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ARTICLE

Religious Resistance and the Public's Health

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Abstract
The Affordable Care Act's preventive services mandate requires private insurance plans to serve public health goals. But the employers that facilitate access to insurance for more than half the population hold political views and economic interests that may run counter to public interests. And now, in the name of for-profit employers' religious rights, the courts are eroding the legal foundations of privately financed public health. Religious objections to the preventive services mandate — of which *Braidwood Management, Inc. v. Becerra* is just the most recent high-profile example — have become a site of opposition to public health. Courts have radically revised standards for religious exemption, adopting an individualistic frame that discounts population-level effects. Recent decisions could invite free exercise claims that go to the heart of securing population health through the workplace.

Keywords: Insurance; religion; public health

Introduction

Employers now play an essential role in the nation's system for preventing and managing public health crises and promoting population health. Through its mandate that health plans provide access to preventive services, the Affordable Care Act (ACA) harnessed private insurance to serve public health goals. The employer-based health plans that insure more than half of the population must cover immunizations against communicable diseases — including COVID-19, seasonal flu, and measles.[1] They must offer contraceptives, medication preventing HIV, and screening for numerous cancers, sexually transmitted infections (STIs), and mental and behavioral health conditions, among many other preventive services.[2]

But firms hold missions, political views, and economic interests that may run counter to public interests. And now, under the banner of the rights of for-profit employers, the courts are eroding the legal foundations of privately financed public health. Religious objections to the preventive services mandate — of which *Braidwood Management, Inc. v. Becerra* is just the most recent high-profile example — have become a point of resistance to public health. Courts have radically revised standards for religious exemption, adopting an individualistic frame that discounts population-level effects. Recent decisions could pave the way for religious objections that go to the heart of securing population health through the workplace.

Part I argues that the ACA's preventive services mandate broke down the historical division between (mostly) private health care and (mostly) public prevention. Legislative reforms and market trends had gradually eroded this division in the decades leading up to the ACA, expanding access to preventive services while favoring a privatized system for financing and delivering them. The ACA's establishment of

[1]*Preventive Services Covered by Private Health Plans Under the Affordable Care Act*, KFF (Feb. 28, 2024) [hereinafter *Preventive Services Covered Under ACA*], https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/ [https://perma.cc/Q2TH-WPLN].
[2]*Id.*

a federal baseline of what private insurance plans, including employer-based plans, must cover provides a crucial lever for securing public interests. But the obligation to protect the public's health is an awkward fit with the management of a workplace. Employers lack incentives to account for population-level effects and long-term consequences when designing health benefits.

Part II argues that expanding religious challenges to the ACA's preventive services mandate have generated a reinterpretation of religious liberty doctrine that poses a significant threat to public health efforts. In a series of suits brought by employers, megachurches, and other institutions, the Supreme Court has developed a religious liberty doctrine that is laser-focused on the individual objector and that ignores, or rejects, population-wide effects. *Braidwood*[3] represents a prime example of where this individualized approach leads. Rather than acknowledge the ACA's public-private system as itself a concession to business interests, courts perceive the involvement of employers as a burden on their religion and propose the development of new public programs as a viable alternative to regulation.

Part III situates religious challenges to the ACA's preventive services within a broader deregulatory campaign: an effort to revive *Lochner v. New York*[4] under the First Amendment. Just as decisions protecting economic liberty stymied public health efforts a century ago, recent decisions elevating the religious liberty of businesses will make it harder to secure healthy living and working conditions and access to health care. Public health policymakers, advocates, and researchers have long recognized the impact of free speech doctrine on public health.[5] They have seen how challenges to pandemic mitigation measures have put religious liberty on a collision course with vaccine mandates.[6] Now they need to treat the campaign for business religious exemptions to insurance regulation as an equally significant threat to the public's health.

I. Employers' Public Health Role

The ACA increased access to health care for individuals and made "strategic investments in the public's health."[7] The preventive services mandate serves both of these ends.[8] Comprehensive insurance coverage of evidence-based preventive services improves access for individuals by removing the out-of-pocket costs that would otherwise apply when they obtain these services from the private physician offices and clinics where they ordinarily receive medical care. It also advances public health goals by reducing mortality and morbidity from a wide range of conditions through early detection and intervention and by decreasing the transmission of communicable diseases through vaccination, screening, counseling, and medication. In this way, the preventive services mandate bridged a divide between the mostly private health care system and the mostly public system for prevention, which had been steadily narrowing in the preceding decades.

[3] 627 F. Supp. 3d 624 *passim* (N.D. Tex. 2022).

[4] 198 U.S. 45 (1905).

