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A COMPELLING INTEREST? USING OLD CONCEPTIONS OF PUBLIC HEALTH LAW TO CHALLENGE THE AFFORDABLE CARE ACT'S CONTRACEPTIVE MANDATE

Joshua Joel*

INTRODUCTION

The history of public health law exposes the best and worst of humanity. In this century, the Nazis justified genocide of millions to advance public health.¹ At the same time, efforts of public health activists have saved millions from death and disease.² Although public health aims could arguably justify near-totalitarian government control,³ governments have also used public health powers to ensure healthier air to breathe, water to drink, and food to eat.⁴ While personal liberties have been crushed through forced racist segregation and sterilization on the platform of advancing public health,⁵ similar curtailment of individual freedoms has saved nations

* J.D. Candidate, 2015, Georgia State University College of Law. I would like to extend a special thank you to Dean Kelly Timmons for her support and guidance; to Professor Leslie Wolf for starting me on this Note; to my wife—Sari—for the years of devotion as we have pursued our dreams; to my children—Rochel, Yaakov, and Nachum—for their joy and love; to my parents for their relentless love and support; and to the Creator for His endless blessings.

1. Virginia Leary et al., *Health, Human Rights and International Law*, 82 AM. SOC'Y INT'L L. PROC. 122, 134 (1990) (“The Nazis thought of the entire Nazi extermination program as a public health problem. Killing became a ‘therapeutic imperative.’”); Robert N. Proctor, *Nazi Medicine and Public Health Policy*, 10 DIMENSIONS 2 (1996), available at http://archive.adl.org/braun/dim_14_1_nazi_med.asp (demonstrating that the Nazi worldview included a strong public health ethic, but “excluded Jews and others deemed racially or genetically unfit from the . . . community,” thereby justifying murder and torture by medical professionals).

2. Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Control of Infectious Diseases*, 48 MORBIDITY & MORTALITY WKLY. REP. 621, 621–629 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4829a1.htm>.

3. See Mark A. Hall, *The Scope and Limits of Public Health Law*, 46 PERSP. BIOLOGY & MED. S199, S208 (2003).

4. Ctrs. for Disease Control & Prevention, *supra* note 2.

5. See *Buck v. Bell*, 274 U.S. 200, 205, 207 (1927) (upholding the forced sterilization of a “feeble-minded white woman” who may produce “inadequate offspring” as constitutional because the welfare of society would be promoted); *Jew Ho v. Williamson*, 103 F. 10, 12–13 (N.D. Cal. 1900) (challenging the constitutionality of mandatory quarantine only enforced against Chinese people); *Plessy v. Ferguson*, 163 U.S. 537, 540 (1896) (sustaining state anti-miscegenation laws, segregation in railroad

from disease through vaccination and quarantine.⁶ The study of public health must center on the tension between government coercive power and individual liberty.⁷

The Centers for Disease Control and Prevention (CDC) touts “family planning” as one of the ten great public health achievements of the twentieth century.⁸ Nevertheless, the availability of contraception has long been at the center of political, social, and legal controversy.⁹ On March 23, 2010, this controversy came to a head when President Barack Obama signed the Patient Protection and Affordable Care Act (ACA or the Act).¹⁰

One of the Act’s provisions, referred to as the “HHS Mandate,” requires health insurers to cover an essential benefits package, including prescription drugs.¹¹ The Act delegates authority to the

transportation, and segregated schools); Richard A. Epstein, *In Defense of the “Old” Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOK. L. REV. 1421, 1424–25 (2004); Paul A. Lombardo, *Medicine, Eugenics, and the Supreme Court: From Coercive Sterilization to Reproductive Freedom*, 13 J. CONTEMP. HEALTH L. & POL’Y 1, 4 (1996).

6. See *Jacobson v. Massachusetts*, 197 U.S. 11, 31–32 n.† (1905) (showing evidence of the efficacy of vaccination); Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Impact of Vaccines Universally Recommended for Children—United States, 1990–1998*, 48 MORBIDITY & MORTALITY WKLY. REP. 243, 243–48 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056803.htm> (describing the impacts of recommended vaccination on the population); Epstein, *supra* note 5, at 1445–47.

7. See LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 10–11 (2nd ed. 2008) (noting that protecting the community’s health is not possible without limiting many private activities) [hereinafter GOSTIN, POWER].

8. *Ten Great Public Health Achievements in the 20th Century*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 13, 2014, 7:38 PM), <http://www.cdc.gov/about/history/tengpha.htm>. Other achievements include vaccination, motor-vehicle safety, safer workplaces, control of infectious diseases, decline in deaths from heart disease and stroke, safer and healthier foods, fluoridation of water, and public awareness of the hazards of tobacco use. *Id.* The CDC claims that decreased family size and ability to space births has improved women’s role in society and contributed to the better health of the family. Ctrs. for Disease Control & Prevention, *Achievements in Public Health, 1900–1999: Family Planning*, 48 MORBIDITY & MORTALITY WKLY. REP. 1073, 1073 (1999), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm>.

9. See Erica S. Mellick, *Time for Plan B: Increasing Access to Emergency Contraception and Minimizing Conflicts of Conscience*, 9 J. HEALTH CARE L. & POL’Y 402, 405–11 (2006).

10. Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 119 (2010); Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES (Mar. 23, 2010), <http://www.nytimes.com/2010/03/24/health/policy/24health.html>; Robert Pear, *Contraceptives Stay Covered in Health Law*, N.Y. TIMES (June 28, 2013), <http://www.nytimes.com/2013/06/29/us/politics/final-rule-issued-for-contraceptive-coverage.html>.

11. 42 U.S.C. § 300gg-13(a) (2012) (requiring health insurers to provide minimum no-cost coverage for “evidence-based” preventive services according to guidelines by United States Preventive Services Task Force, CDC, and HHS). HHS delegated to the Institute of Medicine (IOM) the job of

Department of Health and Human Services (HHS) to determine what prescription drugs the HHS Mandate includes.¹² The HHS definition embraces all FDA-approved preventive care drugs including contraceptives such as Plan B (“morning-after pill”),¹³ Ella (“week-after pill”),¹⁴ and two intrauterine devices (IUDs) that can prevent the implantation of a fertilized egg.¹⁵ Employers who provide insurance and do not comply with the mandate are subject to heavy fines.¹⁶

Strong objection by the Roman Catholic Church and other religious groups prompted HHS to amend its guidelines and exempt non-profit religious institutions from the provision.¹⁷ Nonetheless,

recommending guidelines for this purpose. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8726 (proposed Feb. 15, 2012) (to be codified at 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147). IOM’s report recommended the guidelines to include “[a]ll Food and Drug Administration [(FDA)] approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.” *Id.*

12. 42 U.S.C. § 300gg-13(a)(4) (2012) (“[W]ith respect to women, such additional preventive care . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration”); 45 C.F.R. § 147.130(a)(1)(iv) (2013).

13. See *Birth Control: Medicines to Help You*, FOOD & DRUG ADMIN., <http://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm313215.htm> (last updated Jan. 8, 2015).

14. See *id.*

15. 77 Fed. Reg. 8725; *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1123 (10th Cir. 2013) (describing the contraceptives at issue).

16. See 26 U.S.C. § 4980D(b)(1) (West, Westlaw through P.L. 113-36) (imposing a tax of “\$100 for each day in the noncompliance period with respect to each individual to whom such failure relates.”); *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2775–76 (2014). (“For Hobby Lobby, the bill could amount to \$1.3 million per day or about \$475 million per year; for Conestoga, the assessment could be \$90,000 per day or \$33 million per year; and for Mardel, it could be \$40,000 per day or about \$15 million per year.”).

17. 45 C.F.R. § 147.130(a)(1)(iv)(A) (2013); Coverage of Certain Preventative Services Under the Affordable Care Act, 78 Fed. Reg. 8456, 8458 (Feb. 6, 2013) (to be codified at 45 C.F.R. pts. 147, 148, and 156); Brady Sullivan, *HHS Issues Another Rule on Contraceptive Mandate*, REG BLOG (July 10, 2013), <http://www.law.upenn.edu/blogs/regblog/2013/07/10-sullivan-contraceptive-mandate.html> (indicating that outrage from “[r]eligious rights advocacy groups and the Catholic Church” caused HHS to issue new rules “seeking to accommodate religious non-profits.”). Other religious groups—even those not doctrinally opposed to contraception—have aligned themselves with the Catholic Church’s objections because of the religious freedom implications. Howard Slugh, *Rabbis Side with Catholics, Urge Obama to Drop Mandate*, WKLY. STANDARD (May 24, 2012, 12:19 PM), http://www.weeklystandard.com/blogs/rabbis-side-catholics-urge-obama-drop-mandate_645819.html (“Rabbinical Council of America (RCA), the largest organization of rabbis in the United States, approved a resolution recognizing that the Health and Human Services . . . forces many employers to ‘violate the injunctions of their religion.’”); Timothy George & Chuck Colson, *First They Came for the Catholics: Obama’s Contraceptive Mandate*, CHRISTIANITY TODAY (Feb. 8, 2012, 10:10 AM), <http://www.christianitytoday.com/ct/2012/februaryweb-only/catholics-contraceptive-mandate.html> (urging evangelicals to “stand unequivocally with our Roman Catholic brothers and sisters,” reasoning that “when the government violates the religious liberty of one group, it threatens the religious liberty of

religious groups were unsatisfied.¹⁸ As a result, over 126 non-profit plaintiffs and 193 for-profit corporation plaintiffs filed lawsuits challenging the mandate's constitutionality.¹⁹ The circuit courts split in the cases decided on their merits, and the cases were appealed to the United States Supreme Court.²⁰

In a landmark ruling, *Burwell v. Hobby Lobby Stores, Inc.*, the Supreme Court held that closely held, for-profit corporations are entitled to free-exercise rights, and a regulation restricting the religious activities of a corporation must comply with the Religious Freedom Restoration Act (RFRA).²¹ The Obama administration had claimed that contraception coverage is a vital preventive care service within the government's coercive authority to advance public health.²² Although the *Burwell* majority criticized this argument,²³ the Court found it "unnecessary to adjudicate this issue" and assumed

all."); Asma T. Uddin & Ashley McGuire, *It's About Religious Liberty, Not Birth Control*, ONFAITH (Mar. 7, 2012), http://www.washingtonpost.com/blogs/altmuslimah/post/beyond-the-war-on-women-its-about-religious-liberty-not-birth-control/2012/03/06/gIQAk5ArwR_blog.html (advocating Muslim women to "stand united" with Catholic women "in opposition to the mandate and the affront on religious freedom it so gravely poses" even though Islam disagrees with Catholic doctrine about morality of contraception, sterilization, and abortifacients).

