for the appropriate conditions for quarantine and isolation in order to prevent further transmission of disease).
250. WASH. ADMIN. CODE § 246-100-045; OR. REV. STAT. § 433.128 (10)(b).

severe acute respiratory syndrome (SARS), and flu that can cause a pandemic.²⁵¹ Is it practical to treat any of these diseases spiritually?

I acknowledge that this is a difficult question to ask and potentially a very divisive one. With reference to science and faith healing, one commentator captures the familiar arguments used to support religious accommodations in health, noting:

According to the substantive view, the privileging of science over faith constitutes unacceptable discrimination against religion. In order, therefore, to achieve substantive equality for religion, faith has to be put on a presumptively equal footing with the methods and insight of science. One committed to substantive equality for religion would ask whether, for some families, prayer and/or other spiritual healing techniques function equivalently to conventional medicine in the family life of others. If those who use doctors rather than prayer in the effort to heal their ailing children are presumptively not neglectful, or culpable if the children are not cured, should not those who use prayer instead of conventional medicine be equally immune to charges of neglect or assertions of culpability?²⁵²

A detailed comparison of efficacy of biomedicine and faith healing is beyond the scope of this paper.²⁵³ Suffice it to say that religion has, and does continue to play both a positive and negative role in population health. Nevertheless, it is safe to say that there is no contemporary evidence tending to show that any of the quarantinable diseases have been successfully treated spiritually.²⁵⁴

251. CTRS. FOR DISEASE CONTROL & PREVENTION, LEGAL AUTHORITIES FOR ISOLATION AND QUARANTINE 1 (2014), *available at* <http://www.cdc.gov/quarantine/aboutlawsregulationsquarantineisolation.html>.

252. Ira. C. Lupu, *Reconstructing the Establishment Clause: The Case Against Discretionary Accommodation of Religion*, 140 U. PA L. REV. 555, 584 (1991).

253. *See generally* Kaja Finkler, *Sacred Healing and Biomedicine*, 8 MED. ANTHROPOLOGY Q. 178 (1994) (addressing similarities and differences between sacred healing and biomedicine); Sipco J. Vellenga, *Longing for Health: A Practice of Religious Healing and Biomedicine Compared*, 47 J. RELIGIOUS HEALTH, 326, 326-37 (2008) (arguing that biomedicine and faith healing have at least five principles in common); and Levin, *supra* note 3, at 3 (noting that “there is considerable evidence that one’s religious life has something significant to say about one’s mental health.”).

254. To be fair, this writer is cognizant of some passages in religious texts attesting to religious healing of those afflicted with plague, leprosy, and perhaps tuberculosis. In the Old Testament for example, Aaron stopped a plague that had killed 14,700 people, *Numbers* 16:46-50 (King James);

V. BALANCING PUBLIC SAFETY AND PERSONAL CHOICE OR RELIGION GONE TOO FAR?

Whenever questions arise about balancing individual liberties like freedom of religion, against public health, welfare, and safety laws and regulations, each side digs in and proclaims its view to be the right one. One group ostensibly argues for complete accommodation to religious liberty;²⁵⁵ others (including this writer) argue for great deference to public health authorities;²⁵⁶ and yet others try to find a middle ground.²⁵⁷ My view is that, in times of an epidemic or a

The Qu'ran mentions Jesus healing lepers and the blind, Surah 3. Al 'Imran 49. That having been said, this writer is unaware of contemporary evidence of treatment.

255. See, e.g., Michael McConnell, *Religious Freedom at a Crossroads*, 59 U. CHI. L. REV. 115, 140 (1992) (“[T]he freedom of citizens to exercise their faith should not depend on the vagaries of democratic politics, even if expressed through laws of general applicability.”); and Smith, *supra* note 18, at 266 (“[W]hether the nation’s long standing commitment to special protection for religious freedom should now be discarded presents a major historic decision that is likely to become even more conspicuously contested in coming years.”).
256. This writer’s view is in accord with several cases and legal commentators, e.g. *Brown v. Stone*, 378 So.2d 218, 222 (Miss. 1979) (noting that many courts at various levels have determined that there is no constitutional right to a religious or philosophical exemption when it comes to public health issues); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (“[T]he right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.”); *Lyng v. Northwest Indian Cemetery Protective Ass’n*, 485 U.S. 439, 452 (1987) (“However much we might wish that it were otherwise, government simply could not operate if it were required to satisfy every citizen’s religious needs and desires.”); Ellis West, *The Case Against a Right to Religion-Based Exemptions*, 4 NOTRE DAME J. L. ETHICS & PUB. POL’Y 591 (1990) (suggesting that accommodations are troublesome for reasons that transcend the likely violence they will inflict upon equality of religious liberty. If political entities may make religion-specific policies even when not so required by the Constitution, a number of unappealing consequences may follow); and Alan Garfield, *The Contraception Mandate Debate: Achieving a Balance*, 114 COLUM. L. REV. SIDEBAR 1, 24 (2014) (“But the mandate controversy is more Taliban than Torquemada. It has more to do with religious employers foisting their religion on female employees than with government foisting its secular values on religious employers.”).
257. See, e.g., Lawrence Gostin et al., *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622, 626 (2002) (writing that “[p]ublic health officials are explicitly directed to respect individual religious objections to vaccinations and treatment. Officials must follow specified legal standards before using isolation or quarantine, which are