[5] *See, e.g.*, Jennifer L. Pomeranz, *United States: Protecting Commercial Speech Under the First Amendment*, 50 J.L. Med. & Ethics 265 *passim* (2022); Claudia E. Haupt & Wendy E. Parmet, *Public Health Originalism and the First Amendment*, 78 Wash. & Lee L. Rev. 231 *passim* (2021); Seth E. Mermin & Samantha K. Graff, *The First Amendment and Public Health, at Odds*, 39 Am. J.L. & Med. 298 *passim* (2013); Wendy E. Parmet & Jason A. Smith, *Free Speech and Public Health: A Population-Based Approach to the First Amendment*, 39 Loy. L.A. L. Rev. 363 *passim* (2006).

[6] *See, e.g.*, Wendy E. Parmet, *From the Shadows: The Public Health Implications of the Supreme Court's COVID-Free Exercise Cases*, 49 J.L. Med. & Ethics 564 *passim* (2021); Dorit R. Reiss, *Vaccines Mandates and Religion: Where Are We Headed with the Current Supreme Court?*, 49 J.L. Med. & Ethics 552 *passim* (2021).

[7] Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 Pub. Health Reps.: L. & Pub. Health 130, 130 (2011).

[8] *Id.* at 133 (describing the preventive services mandate as part of the ACA's investments in public health); *see also* Gwendolyn R. Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health*, 39 J.L. Med. & Ethics 366, 371–73 (2011).

Contributing to the longstanding privatization of public health,[9] the ACA put employers on the front lines of public health policy. The majority of the U.S. population relies on private insurance to cover their health care needs — most commonly, insurance comes as a benefit of employment.[10] The preventive services mandate firmly established employers as important gatekeepers of access to vaccines, screening tests, preventive counseling, and medications. It made insurers and employers "the first line of defense against HIV and AIDS"[11] and — as became clear during the COVID-19 pandemic — for the public's health more generally. But employers lack the population-health mission that drives the under-funded public system they are meant to supplement. Employers' incentives are not well aligned with distinctively public interests in universal access to prevention, screening, and early intervention to mitigate the long-term, population-level consequences of unmet health care needs.

A. The Historical Division Between (Mostly) Private Health Care and (Mostly) Public Prevention

The line between health care and public health is difficult to define, particularly in the wake of active efforts to integrate the two.[12] While health care involves delivering items and services to individual patients, public health involves "organized community efforts aimed at the prevention of disease and promotion of health."[13] Both public health and health care workers engage in primary prevention (i.e., screening individuals for risk factors, counseling them to adopt protective behaviors, and administering vaccinations or prescribing medications to prevent the onset of illness or injury), secondary prevention (i.e., screening asymptomatic individuals to catch early-stage disease before its effects are even noticeable), and tertiary prevention (i.e., diagnosing and treating symptomatic patients to prevent progression of a disease or injury).[14] But when a primary care doctor performs these tasks, she applies her medical knowledge and skill to an individual patient.[15] When a public health agency engages in these tasks, its responsibility is to the population as a whole and its interventions are informed by epidemiological findings about the broader determinants of disease and injury.[16]

Historically, a separate, largely publicly financed and administered system provided certain clinical services with high public health importance, usually at low or no cost. These include vaccinations, screening, and treatment for highly communicable diseases, services for family planning and prenatal care, and early childhood programs to identify and mitigate the effects of poor nutrition and common childhood illnesses.[17] Public programs tend to prioritize clinical services that have long-term benefits

[9]Privatization of public health department services began in the 1970s. It expanded considerably in the 80s and 90s, prompting concerns about accountability and emergency preparedness. Christopher Keane et al., *Perceived Outcomes of Public Health Privatization: A National Survey of Local Health Department Directors*, 79 Millbank Q. 115, 115–18, 124, 132–33 (2001). More broadly, public health policy increasingly relies on private institutions, especially employers, to support the capacity of individuals to adopt health-protective behaviors, such as quarantining, isolation, and social distancing. Nan D. Hunter, *"Public-Private" Health Law: Multiple Directions in Public Health*, 10 J. Health Care L. & Pol'y 89, 109–13 (2007).

[10]In 2022, 65.6 percent of the U.S. population was covered by private insurance for all or part of the calendar year. Katherine Keisler-Starkey et al., U.S. Census Bureau, P60-281, Health Insurance Coverage in the United States: 2022 1, 3 (2023), https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf [https://perma.cc/3WP6-SPPS]. 54.5 percent of the total population was covered by employment-based insurance. *Id.* at 3.

[11]Brief for Illinois et al. as Amici Curiae Supporting Defendants at 5, Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-cv-00283-O).

[12]*See* Inst. of Med., Primary Care and Public Health: Exploring Integration to Improve Population Health 17, 27 (2012).

[13]Inst. of Med., The Future of Public Health 41 (1988).