18. Timothy Stoltzfus Jost, *Religious Freedom and Women's Health—The Litigation on Contraception*, 368 NEW ENG. J. MED. 4, 4 (2013). See also Press Release, United States Conference of Catholic Bishops, HHS Final Rule Still Requires Action in Congress, By Courts, Says Cardinal Dolan (July 3, 2013), available at <http://www.usccb.org/news/2013/13-137.cfm>.

19. See, e.g., *Hobby Lobby Stores*, 723 F.3d 1114; *Conestoga Wood Specialties Corp. v. Sec'y of U.S. Dep't of Health & Human Servs*, 724 F.3d 377 (3rd Cir. 2013), *rev'd*, *Burwell*; *Korte v. Sebelius*, 735 F.3d 654, 655 (7th Cir. 2013); *HHS Mandate Information Central*, <http://www.becketfund.org/hhsinformationcentral> (last visited Sept. 16, 2013). In general, plaintiffs argue that requiring religious employers to provide contraception against their religious beliefs violates their constitutional right to free exercise of religion. *Id.*

20. See *Hobby Lobby Stores*, 723 F.3d at 1120 (holding that a for-profit corporation can assert a free-exercise claim); *Conestoga*, 724 F.3d at 381 (holding that a for-profit, secular corporation cannot engage in religious exercise); *Gilardi v. HHS*, 733 F.3d 1208, 1210 (D.C. Cir. 2013) (finding that although secular corporations are not afforded free exercise rights, the contraceptive mandate "trammels" the constitutional right to free exercise of religion of the shareholders); *Korte*, 735 F.3d at 686; *Autocam Corp. v. Sebelius*, 730 F.3d 618, 628 (6th Cir. 2013) (holding that for-profit corporation is not a "person" to engage in religion); *Eden Foods Inc. vs. Sebelius*, 733 F.3d 626, 633 (6th Cir. 2013) (holding that a corporation could not assert a religious freedom claim).

21. *Burwell*, 134 S. Ct. at 2775. See discussion *infra* Part III.D.

22. Petition for Writ of Certiorari at *27–*28, *Sebelius v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 1536 (2014) (No. 13-354), 2013 WL 5290575, at *27–*28 (Sept. 19, 2013).

23. *Burwell*, 134 S. Ct. at 2779 ("[M]any of these [interests] are couched in very broad terms, such as promoting 'public health' and 'gender equality.' RFRA, however, contemplates a 'more focused' inquiry . . .").

“that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA.”²⁴

As demonstrated by *Burwell*, courts often do not to engage in critical analysis of public health legal doctrine because cases can often be resolved within a more formalistic legal framework.²⁵ A more rigorous public health analysis could provide a more predictable framework by which courts could weigh the competing interests implicated by public health legislation and regulation, as well as provide tools to agencies to ensure the legality of their actions. Additionally, it could serve to remove the politicization of regulatory decision-making by vetting those actions within a preconceived framework. Therefore, the purpose of this Note is to suggest a framework by which public health initiatives should be analyzed when they conflict with religious freedoms.²⁶

Part I of this Note presents arguments for and against the notion that mandating contraceptive coverage is an important public health initiative.²⁷ Part II defines and delineates the scope of public health.²⁸

24. *Id.* at 2780, 2786 (Kennedy, J., concurring) (“It is important to confirm that a premise of the Court’s opinion is its assumption that the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees.”). Conservative scholar, Richard A. Epstein, has criticized this assumption as an “intellectual and tactical mistake.” See Richard A. Epstein, *The Defeat of the Contraceptive Mandate in Hobby Lobby: Right Results, Wrong Reasons*, 2014 CATO SUP. CT. REV. 35, 50 (2014).

25. See *Burwell*, 134 S. Ct. at 2780; WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, & THE LAW 5–6 (2009) [hereinafter PARMET, POPULATIONS] (arguing that “despite the ubiquity of public health issues in law,” theorists and courts overlook the “centrality of public health issues” in their analysis and decisions, and do not appreciate the insight the field of public health may “bring to the legal question at hand.”). The district courts that struck down the contraceptive mandate also only relied on the fact that the government only provided general public health interests that were insufficient to fulfill the “compelling interest” standard. See *Hobby Lobby Stores*, 723 F.3d at 1143 (holding that the interests of public health and gender inequality are insufficient because they are too broadly formulated); *Gilardi*, 733 F.3d at 1220 (stating that the government’s public health “recitation is sketchy and highly abstract”); *Korte*, 735 F.3d at 686 (holding that the government’s arguments “flunk the test” because the interests were stated too generally). See also *Conestoga*, 724 F.3d at 412 (Jordan, J., dissenting) (arguing that the Obama administration did not satisfy the RFRA because only general health interests were asserted).

26. This Note does not, however, touch the primary controversy in the *Burwell* case: whether corporations have religious freedom at all. See, e.g., Emily Carlton Cook, *How the Meaning of Incorporation over Time Lends Support for Corporate Free Exercise Rights*, 48 GA. L. REV. 1149, 1154 (2014).

27. See discussion *infra* Part I.

28. See discussion *infra* Part II.

Part III approaches public health in the legal context: first, it delineates the federal government's constitutional power to enforce public health interests; second, it establishes a framework for evaluating public health initiatives; and third, it presents the standard by which courts balance public health interests against incursion on freedom of religion.²⁹ Finally, Part IV suggests that the *Jacobson* factors presented in Part III should be used as a tool to assess whether a compelling interest exists when the federal government enacts legislation that restricts religious freedom, and analyzes the contraceptive mandate to demonstrate the benefit of such an analysis.³⁰

I. THE POLICY DEBATE: IS MANDATORY CONTRACEPTIVE COVERAGE THE APPROPRIATE PRESCRIPTION?

The underlying goal driving the ACA's preventive care coverage requirement is the effort to transform the healthcare system from one that treats illness to one that sustains health.³¹ The ACA considers contraception to be a part of basic preventive care for women and therefore requires coverage without copayments.³² Mandating contraceptive coverage is not new; before the ACA, twenty-eight states had already required insurers to cover contraceptives, twenty of which exempted certain employers and insurers.³³

29. See discussion *infra* Part III.

30. See discussion *infra* Part IV.

31. Dana R. Gossett et al., *Contraception Is a Fundamental Primary Care Service*, 309 JAMA 1997, 1997 (2013); Jost, *supra* note 18, at 4 (noting that the preventive care chapters of the ACA reflect health policy experts' view that healthcare should proactively "prevent disease and preserve wellness").

32. See 77 Fed. Reg. 8725, 8726; *Burwell*, 134 S. Ct. at 2787–88 (Ginsburg, J., dissenting); Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services and Supplies Without Cost Sharing*, GUTTMACHER POL'Y REV., Winter 2011, at 7, 7, available at <http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.pdf> (claiming that "a strong, long-standing body of evidence" shows that contraception has long been considered part of preventive public health care).

33. *State Policies in Brief: Insurance Coverage of Contraceptives*, GUTTMACHER INST. 2 (Oct. 2014), http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf. Three states limit contraceptive coverage refusals to churches and church associations but not hospitals or other entities. *Id.* Seven states expand coverage refusals to include churches, church associations, religious schools, and some religious charities and universities. *Id.* Nine others allow all religious organizations to refuse to provide coverage, including some hospitals. *Id.* At least one of these states exempts even secular organizations with "moral or religious" objections. *Id.* The federal mandate contains a "religious employer" exception and defines

A. Arguments in Favor of the Contraceptive Mandate

Contraceptive mandates originated as a women's rights issue, but proponents also argue that mandates provide "direct, positive" effects on improving the health of women and infants.³⁴ The primary use of contraception is to prevent pregnancy.³⁵ The rate of unintended pregnancies in the United States is higher than in other developed countries,³⁶ particularly among low-income women, women in their teens and early twenties, and minorities.³⁷ One way to minimize unintended pregnancies is to expand access to contraceptive care.³⁸ Therefore, mandate supporters argue that preventing unwanted pregnancies is an important public health initiative.³⁹

it as a nonprofit organization that "primarily employs persons who share the religious tenets of the organization," "serves primarily persons who share the religious tenets of the organization," and whose purpose is to inculcate "religious values." 45 C.F.R. § 147.130(a)(1)(iv)(B) (2013). The federal exemption is modeled after those of California, New York, and Oregon, which are the narrowest of all the state exemptions. *Six Things Everyone Should Know About the HHS Mandate*, U.S. CONF. OF CATHOLIC BISHOPS (Feb. 6, 2012), <http://www.usccb.org/news/2012/12-021.cfm>.

34. BEBE J. ANDERSON & LYNNE S. WILCOX, *Reproductive Health*, in *LAW IN PUBLIC HEALTH PRACTICE* 348, 363 (Richard A. Goodman et al. eds., 2003); Sonfield, *supra* note 32, at 8 (stating that the "most direct, positive effects" of helping couples plan pregnancy are improved "maternal and child health outcomes"). Arguments in favor of contraceptive mandates gained traction in the mid-1990's after insurance companies began providing coverage for Viagra for men. Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, 28 HARV. J.L. & PUB. POL'Y 741, 741 (2005). Women's rights groups argued that providing coverage for contraception would balance the inequality of access to reproductive health services. Lisa A. Hayden, *Gender Discrimination Within the Reproductive Health Care System: Viagra v. Birth Control*, 13 J.L. & HEALTH 172-73 (1999). In fact, the U.S. Equal Employment Opportunity Commission ruled that employers' failure to provide equal coverage to prescription drugs to men and women violated Title VII of the Civil Rights Act. Anderson & Wilcox, *supra* at 363 no. i.