pandemic, public health cannot afford the luxury of debating which viewpoint, between public safety and personal choice, should prevail.

Critics may argue, with some force, that the case for individual liberty in public health is compelling because the U.S. Supreme Court has long held that a competent person has a constitutional right to refuse medical treatment.²⁵⁸ Point well taken. I submit, however, that isolation and quarantine are tools to prevent ill persons from spreading the disease to the population. It is no longer about an individual's choice for treatment. It is about protecting the "herd" from a dangerous disease. As the U.S. Supreme Court so aptly put it in *Prince v. Commonwealth of Massachusetts*, "the right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death."²⁵⁹ Yes, we can have the debate about what process is due to those who are quarantined or isolated. That is entirely appropriate. But automatically granting religious exemptions in quarantine and isolation cases as some of the states have done does a disservice to public health.

Furthermore, granting religious exemptions in quarantine and isolation cases arguably runs afoul of the Equal Protection Clause. Courts have so far not been presented with such a challenge, except in *Moore v. Draper*.²⁶⁰ In *Moore*, the petitioner was confined in the Southwest Florida State Sanitarium at Tampa under the provisions of a Florida statute relating to compulsory isolation and hospitalization of tubercular persons.²⁶¹ The court mentioned that the "[p]etitioner makes a special attack upon the law on the ground that it discriminates against all persons other than those of a certain religious faith and belief."²⁶² The court found that "Section 392.23, Subsection (2), F.S.A. is sufficient protection and guarantee that [petitioner's] religious freedom is not being denied to him. Religious freedom cannot be used as a cloak for any person with a contagious or infectious disease to spread such disease because of his religion."²⁶³ Although this decision neither discusses the statute in question nor the

authorized only to prevent the transmission of contagious diseases to others and must be by the least restrictive means available.").

258. *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 270 (1990).

259. 321 U.S. at 166.

260. 57 So.2d 648 (Fla. 1952).

261. F.S.A. § 392.23(2), *repealed by* Laws 1951, c. 26828, § 14.

262. 57 So. 2d at 650.

263. *Id.*

discrimination issue raised by the petitioner, it raises the possibility that such a challenge is possible.²⁶⁴

Finally, others may contend that denying religious exemptions to quarantined and isolated individuals may violate federal laws, particularly RFRA in light of the Supreme Court's decision in *Burwell v. Hobby Lobby Stores Inc.* The answer is hard to predict. However, quarantine and isolation measures can conform to RFRA, even though the measures may substantially burden an individual's religious conscience. All that RFRA requires is that if the government's action substantially burdens a person's religion, then the government must "[demonstrate] that application of the burden to the person is in furtherance of a compelling governmental interest; and is the least restrictive means of furthering that compelling governmental interest."²⁶⁵

In light of the foregoing discussion, I am persuaded that overwhelming number of states providing statutory religious exemptions for immunizations, and those that provide religious exemptions for contraception, quarantine and isolation, are tipping the balance heavily in favor of religion. To be fair, public health concerns do not necessarily trump religious rights in the view of some. Thus, they would rather see public health suffer than impinge on any one's religious rights. This approach is however, proving to be detrimental to public health, which in turn then ends up hurting the same individuals whose religious rights the states are trying to accommodate. Therein lies the conundrum.

VI. SUGGESTED APPROACHES

Providing recommendations for or against religious exemptions in public health is an exceedingly difficult task. In the words of one commentator, "[t]he United States has a romantic attitude towards religious individuals and institutions, as though they are always right."²⁶⁶ Therefore, any argument for or against religious accommodations in health engenders charged and often passionate defenses.²⁶⁷ Nevertheless many commentators have made

264. See, e.g., Alicia Novak, *The Religious and Philosophical Exemptions to State-Compelled Vaccination: Constitutional and Other Challenges*, 7 U. PA. J. CONST. L. 1101, 1115 (2005) (citing cases where state vaccination exemption statutes were found to violate the equal protection clause).

265. 42 U.S.C. §2000bb-1(b) (2012).