[14]Lawrence O. Gostin & Lindsay F. Wiley, Public Health Law: Power, Duty, Restraint 15–17 (3d ed. 2016).

[15]*Id.* at 17.

[16]*Id.*

[17]*See, e.g.*, Paul Starr, The Social Transformation of American Medicine 191–92 (1982) (describing the historical operation of tuberculosis clinics and "baby clinics," by city health departments); *id.* at 193 (describing "public health sponsorship of preventive medical examinations," including by state health departments in the early twentieth century); George Rosen, A History of Public Health 279 (Johns Hopkins Univ. Press, 2015) (1958) (describing historical surveys of health centers providing a range of services, including "child welfare" "anti-tuberculosis," and "venereal disease clinics"); *id.* at

and population-level effects. Local public health departments typically run most of these clinics, though in recent years departments have increasingly relied on private contractors.[18] Many of these programs have roots in early twentieth-century sanitation campaigns aimed at providing health education, testing, and vaccinations — especially for people living in poverty, immigrant workers, mothers of young children, and people at risk of STIs.[19]

In the early decades of private health insurance, coverage of preventive services was spotty to nonexistent. A few of the pre-paid health plans employers created in the 1930s and 1940s incorporated some degree of preventive care in an effort to keep workers healthy — in the short-term, at least — so they could perform physically demanding labor.[20] When commercial health insurance plans became widely available in the mid-twentieth century, they tended to exclude preventive services for two reasons: most physicians did not yet appreciate the value of prevention and the costs of preventive services were predictable, unlike the "unexpected catastrophic events for which insurance was designed."[21]

When Medicare was first established in the mid-1960s to provide public health insurance for people who are elderly or disabled, it largely mirrored the private insurance plans available at the time, which gave short shrift to preventive services. By statute, Medicare excluded "items or services … which are not reasonable and necessary for the diagnosis or treatment of illness or injury," omitting primary and secondary prevention.[22]

Medicaid, by contrast, was an early adopter of a preventive approach. In 1967 — just two years after passage of the initial Medicare and Medicaid authorizing legislation — Congress mandated that states ensure Medicaid coverage of early and periodic screening, in addition to diagnostic and treatment services, for children up to age 21.[23] This requirement tailored Medicaid coverage to the needs of low-income families, whose children were harmed by significant risk factors and had much to gain from prevention.[24]

Over time, researchers began to prove the economic value of preventive clinical services and prevention was slowly integrated into the health care and insurance sectors. In 1984, the U.S. Public Health Service convened the U.S. Preventive Services Task Force (USPSTF) — a private organization of experts whose mission is to support primary care providers with expert guidance.[25] Five years later, the

208; 210–12 (describing prenatal, infant, and early childhood preventive services sponsored by city, state, and federal programs); Jonathon P. Leider et al., *How Much Do We Spend? Creating Historical Estimates of Public Health Expenditures in the United States at the Federal, State, and Local Levels*, 39 Ann. Rev. Pub. Health 471, 473 (2018) (describing federal support for state and local health departments to deliver maternal and child health services under Titles V and VI of the Social Security Act of 1935); Cheryl A. Vamos et al., *Approaching 4 Decades of Legislation in the National Family Planning Program: An Analysis of Title X's History from 1970 to 2008*, 101 Am. J. Pub. Health 2027, 2027 (2011) (describing the history of public funding for family planning clinics, with grantees including health departments and other public agencies); Inst. of Med., Financing Vaccines in the 21st Century: Assuring Access and Availability 81–82 (2003) (describing historical reliance on "stand-alone public clinics" for adult and childhood vaccinations).

[18] *See supra* note 9.

[19] Keane et al., *supra* note 9, at 203, 277.

[20] Halley S. Faust, *Historical Perspectives on Structural Barriers to Prevention, in* Prevention vs. Treatment: What's the Right Balance? 111, 116 (Halley S. Faust & Paul T. Menzel eds., 2011) (discussing health programs developed for workers who built the Grand Coulee Dam in 1938, which Henry J. Kaiser extended to workers in shipyards and steel mills during World War II).

[21] *Id.* at 117; *see also id.* at 120–21 (describing health insurers' "skepticism about the effectiveness of prevention interventions when done as individual clinical services in primary care settings" and concerns about the potential for fraudulent billing by physicians).

[22] Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862, 79 Stat. 286, 325 (1965) (codified as amended at 42 U.S.C. § 1395y(a)(1)(A)); *see also* Faust, *supra* note 20, at 126.

[23] *Id.* at 127; Social Security Amendments of 1967, Pub. L. No. 90-248, § 302, 81 Stat. 821, 929 (1968) (codified as amended at 42 U.S.C. § 1396d(a)(4)(B)).