35. Gossett et al., *supra* note 31, at 1997.

36. *Id.* (citing Susheela Singh et al., *Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes*, 41 STUD. FAM. PLAN. 241, 241-50 (2010)). Unwanted pregnancies are defined as those that occur two or more years earlier than desired or those that are not wanted at all. Susheela Singh et al., *supra*, at 242 (2010). It is estimated that there are over 3 million unintended pregnancies in the United States annually. Gossett et al., *supra* note 31, at 1997 (citing Singh et al., *supra*, at 241-50).

37. Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancies in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL AND REPROD. HEALTH 90, 92-94 (2006) (demonstrating by empirical evidence that these groups have the most unintended pregnancies).

38. Singh et al., *supra* note 36, at 248 (suggesting based upon epidemiological data that increased access to contraceptive use decreases unintended pregnancy rates).

39. Gossett et al., *supra* note 31, at 1997.

1. *The Problem: The Effects of Unintended Pregnancy*

In its report, the Institute of Medicine (IOM) based its recommendation on the argument that “unintended pregnancies have adverse health consequences for both mothers and children.”⁴⁰ Maternal mortality and risks associated with pregnancy are higher in unplanned pregnancies.⁴¹ The IOM found that consequences of unplanned pregnancies include inadequate prenatal care, depression, higher likelihood of smoking or consuming alcohol during pregnancy, and increased likelihood of preterm birth and low birth weight.⁴² Contraception also lowers abortion rates.⁴³ The report further found that spacing pregnancies decreases the risk for adverse pregnancy outcomes and allows for women with chronic medical conditions to delay conception.⁴⁴

Additionally, supporters urge that availability of contraception also provides non-contraceptive medical benefits.⁴⁵ For example, women use contraceptives to treat menstrual disorders and even acne; contraceptive pills have also been known to reduce the risk of ovarian and endometrial cancer.⁴⁶ Lastly, supporters argue that

40. Petition for Writ of Certiorari at 7, *Sebelius v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 1536 (2014) (No. 13-354), 2013 WL 5290575, at *6 (Sept. 19, 2013).

41. Gossett et al., *supra* note 31, at 1997. The specific argument is that the risk of death from oral contraceptive use is only 1 in 1,667,000, “roughly the same risk as being struck by lightning,” whereas 15 of 100,000 women die in childbirth. *Id.*

42. INST. OF MED., COMM. ON PREVENTIVE SERVS. FOR WOMEN, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 103 (2011), available at http://www.nap.edu/catalog.php?record_id=13181. Contrary to the IOM report and the Guttmacher Institute’s arguments, studies in the United States indicate that although most women who become pregnant unintentionally delay antenatal care, once the pregnancy is discovered there is little discrepancy between intended and unintended pregnancies. Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 *STUD. FAM. PLAN.* 18, 22–23 (2008). Additionally, many studies exist regarding the effect of unintended pregnancy on the risk of “congenital anomalies, spontaneous abortion, premature delivery, and low birth weight,” and the studies have produced mixed results. *Id.* at 24. A few studies in developed countries have found a correlation between unintended pregnancies and “maternal risk behaviors, including alcohol and illicit drug use, cigarette smoking, and caffeine intake.” *Id.* at 21. But, three “large, rigorous” studies in the United States found that maternal risk behaviors are not effected by pregnancy intention. *Id.* at 22.

43. Petition for Writ of Certiorari, *supra* note 40, at 7.

44. INST. OF MED., *supra* note 42, at 103.

45. Gossett et al., *supra* note 31, at 1997.

46. INST. OF MED., *supra* note 42, at 107; Gossett et al., *supra* note 31, at 1997 (listing “menorrhagia, dysmenorrhea, and chronic pelvic pain” among the non-pregnancy ailments often treated with contraceptive pills).

women receive social benefits from contraceptive use; pregnancy planning frees women to pursue higher education, professional opportunities, and financial security before establishing a family.⁴⁷

2. *The Solution: Easier and Cheaper Access to Contraceptive Care*

Proponents of the contraceptive mandate argue that providing no-cost contraceptive care is the best way to address the problem of unwanted pregnancies.⁴⁸ They point to statistics showing that increased contraceptive use parallels declines in unintended pregnancy and abortion.⁴⁹ Also, improved access to contraceptives through expanded family planning programs in states like California and Arkansas precipitated a sharp decline in abortions and unintended pregnancies.⁵⁰ The argument is that reducing cost will instigate greater usage of the most common and effective contraceptives, the pill and sterilization, and therefore the number of unintended pregnancies will decline.⁵¹

B. *Arguments Against the Contraceptive Mandate*

The mandate's opponents attack this chain of reasoning and suggest that contraceptive mandates are ineffective in the face of the "unique qualities of the sexual transaction," and that easy access to contraception may potentially increase unwanted pregnancy by increasing the demand for sex outside of marriage.⁵² Further, the mandate's opponents argue that the mandate will likely do little to

47. Gossett et al., *supra* note 31, at 1997–98 (arguing non-medical benefits of contraception).

48. Sonfield, *supra* note 32, at 7 (arguing that contraceptive coverage is a low-cost way of addressing the "daunting barrier" low-income women face in accessing contraception).

49. INST. OF MED., *supra* note 42, at 105; Sonfield, *supra* note 32, at 8 (claiming increased contraceptive use is responsible for a seventy-seven percent decline in pregnancies among 15–17 year olds from 1995 to 2002).

50. Sonfield, *supra* note 32, at 8. In California, 2,870,000 unintended pregnancies and 118,000 abortions were avoided. *Id.* Arkansas saw an eighty-four percent drop in repeat births within twelve months. *Id.*

51. INST. OF MED., *supra* note 42, at 108–09.

52. Helen M. Alvaré, *No Compelling Interest: The "Birth Control" Mandate and Religious Freedom*, 58 VILL. L. REV. 379, 380 (2013) [hereinafter Alvaré, *No Compelling Interest*].

decrease unwanted pregnancies because low-income women, who represent the highest number of unwanted pregnancies, are already “amply supplied with free or low-cost contraception” by state and federal governments.⁵³ Women’s failure to access this contraception indicates that their reasons for not using contraceptives have less to do with cost than with other factors that are not affected by the mandate.⁵⁴

Perhaps the most salient argument against the contraceptive mandate is that its sole basis, the IOM report, is flawed.⁵⁵ First, throughout its treatment of statistical evidence, the report fails to prove causation between unwanted pregnancy and health problems and does “no more than suggest correlation.”⁵⁶ In fact, the reality might be the reverse; it is highly plausible that a woman’s predisposition to risk-taking accounts for both unintended pregnancies and problems such as smoking and drinking during pregnancy.⁵⁷ Opponents also argue that increased access to oral contraception may even damage women’s health because some

53. *Id.* Alvaré notes that most low-income women already have access to contraception through Medicaid and other government programs and fail to use it. *Id.* at 425. *See also* 42 U.S.C. § 1396d(a)(4)(C) (including “family planning” as a Medicaid benefit for women of child-bearing age who are sexually active).

54. Alvaré, *No Compelling Interest*, *supra* note 52, at 380.

55. *Id.* at 391 (arguing that the IOM report’s conclusions are flawed and cannot support the government’s claim, and pointing out that the IOM furnished nearly the entire basis of the mandate). Alvaré, in a separate article, asserts that the report was “crafted by hard-line ideological partisans,” who were “pre-committed to the results they ultimately advocated,” and only heard from witnesses who “were similarly ideologically committed.” Helen Alvaré, *Bad Science and Failed Freedom Protections in the HHS Mandate*, PUB. DISCOURSE (Feb. 5, 2013), <http://www.thepublicdiscourse.com/2013/02/7847>. Catholic hospitals, the largest nonprofit health care provider in the United States, were not invited to testify. *Id.* Indeed, one of the primary studies relied upon in the IOM was crafted by a senior fellow of the Guttmacher Institute, an affiliate of Planned Parenthood, who is a longtime supporter of large-scale birth control and abortion. Alvaré, *No Compelling Interest*, *supra* note 52, at 399.

56. Alvaré, *No Compelling Interest*, *supra* note 52, at 393. In fact, the actual texts of the studies cited by the IOM only claim “association” and do not assert causation at all. *Id.* at 393. *See also supra* note 42. Sources cited in the report are irrelevant to claims asserted, and at least one of the primary statistical studies used have been negatively peer reviewed. Alvaré, *No Compelling Interest*, *supra* note 52, at 393. The report cites a study about gestational diabetes and cardiovascular disease to support an assertion about low birth weight in children. *Id.* One review of a study used stated that it was based on “questionable assumptions” and the numbers “may be considerably inflated.” *Id.* at 396 (citing Austin L. Hughes, *The Case for a Compelling Government Interest in the HHS Mandate: Examining the Scientific Evidence* (Dec. 2012) (unpublished manuscript) (on file with author)).

57. Alvaré, *No Compelling Interest*, *supra* note 52, at 414.

studies have shown that increased access to contraception has increased the rates of sexually transmitted diseases.⁵⁸ Regarding children's health, opponents argue better protection is afforded by "encouraging mothers to seek prenatal care, breastfeed, and avoid smoking and drinking during pregnancy" and not by preventing births.⁵⁹

Second, even assuming the IOM's report is methodologically sound, opponents question the argument that access to contraception can reduce unwanted pregnancy.⁶⁰ The government can merely provide access, but cannot force a woman to use contraception.⁶¹ In fact, women do not use contraception for many reasons, many of which are not cost-related.⁶² For example, studies have shown that the perception of low risk for pregnancy is the primary reason for not using birth control.⁶³ The IOM itself, in both 1995 and 2010, claimed that "despite the availability of safe and effective preventive methods," there was little progress in preventing unwanted pregnancy.⁶⁴

Although there are unquestionably two sides to the policy coin regarding the contraceptive mandate, it is insufficient to rely on policy alone in determining whether a public health action is an appropriate use of government coercive power.⁶⁵ For that purpose,

58. *Id.* at 414–15.