266. HAMILTON, *supra* note 17, at 3.

267. Compare Editorial, *supra* note 195 (noting that "allowing religious doctrine to prevail over the need for competent emergency care and a woman's right to complete and accurate information about her condition and treatment choices violates medical ethics and existing law.") with

recommendations ranging from a complete abolition of state religious exemptions,²⁶⁸ to reaching for a more optimal balance between religious freedom and public health,²⁶⁹ to complete accommodation of religious exemptions by the states.²⁷⁰ It seems to me that these recommendations have either been ignored or have been palpably unpersuasive to many state legislatures. So where do we go from here? Notwithstanding some of the recommendations already offered, there are two approaches that have not been discussed extensively in the literature and yet are germane to public health. The first is that state lawmakers should be encouraged to apply evidence-based law,²⁷¹ just like public health practitioners and physicians apply the principles of evidence-based medicine in their work. “Evidence-based medicine (EBM) [is] defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.”²⁷² Likewise, evidence-based law relies on the best available scientific evidence and data by lawmakers as a basis for lawmaking. Unfortunately, state legislators are inclined to rely on anecdotal evidence and common wisdom unsupported by scientific research.²⁷³ For example, despite studies showing the disadvantages of religious exemptions in public health, forty-eight states statutorily provide for religious exemptions for school vaccination laws,²⁷⁴ while twenty-one states offer exemptions from contraceptive coverage, usually for

Christopher C. Lund, *Religious Liberty After Gonzales: A Look at State RFRAs*, 55 S.D. L. REV. 466, 497 (2010) (stating that “[f]inally and most importantly, we must work harder to convince people why religious liberty is worth protecting. Without that understanding, legislators will never vote for RFRAs. Without that understanding, judges will hesitate to interpret them fairly. Without that understanding, religious liberty will soon become a second-class right, relegated to theory and to memory. We should fight that at all costs.”).

268. Novak, *supra* note 264, at 1125.

269. Timothy Aspinwall, *Religious Exemptions to Childhood Immunization Statutes: Reaching for a More Optimal Balance Between Religious Freedom and Public Health*, 29 LOY. U. CHI. L.J. 109, 132 (1997).

270. Smith, *supra* note 18, at 266.

271. *See generally* Jeffrey Rachlinski, Comment, *Evidence Based Law*, 96 CORNELL. L. REV. 901 (2011) (noting that the point of evidence based law is to create better law—law informed by reality).

272. Arnold J. Rosoff, *Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POL., POL’Y & L. 327, 327 (2001).

273. Shai Wozner, Comment, *Evidence Based Law by Jeffrey Rachlinski*, 96 CORNELL. L. REV. 925, 926 (2011).

274. *See* NAT’L CONF. OF ST. LEGISLATURES, *supra* note 31.

religious reasons, for insurers or employers in their policies.²⁷⁵ A few state statutes contain language that appears to grant religious exemptions for quarantine and isolation detainees.²⁷⁶ This underscores the point that scientific evidence, or empiricism, is lacking in the law. As Professor Jeffrey Rachlinski has noted, legal empiricism has remained in the scholarly academies and has not assumed a similar presence in the field of legal practice or rulemaking (*e.g.*, legislatures and courts).²⁷⁷ This has been and will continue to be harmful to public health.

The second approach for public health is to find insider-champions. Public health needs innovative leaders who are willing to challenge the status quo. Three such persons merit mentioning here. First is the former mayor of New York City, Michael Bloomberg. Professor Lawrence Gostin has written that the public health community views Bloomberg “as an urban innovator—a rare political and business leader willing to fight for a built environment conducive to healthier, safer lifestyles.”²⁷⁸ Bloomberg “has used the engine of government to make New York City a laboratory for innovation—raising the visibility of public health, testing policy effectiveness, and probing the boundaries of state power.”²⁷⁹ Even though some of his policies were struck down by the courts,²⁸⁰ Bloomberg has proved to be an insider-champion for public health in ways that have changed public health forever.

The second insider-champion is former surgeon general C. Everett Koop. According to the Washington Post, “Koop is justly renowned for his role in the tobacco wars of the 1990s. His repeated warnings that tobacco use was deadly and increasing among children anchored a series of famous congressional hearings that led to warning labels, bans on Joe Camel-type advertising and finally, in 2009, the FDA’s regulation of tobacco.”²⁸¹ Additionally, Koop’s role in the fight against HIV/AIDS is legendary. The Washington Post notes:

275. NAT’L CONF. OF ST. LEGISLATURES, *supra* note 32.

276. *See infra* Part IV.

277. Wozner, *supra* note 273.

278. Lawrence Gostin, *Bloomberg’s Health Legacy—Urban Innovator or Meddling Nanny?*, 43 HASTINGS CTR. REP. 19, 19 (2013).