59. *Id.* at 392. The United States Preventive Task Force, a panel of experts that research preventative health measure, already requires these services to be provided to the insured cost-free. *Id.* (citing 42 U.S.C. § 300gg-13(a)(4) (2006)).

60. *Id.* at 396 (analyzing and criticizing each step of the logic supporting the HHS mandate).

61. *Id.* at 398.

62. *Id.* at 383–84. One study, for example, found that over seventy-five percent of women did not use contraception because they "did not expect to have sex" or "did not think they could get pregnant." William Mosher et al., *Predictors of Non-use of Contraception, and Reasons for Non-use: Key Factors Affecting Unintended Pregnancy in the United States*, NAT'L CTR. FOR HEALTH STATISTICS 9, available at <http://paa2012.princeton.edu/papers/122088>.

63. Mosher, *supra* note 62, at 9. Another study showed that simple ambivalence about pregnancy is strongly connected to non-use of contraception. Jennifer J. Frost et al., *Factors Associated with Contraceptive Use and Nonuse, United States, 2004*, 39 PERSP. ON SEXUAL & REPROD. HEALTH 90, 97 (2007).

64. Alvaré, *No Compelling Interest*, *supra* note 52, at 400 (internal citation omitted).

65. See PARMET, POPULATIONS, *supra* note 25, at 28–45 (discussing the centrality of law to the public health debate).

attention must be given to the limitations and scope of public health in a legal framework.

II. THE DEFINITION AND SCOPE OF PUBLIC HEALTH

“Public health” is a challenging concept to define, and an effort to encapsulate its entire spectrum is difficult.⁶⁶ Charles-Edward A. Winslow, an early public health scholar, defined public health as “the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organised community efforts.”⁶⁷ While the medical care system treats individual patients, the public health system’s “patient” is the entire community, focusing on the wellbeing of a population.⁶⁸

Additionally, the breadth of how “health” is defined greatly affects the question of whether an initiative appropriately reaches public health aims.⁶⁹ The narrowest view of public health focuses on “the immediate risk factors for injury and disease.”⁷⁰ This definition limits public health to government intervention, specifically public officials “taking appropriate measures pursuant to specific legal authority . . . to protect the health of the public.”⁷¹ It also limits public health duties to “discrete powers such as surveillance . . . injury prevention . . . and infectious disease

66. *Id.* at 7 (“Despite the frequent use of the term *public health*, the phrase is surprisingly difficult to define.”); PUBLIC HEALTH LAW & ETHICS 1–8 (Lawrence O. Gostin, ed., 2nd ed. 2010) [hereinafter PUBLIC HEALTH LAW & ETHICS]; Lawrence O. Gostin et al., *The Law and the Public’s Health*, in LAW IN PUBLIC HEALTH PRACTICE 3, 4 (Richard A. Goodman et al. eds., 2003) [hereinafter Gostin, *Public’s Health*] (“The effort to capture the entire spectrum of public health activity in one definition is bound to be complex and challenging.”); Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J.L. MED. & ETHICS 144, 144–47 (2002) (advancing three alternative definitions of public health).

67. ROBERT BEAGLEHOLE & RUTH BONITA, PUBLIC HEALTH AT THE CROSSROADS: ACHIEVEMENTS AND PROSPECTS 174 (2nd ed. 2004) (quoting Charles-Edward A. Winslow).

68. Gostin, *Public’s Health*, *supra* note 66, at 5; PARMET, POPULATIONS, *supra* note 25, at 8. For example, to address the serious public health concerns of cigarette smoking, the medical-care system treats and counsels individuals regarding lung cancer, emphysema, and heart disease, whereas a public health approach focuses on changing social norms and preventing tobacco addiction. Gostin, *Public’s Health*, *supra* note 66, at 4.

69. PARMET, POPULATIONS, *supra* note 25, at 7–9.

70. PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 3.

71. Rothstein, *supra* note 66, at 146.

control.”⁷² A more expansive view focuses on the general health of the population, and enlists the community as a whole—both private and public sectors—in the effort.⁷³ This view focuses on the “empirical and ethical relationship between the health of individuals and the well-being of their communities.”⁷⁴

The World Health Organization views public health more expansively as a “state of complete physical, mental, and social well-being,” which broadens the horizon of public health initiatives to cover virtually any program to promote human happiness.⁷⁵ However, according to the dictionary definition of health—“the state of being sound in body or mind”⁷⁶—only those initiatives that promote the proper and efficient functioning of people’s mental or physical health are justified.⁷⁷ Even according to this slightly narrower definition, however, public health could arguably be viewed to include any initiative that creates an environment more conducive to healthy living.⁷⁸

Finally, the most expansive definition focuses on the “socioeconomic foundations of health” and human rights.⁷⁹ According to this view, public health may reach such social issues as distribution of wealth, war, racial equality, civic duties, and lifestyle,

72. PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 3–4.

73. PARMET, POPULATIONS, *supra* note 25, at 14; Rothstein, *supra* note 66, at 145.

74. PARMET, POPULATIONS, *supra* note 25, at 14.

75. *Id.* at 7–8 (observing that WHO’s definition “equate[s] health with the totality of human happiness,” and inferring from that definition that public health would “necessarily encompass an extremely broad set of activities, including all collective actions undertaken to provide the conditions for human happiness”) See also WORLD HEALTH ORG., *Constitution of the World Health Organization 1*, http://www.who.int/governance/eb/who_constitution_en.pdf (defining public health).

76. WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 1043 (1986).

77. See PARMET, POPULATIONS, *supra* note 25, at 7–8 (demonstrating that the dictionary definition of “health” affects the understanding of the scope of public health). The United States Supreme Court took this limited dictionary-definition view of public health to interpret and limit the scope of environmental regulation, and blatantly rejected the view that public health referred to “preventive medicine, organized care of the sick, etc.” *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 465–66 (2001) (citation omitted). The Supreme Court rather interpreted public health to simply mean “the health of the public.” *Id.* at 466.

78. PARMET, POPULATIONS, *supra* note 25, at 8 (noting that according to the IOM’s definition, public health translates to what we do to “ensure the conditions for people’s bodies” to perform properly). *But see* Epstein, *supra* note 5, at 1425–26 (arguing for a far more limited definition of public health, which focuses on prevention of only those “public bads” that can be inflicted on another with consent); Hall, *supra* note 3, at S208 (limiting public health to the more “traditional” approach).

79. PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 4; Rothstein, *supra* note 66, at 144.

because they are “important factors in individual well-being and community functioning.”⁸⁰

III. PUBLIC HEALTH LAW: THE LIMITATIONS OF GOVERNMENT AUTHORITY AND REACH

“Critical elements” by which public health objectives are achieved are government legislation and regulation.⁸¹ Therefore, the public health system falls into inevitable contact—and sometimes conflict—with the legal system.⁸² For example, mandatory vaccinations prevent and diagnose outbreak of disease, but implicate rights to personal autonomy, bodily integrity, or religious freedom.⁸³ Similarly, prohibitions against public smoking prevent personal injury, but implicate freedom of association.⁸⁴ Even emissions-control or other environmental regulation may promote a healthy habitat for human life, but can encroach on individual property rights.⁸⁵

The Framers viewed the government’s duty to protect the health and welfare of the public as one of its primary purposes in its responsibility to advance the common good of its citizens,⁸⁶ but they

80. PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 4. This last view is gaining popularity, and public health practitioners have even used it to justify involvement in city planning, safe housing, diet, exercise, violence, war, and racial discrimination. *Id.*

81. Stephen L. Isaacs, *Where the Public Good Prevailed*, 12 AM. PROSPECT, no. 10, June 2001, available at <http://prospect.org/article/where-public-good-prevailed>.

82. Gostin, *Public’s Health*, *supra* note 66, at 3.

83. *See Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) (holding a mandatory vaccination statute to be constitutional even though the plaintiff argued that vaccinations violated his religious principles and personal autonomy); GOSTIN, POWER, *supra* note 7, at 44.

84. *See Am. Legion Post #149 v. Wash. State Dep’t of Health*, 192 P.3d 306, 324–25 (Wash. 2008) (holding that restricting individuals’ freedom to smoke in private facility to enhance the public health does not interfere with freedom of association because smoking is not a fundamental right or liberty); *Tucson v. Grezaffi*, 23 P.3d 675, 681 (Ariz. Ct. App. 2001) (holding that ordinance forbidding public smoking in restaurants did not violate an individual’s right to freedom of association and was constitutional because it was a rational, legitimate means of safeguarding the general health, safety, and welfare of the community); GOSTIN, POWER, *supra* note 7, at 44.

85. GOSTIN, POWER, *supra* note 7, at 46. *See also Lucas v. S.C. Coastal Council*, 505 U.S. 1003, 1019 (1992) (holding that legislation constitutes an unconstitutional taking when it causes an individual to sacrifice all beneficial use of the land for the sake of the common good); Terry W. Frazier, *Protecting Ecological Integrity Within the Balancing Function of Property Law*, 28 ENVTL. L. 53, 53 (1998) (noting the tension between ecologically-based property rules and property law values).

86. *See U.S. CONST.* pmb1. (“We . . . , in order to . . . promote the general Welfare . . . do ordain and establish this Constitution”); Wendy E. Parmet, *Health Care and the Constitution: Public Health and*

also inculcated profound protections of personal liberty in the Constitution.⁸⁷ Therefore, typical public health law discussion seeks to ascertain the balance between positive power of government to act on behalf of its citizens' health and restraining that power to protect individual rights, liberty, and freedom.⁸⁸

A. States' Power to Mandate Public Health Initiatives

It has long been settled that regulation and legislation to protect the public health falls under the traditional state police powers.⁸⁹ The police powers refer to government authority to limit or even eliminate certain private interests to promote comfort, health, morals, or prosperity, as embodied in the maxim *sic utere tuo ut alienum non laedas*, which means "use your property in such a manner as not to injure that of another."⁹⁰ Discretion is afforded to the sovereign to

the Role of the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267, 270 (1992) (arguing that "[t]he framing generation assumed that governments had a significant role to play in protecting health and providing care to the ill," and that the framers saw "that governments were empowered to protect and, therefore, legitimate only when they protected the public health.").

87. See U.S. CONST. amend. XIV, § 1.

88. PARMET, POPULATIONS, *supra* note 25, at 31. Lawrence Gostin, a preeminent scholar on public health law, offers a nuanced definition of public health law reflecting the values of law:

Public health law is the study of the legal powers and duties of the state, in collaboration with its partners . . . to ensure the conditions for people to be healthy . . . and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.

GOSTIN, POWER, *supra* note 7, at 4.

89. *Cf.* *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824) (referring to the police powers as "that immense mass of legislation, which embraces every thing within the territory of a State . . . all which can be most advantageously exercised by the States themselves. Inspection laws, quarantine laws, health laws of every description . . . are component parts of this mass."); *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (holding 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").

90. Gostin, *Public's Health*, *supra* note 66, at 14. However, the Supreme Court has consistently refused to impose an affirmative duty on government to protect the health of its citizens. See *Town of Castle Rock v. Gonzales*, 545 U.S. 748, 768 (2005) (finding that a state mandatory arrest statute did not impose an affirmative duty on the police to arrest); *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 191 (1989) (holding that the government had no affirmative duty to protect a child from an abusive father even though the social services department knew of the abusive relationship and failed to take steps to prevent further injury); *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 507 (1989) (rejecting a claim that government had obligation to provide health services stating that "[o]ur cases have recognized that the Due Process Clauses generally confer no affirmative right to government aid,

determine what is unhealthy and how to regulate it, but that power is limited by constitutional protections of individual liberty.⁹¹

B. Federal Government's Powers Under the Commerce Clause

The federal government's primary power to promote public health stems from the Commerce Clause.⁹² Initially, public health powers fell exclusively to the states as a result of a narrower understanding of the Commerce Clause.⁹³ Since the early 1900's, however, the Supreme Court has interpreted the Commerce Clause broadly, thereby giving Congress the authority to regulate virtually every activity that has a "substantial and harmful effect" on interstate commerce.⁹⁴ This has enabled Congress to usurp many traditional state police powers.⁹⁵

In recent cases, however, the Supreme Court has limited the scope of the Commerce Clause to those activities that are inherently

even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.") (quoting *Deshaney*, 489 U.S. at 196).

91. *Jacobson*, 197 U.S. at 25; Gostin, *Public's Health*, *supra* note 66, at 15. Constitutional limits on public health police powers will be developed *infra* Part II.C.

92. U.S. CONST. art. I, § 9, cl. 5; U.S. CONST. art. I, § 8, cl. 3; PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 118. Additionally, the government may influence healthy behavior using tax relief to encourage healthy activity and tax burdens to discourage risky behavior. Gostin, *Public's Health*, *supra* note 66, at 13. *See also* *South Dakota v. Dole*, 483 U.S. 203, 205, 211–12 (1987) (holding that Congress may condition receipt of tax funds on states enacting drinking-age legislation to promote the general health and welfare). Also, Congress may enforce the Thirteenth, Fourteenth, and Fifteenth civil rights amendments to promote scientific progress. U.S. CONST. art. I, § 8, cl. 1; U.S. CONST. amends. XIII, XIV, XV. It also gives the President power to make treaties with other nations. U.S. CONST. art. II, § 2, cl. 2. All of these activities can be used in the advancement of public health aims. PUBLIC HEALTH LAW & ETHICS, *supra* note 66, at 118 (describing the various ways Congress may promote public health).

93. *Gibbons*, 22 U.S. at 203, 205–06 (emphasizing that quarantine and inspection laws are health laws and not commerce, and are the exclusive power of the states); Epstein, *supra* note 5, at 1431–32.

94. *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 257–58 (1964) (holding Title II of the Civil Rights Act of 1964, outlawing discrimination in the hospitality industry, to be constitutional even though it legislated "moral wrongs" because of the "disruptive effect that racial discrimination has had on commercial intercourse"); *Wickard v. Filburn*, 317 U.S. 111, 123–24, 125, 127–28 (1942) (upholding regulation imposing wheat growth quotas on an individual not growing for sale because "his contribution, taken together with that of many others similarly situated" effects interstate commerce in a way that "is far from trivial"); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 31–32 (1937) (construing the National Labor Relations Act as constitutional because it governed activities "affecting" interstate commerce); *Gibbons*, 22 U.S. at 190, 189–90, 196 (defining commerce to mean "intercourse between nations, and parts of nations, in all its branches," and holding that Congressional power to regulate that commerce "may be exercised to its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution").

95. GOSTIN, POWER, *supra* note 7, at 105.

economic even if enacted to promote a social cause, but not to social or moral activities.⁹⁶ Therefore, Congressional action to promote public health falls under the authority of the Commerce Clause as long as Congress purports to regulate an “economic endeavor.”⁹⁷

C. Early Limitation of Government Authority: Jacobson v. Massachusetts

The turn of the nineteenth century marked the rise of public health consciousness in America.⁹⁸ During that time, public health departments were professionalized and the menacing threat of infectious diseases began to abate.⁹⁹ Meanwhile, debate over compulsory vaccination raged in the media and in the state courts.¹⁰⁰ The United States Supreme Court stepped into the fray and handed down the most influential decision in public health law: *Jacobson v.*

96. *United States v. Lopez*, 514 U.S. 549, 561 (1995) (holding that the Gun Free School Zones act exceeded Congressional authority because it had “nothing to do with ‘commerce’ or any sort of economic enterprise” and is “not an essential part of a larger regulation of economic activity”); *United States v. Morrison*, 529 U.S. 598, 609–11 (2000) (striking the civil remedy provision of the Violence Against Women Act because gender-motivated crimes are not activities of an “economic nature” even though they may have economic consequences).

97. *Morrison*, 529 U.S. at 609–11; GOSTIN, POWER, *supra* note 7, at 105–06. The enactment of the 1906 Pure Food and Drug Act, the precursor to the 1938 Federal Food, Drug, and Cosmetic Act, which created the FDA, was premised on Congress’s power to regulate interstate commerce. George W. Evans & Arnold I. Friede, *The Food and Drug Administration’s Regulation of Prescription Drug Manufacturer Speech: A First Amendment Analysis*, 58 FOOD & DRUG L.J. 365, 373–74 (2003).

98. PARMET, POPULATIONS, *supra* note 25, at 38 (describing the turn of the nineteenth century as the “zenith” of public health’s influence and citing examples).

99. *Id.* (describing the professionalization of public health departments and its impact on infectious disease, and the “epidemiological transition” in which chronic diseases such as cancer and coronary heart disease replaced infectious diseases as a major cause of death).

100. GOSTIN, POWER, *supra* note 7, at 122. Anti-vaccination activists called compulsory smallpox vaccinations the “greatest crime of the age” which “slaughter[s] tens of thousands of innocent children.” *Id.* (quoting *Vaccine is a Crime: Porter Cope of Philadelphia, Claims It Is the Only Cause of Smallpox*, WASH. POST, July 29, 1905). The mainstream press called the debate “a conflict between intelligence and ignorance, civilization and barbarism” and labeled anti-vaccinationists “familiar species of crank.” *Id.* (quoting *Editorial*, N.Y. TIMES, Sept. 26, 1885 and *The Anti-Vaccinationists’ Triumph*, N.Y. TIMES, Aug. 18, 1898). Additionally, the state courts were “heavily engaged in the vaccination controversy” even prior to *Jacobson*. *Id.*

Massachusetts.¹⁰¹ The genesis of American public health law, *Jacobson* enlightens debate to this day.¹⁰²

In an effort to combat a smallpox outbreak, the city of Cambridge, Massachusetts, acting on expressed statutory authority, enacted a regulation requiring all citizens to receive the smallpox vaccine.¹⁰³ A local Lutheran pastor, Henning Jacobson, whose minority religion influenced his alignment with anti-vaccination groups, refused free vaccination.¹⁰⁴ He was criminally charged and fined five dollars.¹⁰⁵ Jacobson challenged his conviction in Massachusetts courts asserting that “a compulsory vaccination law is unreasonable, arbitrary, and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best”¹⁰⁶ The Massachusetts court ruled against him,

101. See generally *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). See also PARMET, POPULATIONS, *supra* note 25, at 38 (describing *Jacobson* as the Supreme Court’s “most important case concerning a core public health law”).

102. See Wendy E. Parmet, Richard A. Goodman, & Amy Farber, *Individual Rights Versus the Public Health—100 Years After Jacobson v. Massachusetts*, 352 NEW ENG. J. MED. 652, 652, 654 (2005) [hereinafter Parmet, *Individual Rights*] (arguing that physicians, policymakers, and public health officials should consider lessons learned from *Jacobson* when using law to promote public health such as the importance of considering the different views of diverse social groups to gain widespread acceptance for public health intervention). See also *Stenberg v. Carhart*, 530 U.S. 914, 970–72 (2000) (Kennedy, J. dissenting) (citing *Jacobson* to argue that the legislature only need show common belief of medical knowledge to justify “tak[ing] sides in a medical debate” about partial birth abortions); *Boone v. Boozman*, 217 F.Supp.2d 938, 955–56 (E.D. Ark. 2002) (using *Jacobson*’s holding to uphold a mandatory vaccination statute and holding that *Jacobson* is relevant even according to modern substantive due process doctrine until otherwise overruled by the Supreme Court).