279. *Id.*

280. *See* Matter of N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y. City Dept. of Health & Mental Hygiene, 16 N.E.3d 538 (2014) (holding that that the New York City Board of Health, in adopting the Sugary Drinks Portion Cap Rule, exceeded the scope of its regulatory authority).

281. Joshua Green, *Former Surgeon General C. Everett Koop: An Unsung Hero in the Fight Against AIDS*, WASH. POST, Feb. 27, 2013,

Koop was a noted social conservative who disapproved of homosexuality. But as a doctor, he recognized the epidemiological implications of what was happening and fought tirelessly to contain them. Whenever he testified before Congress, he knocked down the conservative talking point that “AIDS is not a no-fault disease.” He labored to disabuse Republicans . . . of their crackpot conviction that AIDS spread through spores and could be transmitted by spoons and scissors. He intentionally highlighted the tragedies of pediatric AIDS and hemophiliacs like Ryan White who contracted the disease through transfusions to shape public consciousness of AIDS as affecting more than gay men and intravenous drug users. Ultimately, this strategy yielded landmark legislation, the Ryan White CARE Act.²⁸²

Thus, Koop’s efforts helped shift public awareness in a way that made legislation possible.²⁸³

Finally, a third insider-champion is Bill Gates acting through the Bill and Melinda Gates Foundation. The Foundation is “an enormous funder of biomedical research that has quickly rearranged the public health universe.”²⁸⁴ The Foundation applies science and technology to address the most severe health problems in the developing world,²⁸⁵ including HIV/AIDs, malaria, and tuberculosis. It has also funded vaccine delivery programs thereby saving millions of lives a year.²⁸⁶ But more important to this discussion is the Foundation’s support of evidence-based decision-making. The Foundation invests in providing reliable information and analysis to help health officials review new vaccines and thereby speed up their decision-making.²⁸⁷

I acknowledge here that others may quibble with the second approach as a departure from the central thesis of the paper regarding religious exemptions. To some extent, I am willing to concede that

<http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/27/former-surgeon-general-everett-koop-an-unsung-hero-in-the-fight-against-aids/>.

282. *Id.*

283. *See id.*

284. Peter Lee, *Towards a Distributive Commons in Patent Law*, WIS. L. REV. 917, 969 (2009) (citations omitted).

285. *Id.*

286. *See* BILL & MELINDA GATES FOUND., VACCINE DELIVERY STRATEGY OVERVIEW, <http://www.gatesfoundation.org/What-We-Do/Global-Development/Vaccine-Delivery> (last visited Nov. 1, 2014).

287. *See id.*

point. However, the suggested approach centers on individuals who have focused on protection of entire populations, rather than personal autonomy or individual rights. I mention these three champions because they have shown a penchant for relying on scientific evidence to formulate public health policy and programs. In so doing, they have gone against dogma and become innovators. These are the insider-champions who can confront state laws on religious exemptions and legislators and make a difference on what is written into public health laws and how the laws are implemented.

CONCLUSION

This paper started by asking three questions: First, do religious exemptions in public health activities allow the government to unduly prefer religion over non-religion? Second, is immunizing religious conduct from scrutiny consistent with public welfare, health, and safety? Third, is the overwhelming number of states (forty-eight) providing statutory religious exemptions for immunizations and nearly half that provide exemptions for contraception, tipping the balance heavily in favor of religion?

The answer to the first question is a qualified yes. For example, in *McCarthy v. Boozman*,²⁸⁸ a parent challenged the Arkansas statute requiring the vaccination of all school children. The statute provided a religious exemption to members of a recognized church or religious denomination.²⁸⁹ In finding the religious exemption unconstitutional, the court noted that “the preferential restriction contained in Arkansas’ religious exemption provision contravenes the Establishment Clause’s principles of governmental neutrality,”²⁹⁰ that the exemption failed to satisfy the commands of the Free Exercise Clause of the First Amendment, and also violated the Equal Protection Clause of the Fourteenth Amendment.²⁹¹ But this question is qualified by the fact that the exemptions have been held to be valid in general. Legislatures can choose to grant exemptions, but the constitution does not require them.²⁹² So, although legislatures may grant exemptions, they must not favor some religion unfairly over others.²⁹³

288. *McCarthy v. Boozman*, 212 F. Supp. 2d 945 (W.D. Ark. 2002).

289. *Id.* at 950.

290. *Id.* at 949.

291. *Id.*

292. GREENWALT, *supra* note 33, at 31.

293. *Id.*

As for the second question, regarding whether immunizing religious conduct is consistent with public welfare, health, and safety, the answer seems to be no. The studies cited in Part II (A)(2) herein show that religious exemptions place public health at a risk. Finally, regarding the third question, I am persuaded that the overwhelming number of states providing statutory religious exemptions for immunizations and the nearly half that provide exemptions for contraception are responsible for tipping the balance heavily in favor of religion.