103. *Jacobson*, 197 U.S. at 12. The statute provided: “[T]he board of health of a city or town, if, in its opinion, it is necessary for the public health or safety, shall require and enforce the vaccination and revaccination of all the inhabitants thereof, and shall provide them with the means of free vaccination.” *Id.* The Cambridge regulation stated:

Whereas, smallpox has been prevalent to some extent in the city of Cambridge, and still continues to increase; and whereas, it is necessary for the speedy extermination of the disease that all persons not protected by vaccination should be vaccinated; and whereas, in the opinion of the board, the public health and safety require the vaccination or revaccination of all the inhabitants of Cambridge; be it ordered, that all the inhabitants habitans [sic] of the city who have not been successfully vaccinated since March 1st, 1897, be vaccinated or revaccinated.

Id. at 12–13.

104. Parmet, *Individual Rights*, *supra* note 102, at 653 (noting that Jacobson’s minority religious status may have played a role in his disagreement with the Board of Health, and suggesting that doctors’ discriminatory attitudes toward “Italians, negroes and other employees” undermined public trust in the vaccination program).

105. *Jacobson*, 197 U.S. at 12–13.

106. *Id.* at 26.

finding that the enactment advanced the public health in a way that was not arbitrary or capricious and was within the state's constitutional power.¹⁰⁷ In affirming the lower court's ruling, Justice Harlan created the legal framework by which public health initiatives are evaluated.¹⁰⁸

Lawrence O. Gostin distilled the analysis into five standards: necessity, proportionality, harm avoidance, fairness, and most importantly, reasonable means.¹⁰⁹

I. Necessity

Justice Harlan emphasized that state police powers are authorized only if necessary to the case.¹¹⁰ He notes that a community may use means to protect itself which “might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was *reasonably required for the safety of the public*, as to authorize or compel the courts to interfere for the protection of such persons.”¹¹¹

Therefore, government can only compel behavior if it is acting “in the face of a demonstrable health threat.”¹¹² However, the Court only requires “what the people believe is for the common welfare must be accepted as tending to promote the common welfare, whether it does in fact or not,”¹¹³ and does not appear to require the government to justify its actions with scientific, epidemiologic, or medical

107. *Commonwealth v. Pear*, 66 N.E. 719, 721–22 (Mass. 1903), *aff'd*, *Jacobson*, 197 U.S. 11. Deferential treatment to public health agencies was typical of state courts' treatment of mandatory vaccination laws. *See, e.g.*, *Blue v. Beach*, 56 N.E. 89, 91 (Ind. 1900) (holding courts have no concern as to the effectiveness of the smallpox vaccine); *Morris v. City of Columbus*, 30 S.E. 850, 851–52 (Ga. 1898) (holding that the right to compel vaccination is based on necessity, and outbreak nearby towns justified compelling vaccinations); *Bissel v. Davison*, 32 A. 348, 349–50 (Conn. 1894) (permitting public schools to require vaccination as a prerequisite for admission).

108. *See* GOSTIN, POWER, *supra* note 7, at 130 (noting that federal and state courts have consistently affirmed *Jacobson's* holding and reasoning, and that it endures as a reasonable formulation of the boundaries between individual and collective interests).

109. *See id.* at 126–28. Since *Jacobson*, the Supreme Court upheld regulations of food, milk, and sanitation on the same principle. GOSTIN, POWER, *supra* note 7, at 126.

110. *Jacobson*, 197 U.S. at 28.

111. *Id.* (emphasis added).

112. GOSTIN, POWER, *supra* note 7, at 127.

113. *Jacobson*, 197 U.S. at 35 (quoting *Viemeister v. White*, 72 N.E. 97 (N.Y. 1904)).

evidence.¹¹⁴ Courts have emphasized that deference must be given to the legislature in making the determinations of what is necessary to reach a public health objective.¹¹⁵

2. Proportionality

Additionally, public health officials cannot overreach in ways that invade personal autonomy unnecessarily.¹¹⁶ Although the police powers may be used to promote public health in a manner that burdens individuals, the Court held that a regulation is unconstitutional if it imposes a harm that is disproportionate to the benefit expected.¹¹⁷ This creates a “balancing test” between the public good and the degree of intervention.¹¹⁸

3. Harm Avoidance

Further, Justice Harlan emphasized that Jacobson would not be injured or harmed by the immunization,¹¹⁹ but if a public health

114. GOSTIN, POWER, *supra* note 7, at 559–60 n.48. Nonetheless, Wendy E. Parmet points out that “the Court’s opinion contained extensive citations to historical and statistical data Thus, the Court effectively endorsed the use of epidemiological evidence to determine the appropriateness of the state’s action.” PARMET, POPULATIONS *supra* note 25, at 39–40.

115. S.C. State Highway Dep’t v. Barnwell Bros., Inc., 303 U.S. 177, 190–91 (1938) (holding that when a legislative action is within the police power “fairly debatable questions as to its reasonableness, wisdom, and propriety are not for the determination of courts, but for the legislative body”). Justice Ruth Bader Ginsburg, in her *Burwell* dissent, appears to defer to the legislative findings in determining whether the contraceptive mandate is a public health need. See *Burwell*, 134 S. Ct. at 2788 (Ginsburg, J., dissenting).

116. GOSTIN, POWER, *supra* note 7, at 127 (“Public health authorities have a constitutional responsibility not to overreach in ways that unnecessarily invade personal spheres of autonomy.”).

117. *Jacobson*, 197 U.S. at 38 (holding that the police powers exercised by legislature or local elected officials “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.”).

118. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (noting that *Jacobson* “balanced an individual’s liberty” against the “State’s interest in preventing disease”); *Bates v. City of Little Rock*, 361 U.S. 516, 524 (1960) (holding that only a “compelling” state interest justifies “significant encroachment upon personal liberty”).

119. *Jacobson*, 197 U.S. at 36–37. Although *Jacobson* offered to prove that vaccination can cause injury or death and the results of a vaccination were not always certain, Justice Harlan dismissed these claims because *Jacobson* did not prove that “he was in fact not a fit subject of vaccination” *Id.* The obvious inference from Justice Harlan’s reasoning is that if one could show that a public health intervention would cause an individual actual harm the intervention may be beyond the scope of governmental authority. GOSTIN, POWER, *supra* note 7, at 127. The court, in fact, clarified that the holding was limited to a subject who is “perfect[ly] health[y] and a fit subject of vaccination,” but was

intervention would cause serious harm to its subject, it would not pass constitutional muster.¹²⁰ Subsequent lower court cases reiterated this condition, emphasizing that public health powers are designed to promote the common good and not punish individuals.¹²¹

4. *Fairness*

Two previous cases in the same time period added a new requirement: fairness.¹²² In *Yick Wo v. Hopkins*, the Supreme Court struck down a San Francisco ordinance prohibiting clothes-washing in wooden buildings, because it was discriminatorily enforced against Chinese owners.¹²³ Similarly, in *Jew Ho v. Williamson*, public health authorities in San Francisco quarantined an entire district known as Chinatown due to an outbreak of bubonic plague, yet only enforced the quarantine against people of Chinese nationality.¹²⁴ The district court held the intervention unconstitutional because it was enforced with “an evil eye and an unequal hand.”¹²⁵

5. *Reasonable Means*

The last requirement of the *Jacobson* court is that a public health agency, when acting in response to a threat, may only use methods that have a “substantial relation” to ameliorating the harm, and those means cannot be “a plain, palpable invasion of rights.”¹²⁶ This creates a means/ends test, requiring a reasonable relationship between the

not addressing the issue of one for whom vaccination would “seriously impair his health, or probably cause his death.” *Jacobson*, 197 U.S. at 39.

120. *Jacobson*, 197 U.S. at 39 (clarifying that the court was not holding that an absolute rule requiring vaccination regardless of the fitness of the subject would be constitutional).

121. GOSTIN, POWER, *supra* note 7, at 128. *See, e.g.*, *Kirk v. Wyman*, 83 S.E. 387, 391 (S.C. 1909) (holding public health authorities are required to provide safe and habitable conditions to individuals in isolation).

122. *Yick Wo v. Hopkins*, 118 U.S. 356 (1886); *Jew Ho v. Williamson*, 103 F. 10, 12–13 (N.D. Cal. 1900); Gostin, *Public’s Health*, *supra* note 66, at 128 (adding the “fairness” requirement to public health analysis based on these cases).

123. *Yick Wo*, 118 U.S. at 373–74 (finding law banning laundries in wooden buildings targeted at the Chinese population unconstitutional because the law was applied in an “unequal and oppressive” way and were enacted to close down Chinese business).

124. *Jew Ho*, 103 F. at 12–13.

125. *Id.* at 23.

126. *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905).

intervention and the objective.¹²⁷ This requirement has garnered much debate in modern public health law, focusing on how direct the causation must be between the means and the end.¹²⁸

D. Standard of Review: Smith and the Religious Freedom and Restoration Act

Although the *Jacobson* Court established the framework to determine whether a public health interest is an appropriate use of government power, modern day jurisprudence requires an additional consideration: standard of review.¹²⁹ Focusing on the reasonable means test described above, the outcome of a modern-day challenge to a public health initiative will depend greatly on the standard of review.¹³⁰ In other words, if the standard of review requires a compelling interest, a public health initiative may not stand, even if the government was acting to advance a valid aim.¹³¹

The contraceptive mandate implicates religious freedom concerns, so a discussion of First Amendment Free Exercise doctrine is crucial to determine its appropriateness.¹³² In a 1990 case, *Employment Div.*

127. *Nebbia v. New York*, 291 U.S. 502, 510–11 (1934) (“[T]he guaranty of due process, as has often been held, demands . . . the means selected shall have a real and substantial relation to the object sought to be attained.”); *Cal. Reduction Co. v. Sanitary Reduction Works*, 199 U.S. 306, 318–19 (1905) (citing *Jacobson* for the notion that courts should not strike down a regulation that has a “real, substantial relation” to the objective trying to be reached).

128. See Hall, *supra* note 3, at S207 (arguing against the belief that public health can tackle issues because that moves the discipline beyond the “pathogenic model” which targets specific agents that threaten health in “a direct and clear causal path”). For example, mandatory seat belt use is only justified because there is a “discrete intervention whose effectiveness is beyond dispute.” *Id.* at S208.

129. GOSTIN, POWER, *supra* note 7, at 138 (2nd ed. 2008) (indicating that the level of review will dictate how the court balances competing interests and how much deference the court gives to public health legislation).

130. *Id.* at 128.

131. *Id.* at 141 (explaining that under strict scrutiny, a government entity must show a “compelling interest . . . between means and ends” and that there were no less restrictive means). Some of the *Jacobson* criteria are included into the strict scrutiny test but only create a floor for court scrutiny. *Id.*

132. See *Conestoga Wood Specialties Corp. v. Sec’y of U.S. Dep’t of Health & Human Servs.*, 724 F.3d 377, 407–15 (3rd Cir. 2013) (Jordan, J., dissenting); *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1143–45 (10th Cir. 2013). While the main controversy in these cases surrounds whether a corporate entity may or may not assert a religious freedom claim, a sub-issue in the cases is whether the public health interests are sufficiently compelling. See *Conestoga*, 724 F.3d at 407–15 (Jordan, J., dissenting); *Hobby Lobby Stores*, 723 F.3d at 1143–45. A resolution of this sub-issue may affect future public health legislation even if the Supreme Court were to find that a corporation cannot assert a free exercise claim.

v. Smith,¹³³ the Supreme Court modified free-exercise jurisprudence and ruled that “neutral laws of general applicability” that are otherwise valid exercises of a state’s police powers are constitutional, and an individual is not relieved from complying with them.¹³⁴ The Court rejected the use of strict scrutiny for general, neutral laws¹³⁵ and embraced a “rational basis” test on actions burdening religion.¹³⁶

In response to *Smith*, Congress passed the Religious Freedom Restoration Act of 1993 (RFRA).¹³⁷ The purpose of the Act was to restore the “compelling interest” test that the Court expressly rejected in *Smith*.¹³⁸ The Act imposes a two-part test in assessing a rule of general applicability: (1) it must further a compelling interest and (2) it must use the least restrictive means to do so.¹³⁹ Although the Supreme Court has held RFRA to be unconstitutional when applied to state and local government,¹⁴⁰ the Court has applied RFRA to rule in favor of religious freedom in at least one case against the federal government: *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*.¹⁴¹ This strict scrutiny standard requires the federal

133. 494 U.S. 872, 872 (1990).

134. *Emp’t Div., Dep’t of Human Res. v. Smith*, 494 U.S. 872, 901 (1990); ERWIN CHEREMINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES*, 1303 (4th ed. 2011) (stating that *Smith* expressly changed the law). The case centered around Alfred Smith and Galen Black, Native Americans in Oregon, who challenged an Oregon statute prohibiting use of “peyote,” a “controlled substance,” which they used for ritual purposes. *Smith*, 494 U.S. at 874. Conviction caused them to lose employment and unemployment benefits. *Id.*

135. *Smith*, 494 U.S. at 888. The court distinguished previous free exercise challenges that seemed to point the other direction because all those cases involved a synthesis of claims, whereas *Smith* involved only a free exercise claim. *Id.*

136. CHEREMINSKY, *supra* note 134, at 1304.

137. 42 U.S.C. § 2000bb (2012).

138. *Id.* at (b)(1) (declaring the purpose of the statute to “restore the compelling interest test as set forth in *Sherbert v. Verner*, 374 U.S. 398 (1963) and *Wisconsin v. Yoder*, 406 U.S. 205 (1972) . . .”).

139. 42 U.S.C. § 2000bb-1(b) (2012).

140. *Boerne v. Flores*, 521 U.S. 507, 511 (1997) (finding the RFRA unconstitutional). The city of Boerne, Texas denied a building permit to a Catholic Church because it was deemed a historic landmark. *Id.* at 512. The church challenged the ordinance designating the area a historic district under the RFRA. *Id.*

141. *See generally* *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418 (2006). A religious sect that used a controlled substance to make a ritual tea challenged the Controlled Substances Act under the RFRA. *Id.* at 418. The court applied strict scrutiny to rule in favor of the religious group. *Id.* at 419–20. Specifically, the court found that “mere invocation of the general characteristics” is insufficient. *Id.* at 420. Although the court did not specifically address the constitutionality of the act in the context of the federal government, the unanimous ruling relied on its validity. *Id.* at 419–20.

government to show a “tight relationship between means and ends” and that there is no less restrictive means when advancing a public health initiative that intrudes on religious freedom.¹⁴² Also, the Court held that the government must go beyond “mere invocation of the general characteristics” and must “show with more particularity” how an even strong interest is adversely affected by a religious exemption.¹⁴³

In sum, according to the *Jacobson* framework of public health analysis, five questions should be asked: (1) Does the public good outweigh the invasion into personal autonomy?¹⁴⁴ (2) Is the government initiative “necessary for the safety of the public”?¹⁴⁵ (3) Does the action cause significant harm to the individual?¹⁴⁶ (4) Was the initiative adopted in a way that reflects “an evil eye and an unequal hand”?¹⁴⁷ (5) Does the legislation represent the most reasonable means by which to accomplish the goal?¹⁴⁸ Under this framework, arguments for or against a government public health measure must focus on clear public health legal doctrine.¹⁴⁹ A lack of analytical framework lends itself to speculation not grounded in facts or statistical analysis and does not provide judges with a way to evaluate public health initiatives.¹⁵⁰ Much of the decision-making is in danger of being left to policy-based or political discretion. Rather than assuming away the issue, Hobby Lobby, Conestoga, or Justice Alito could have made strong arguments against the compelling interest of the contraceptive mandate.

142. GOSTIN, POWER, *supra* note 7, at 141.

143. *O Centro*, 546 U.S. at 431–32 (quoting *Wisconsin v. Yoder*, 406 U.S. 205, 236 (1972)).

144. *See supra* Part III.C.2.

145. *See supra* Part III.C.1.

146. *See supra* Part III.C.3.

147. *See supra* Part III.C.4.

148. *See supra* Part III.C.5.

149. *See Korte v. Sebelius*, 735 F.3d 654, 686 (7th Cir. 2013). The courts, in fact, seemed to imply that if the Obama administration would have engaged in a more rigorous public health argument, perhaps a compelling interest would have been found. *See id.* (stating that the issue is “contestable and contested” and the government was guaranteed to “flunk the test” because they stated the aims too broadly).

150. *See, e.g., Gilardi v. U.S. Dep’t of Health and Human Servs.*, 733 F.3d 1208, 1220 (D.C. Cir. 2013). In fact, in *Gilardi*, the majority opinion holds that a compelling scientific public health interest is not present; whereas, the dissent claims that the mandate “obviously serves the compelling interests of promoting public health, welfare, and gender equality.” *Id.* at 1220, at 1239.

IV. IS THE MANDATE REALLY COMPELLING? WHAT THE COURT COULD HAVE FOUND

In most contexts, the public health doctrine requires courts to balance the harms of an action against the expected benefits.¹⁵¹ However, when legislation implicates religious freedom, the RFRA statutorily requires more than just proportionality: it requires a “compelling interest.”¹⁵² With regard to the contraceptive mandate, three of the lower courts found that it does not promote a compelling government interest as required by the RFRA as interpreted in *O Centro*.¹⁵³ In *Burwell*, the Supreme Court appears to agree.¹⁵⁴ The Court said that RFRA requires a “more focused” inquiry, and HHS only asserted “very broadly framed interests.”¹⁵⁵ The Court did not, however, engage in a rigorous public health legal analysis but preferred to assume away this issue and decide the case on other grounds.¹⁵⁶ Had the Court analyzed the issue through the lens of the *Jacobson* factors presented above,¹⁵⁷ perhaps it would have revealed

151. *See supra* Part III.C.2.

152. *See supra* Part III.D.

153. *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 544 U.S. 418 (2006); *Korte v. Sebelius*, 735 F.3d 654, 686 (7th Cir. 2013); *Gilardi*, 733 F.3d at 1220; *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1142 (10th Cir. 2013). In *Hobby Lobby Stores*, the court held that the government’s interest to promote public health and inequality were too broadly formulated to withstand a compelling interest test. *Hobby Lobby Stores*, 723 F.3d at 1143. Similarly, in *Gilardi*, the court held the government merely recited public health justifications that were “sketchy and highly abstract.” *Gilardi*, 733 F.3d at 1220. Lastly, in *Korte*, the court found that the governmental interests were stated “at such a high level of generality” that “the government guarantees that the mandate will flunk the test.” *Korte*, 735 F.3d at 686.

154. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779 (2014). *See also id.* at 2800 (Ginsburg, J., dissenting) (noting that even the majority opinion “stepp[ed] back from its assumption that compelling interests support the contraceptive coverage requirement”).

155. *Id.* at 2779.

156. *Id.* at 2780. *See Epstein, supra* note 24, at 51 (criticizing Justice Samuel Alito’s *Burwell* decision for assuming “that the advancement of ‘women’s health’ was a compelling state interest that warranted the imposition of the contraceptive mandate against Hobby Lobby”). The lower courts did not assume the issue. For example, the *Gilardi* court appears to analyze the public health claims but does not utilize any sort of legal framework in doing so. *Gilardi*, 732 F.3d at 1220. Rather, it asserts that the government’s failure to acknowledge the “tug-of-war” of scientific evidence “gives us pause.” *Id.* at 1221. In *Korte*, the court asserts that the lack of evidence as to the least restrictive means implies that “it is nearly impossible” to justify the public health interests but does not engage in analysis of the public health aims. *Korte*, 735 F.3d at 686.

157. *See supra* Part III.C.

that the contraceptive mandate is not as compelling as its proponents make it seem.¹⁵⁸

When applying judicial scrutiny, the court will uphold a neutral law of general applicability even if it burdens certain religious groups' practices.¹⁵⁹ As long as the religious group is not targeted for punishment or motivated by a desire to interfere with religion, the law is constitutional.¹⁶⁰ In a similar vein, the *Wick-Ho* requirement of fairness is only transgressed if the law is designed to specifically target a racial or religious group or is only enforced against one of these groups.¹⁶¹ The mandate, therefore, cannot be attacked for being applied in a discriminatory fashion. Although religious groups may be adversely affected by it, the law applies to all for-profit employers without distinction.¹⁶²

Nonetheless, the mandate is not "necessary" in the legal sense of the term. In the classic construct of public health doctrine, government is only entitled to act in the "face of a demonstrable health threat" and even then may only be able to do what is necessary for the safety of the public.¹⁶³ The *Jacobson* Court likely did not envision the broad view that many scholars would eventually take of public health because the doctrine at that time focused only on addressing immediate health threats.¹⁶⁴

In the context of the contraceptive mandate, the supporters show some connection between contraceptive coverage and a decrease in unwanted pregnancies, but they hardly show a "necessity."¹⁶⁵ First,

158. See Epstein, *supra* note 24, at 51–53.

159. *Emp't Div., Dep't of Human Res. v. Smith*, 494 U.S. 872, 879 (1990) (upholding a neutral ban on peyote even though the hallucinogenic substance was required by Native Americans for religious reasons because it was a rule of "general applicability").

160. *Church of the Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 531–32 (1993) (declaring a city ordinance banning ritual sacrifice unconstitutional because it was enacted with the purpose of restricted religious practice).

161. See *supra* Part III.C.4.

162. See 45 C.F.R. § 147.130(a)(1)(iv)(B) (2013) (carving out religious exemption only for non-profit religious institutions).

163. See *supra* Part III.C.1; GOSTIN, POWER, *supra* note 7, at 127.

164. See Epstein, *supra* note 5, at 1425 (describing the original, more limited view of public health). Similarly, "[t]he global interest in public health and safety may justify the general control of the street and commercial use of drugs under the Controlled Substances Act, but it hardly justifies the restriction as it applies to the ingestion of peyote as part of a religious rite." Epstein, *supra* note 24, at 52.

165. See *supra* Part I.A.2.

as opponents point out, contraception is readily available through various government programs and yet it is still considered a public health crisis.¹⁶⁶ Arguably the issue is not the availability of contraceptive methods but rather a dearth in education on contraception use and responsible sexual behavior. Second, the provision of free contraception through employer-based insurance may not be compelling because there are other ways of affecting a decrease in unwanted pregnancies such as tax deductions for contraceptive purchases, expansion of federal programs under Medicaid or Title X of the Public Health Services Act, government reimbursement for contraception, or incentives for drug companies to provide contraceptives to healthcare providers free of charge.¹⁶⁷ Lastly, leaving the religiously controversial contraceptives out of the mandate would not frustrate the larger goals because those who do not oppose all forms of contraception could still provide forms they hold permissible.¹⁶⁸ Therefore, it is difficult to argue that forcing businesses to provide the three controversial methods is necessary.

Further, the government can only enforce a public health initiative if the methods used substantially relate to the aim the government attempts to achieve.¹⁶⁹ Therefore, in assessing an initiative, courts look for a strong causative nexus between the action being undertaken and the harm the government attempts to ameliorate.¹⁷⁰ The contraceptive mandate claims to achieve a decrease in unwanted pregnancies and a corresponding increase the health of families and

166. *See supra* note 53.

167. *See Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781–82 (2014); *Conestoga Wood Specialties Corp. v. Sec’y of U.S. Dep’t of Health & Human Servs.*, 724 F.3d 377, 414 (3rd Cir. 2013) (Jordan, J., dissenting) (quoting Appellant’s Brief at 51); *Gilardi v. U.S. Dep’t of Health & Human Servs.*, 733 F.3d 1208, 1221 (D.C. Cir. 2013). The government did not assert why any of these options would be unworkable. *Conestoga*, 724 F.3d at 415. Although these considerations go to the last prong of the test—the “least restrictive means”—they may also show of a lack of necessity in creating a compelling interest for a contraceptive mandate. *See Epstein, supra* note 24, at 52–53.

168. *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1144 (10th Cir. 2013). This argument may not satisfy some religious objectors who believe every form of contraception is prohibited.

169. *See supra* Part III.C.5.

170. *Id.*

mothers.¹⁷¹ Unfortunately, it falls short of achieving the desired nexus.¹⁷²

First, even though the IOM report claims that access to contraception will improve family health, statistical evidence falls short of proving causation between contraceptive coverage and a decrease in unwanted pregnancies.¹⁷³ Second, even assuming that there is a relation between contraceptive coverage and unwanted pregnancy, no causation is apparent between a decrease in unwanted pregnancy and improved family health.¹⁷⁴ The report merely demonstrates a correlative relationship.¹⁷⁵ As opponents argue, predisposition to risk-taking may account for both increased instances of unwanted pregnancy and other health conditions such as smoking, drinking, and obtaining substandard medical care for children.¹⁷⁶ Perhaps the Court would have been more willing to let the mandate stand if HHS had shown that it relied on stronger scientific or epidemiological sources than the IOM report in fashioning the mandate or if the IOM based its report on stronger evidence showing a causative nexus. But, because that was not possible, the Court could not have found a compelling interest to exist.

Further, in the issue before the *Jacobson* Court, the focus was on the physical harm that a public health action could inflict on individuals.¹⁷⁷ One of the underlying principles in the *Jacobson* decision is that public health initiatives should be designed to promote the common good and not to punish individuals.¹⁷⁸ As the Court points out, from the perspective of religious individuals, the contraceptive mandate could cause catastrophic harm.¹⁷⁹ Although the business owners are not being forced to actually take the

171. See *supra* note 32 and accompanying text.

172. See *Gilardi*, 732 F.3d at 1220 (“But the government does little to demonstrate a nexus between this array of issues and the mandate.”).

173. See *supra* notes 56–57 and accompanying text.

174. See *supra* notes 56–57 and accompanying text.

175. See *supra* notes 56–57 and accompanying text.

176. See *supra* notes 56–57 and accompanying text.

177. See *supra* Part III.C.3.

178. See *supra* Part III.C.3.

179. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2775–76 (2014).

contraceptives, the *Gilardi* court notes that according to Catholic doctrine, “instructing or encouraging someone else to commit a wrongful act is itself a grave moral wrong—i.e., ‘scandal’—under Catholic doctrine,” and “the Mandate thrusts Catholic employers into a ‘perfect storm’ of moral complicity in the forbidden actions.”¹⁸⁰ Although the *Burwell* dissent takes the position that “the connection between the families’ religious objections and the contraceptive coverage requirement is too attenuated to rank as substantial,”¹⁸¹ the majority strongly argues that such an inquiry is irrelevant.¹⁸² RFRA asks the court to answer whether the mandate imposes a substantial burden on “*their religious beliefs*” and not to question whether those sincerely held beliefs are right or wrong.¹⁸³ It is not the place of the courts to speculate as to the “moral responsibility” of a sin, but rather the court must be sensitive the religious beliefs of the individual.¹⁸⁴

Additionally, the mandate imposes such a heavy fine on businesses that cannot comply because of their religious beliefs that it effectively puts religious business owners in an impossible situation where they are forced to choose between violating their religious convictions and facing irreparable harm.¹⁸⁵ Alternatively, in cases like *Burwell*, the mandate would force a religious individual to make a choice as to which religious belief he will follow.¹⁸⁶ Although the purpose of the penalty is to incentivize compliance, it effectively punishes religious business owners who cannot, in good conscience,

180. *Gilardi v. U.S. Dep’t of Health and Human Servs.*, 733 F.3d 1208, 1215 (D.C. Cir. 2013) (quoting Br. of Catholic Theologians at 3, 5).

181. *Burwell*, 124 S. Ct. at 2799. The dissent argues that the “requirement carries no command that Hobby Lobby or Conestoga purchase or provide the contraceptives they find objectionable. Instead, it calls on the companies . . . to direct money into undifferentiated funds that finance a wide variety of benefits under comprehensive health plans.” *Id.*

182. *Id.* at 2778.

183. *Id.*

184. *Gilardi*, 732 F.3d at 1215 (citing *United States v. Lee*, 455 U.S. 252, 261 n. 12 (1982)).

185. See 26 U.S.C.A § 4980D(b)(1) (West, Westlaw through P.L. 113-125 (excluding P.L. 113-121)) (imposing a tax of “\$100 for each day in the noncompliance period with respect to each individual to whom such failure relates”); *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1146–47 (10th Cir. 2013) (describing the business owner’s predicament as a “Hobson’s choice”).

186. *Burwell*, 134 S. Ct. at 2776–77 (noting that the companies were religiously obliged to provide health insurance to their employees, and asking them to not provide health insurance at all would be a violation of their religion).

comply. This Hobson's choice is precisely the sort of religious freedom RFRA is designed to protect.

CONCLUSION

Public health law remains a hotly debated subject, socially and politically charged from both right and left. In its attempt to provide proper preventative healthcare, the Obama Administration overstepped its bounds with the HHS Mandate, representing a classic case of government overreach into the religious liberty of its citizens. The Administration disguised the Mandate as a public health initiative. Nonetheless, it failed to provide concrete justification for the invasion on individual liberty, indicating that the purpose was less to promote the common good and more to advance a political or social agenda at the expense of religious freedom.

The judicial system is tasked with developing an objective framework based on judicial precedent to evaluate public health initiatives. This framework provides proponents with a predictable framework with which they can advocate their cause and religious and social minorities with the necessary tools to defend themselves against inappropriate government coercion. Although the Supreme Court in *Burwell* chose not to provide that framework, a return to the *Jacobson* paradigm would provide that direction.