[24] Sara Rosenbaum, *When Old Is New: Medicaid's EPSDT Benefit at Fifty, and the Future of Child Health Policy*, 94 Millbank Q. 716, 718 (2016).

[25] Steven H. Woolf & David Atkins, *The Evolving Role of Prevention in Health Care: Contributions of the U.S. Preventive Services Task Force*, 20 Am. J. Preventive Med. 13, 13–14 (2001).

USPSTF issued its first report on evidence-based recommendations for preventive care.[26] Private insurers and employers became more willing to finance these services and primary care providers became more interested in providing them.[27] Throughout the 1980s and 1990s, Congress added Medicare coverage for specific vaccinations and cancer screening tests.[28] Political will grew for state legislatures to require private plans to cover certain preventive services, especially mammography screening.[29] This rise of health insurance coverage for preventive services in the late twentieth century was accompanied by a "countervailing" trend of "reduction in services provided by public health departments because of reduced budgets and personnel nationwide."[30]

In the years leading up to the ACA, when employers had greater discretion over which preventive services they included in their health benefit plans, there were wide discrepancies between the coverage they elected to provide and the preventive services that most effectively lowered long-term mortality and morbidity.[31] By the 2000s, most employers included some level of routine check-ups, screenings, and immunizations in their benefit plans — and more than three-quarters covered physical examinations, childhood immunizations, and mammography screening — but the coverage was far from comprehensive.[32] Some, but not all, of these services were required by some, but not all, states.[33] State legislatures adopted piece-meal mandates reflecting their political priorities but self-insuring employers were shielded from these requirements by federal preemption.[34] Employers selectively chose to cover additional preventive services furthering their economic interests. Coverage rates for childhood vaccinations and cancer screenings were considerably higher than for smoking cessation, counseling for substance and alcohol use disorders, and screening for STIs.[35] The latter services were less likely to be mandated by states and less likely to be covered by employers despite the evidence of their benefits for individual and public health — probably because they disproportionately benefit marginalized groups.[36]

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[26]U.S. Preventive Servs. Task Force, Guide to Clinical Preventive Services: An Assessment of the Effectiveness of Interventions (Michael Fisher ed., 1989).

[27]Faust, *supra* note 20 at 121.

[28]*Id.* at 126 (describing bills authorizing coverage for pneumococcal vaccination in 1981, hepatitis B vaccination in 1984, mammography in 1988, and pap smears in 1989). Authorization for coverage of vaccinations (now including COVID-19) is codified at 42 U.S.C. § 1395x(s)(10)(A). Authorization for coverage of cancer and other screenings recommended by the USPSTF is now codified at 42 U.S.C. § 1395x(ddd)(1).

[29]Gail A. Jensen & Michael A. Morrisey, *Employer-Sponsored Health Insurance and Mandated Benefit Laws*, 77 Milbank Q. 425, 428 tbl.1 (1999) (showing that most states mandated coverage of mammography by 1999).

[30]Faust, *supra* note 20, at 126.

[31]Maris Ann Bondi et al., *Employer Coverage of Clinical Preventive Services in the United States*, 20 Am. J. Health Promotion 214, 215 (2006).

[32]*Id.* at 218 tbl.3.

[33]Victoria Craig Bunce & J.P. Wieske, Council for Affordable Health Ins., Health Insurance Mandates in the States 2009, 56 tbl.2 (2009), https://www2.cbia.com/ieb/ag/CostOfCare/RisingCosts/CAHI_HealthInsuranceMandates2009.pdf [https://perma.cc/FQA6-DM9Z] (report from a nonprofit organization representing insurers documenting state coverage mandates for various preventive services as of 2009, including: well-child visits (34 states), mammography (50), cervical cancer screening (31), colorectal cancer screening (33), prostate cancer screening (36), ovarian cancer screening (7), contraception (29), HPV vaccination (13), shingles vaccination (1), and smoking cessation (5)).

[34]Some employers offer a self-insured plan whereby the employer pays claims directly from its own funds, typically while relying on third-party contractors to administer provider networks and utilization management. *2023 Employer Health Benefit Survey: Report*, KFF (Oct. 18, 2023), https://www.kff.org/report-section/ehbs-2023-section-10-plan-funding/ [https://perma.cc/JU2Q-RGAC]. Other employers fully insure by contracting with one or more health insurance companies to offer health plans to employees. *Id.* Sixty-five percent of employees are covered by self-insured plans, which federal law shields from state health insurance regulations. *Id.*

[35]*See* Faust, *supra* note 20, at 122 tbl.6.1; Bondi et al., *supra* note 31, at 218 tbl.3.

[36]Inst. of Med., Clinical Preventive Services for Women: Closing the Gaps 51, fig.3-1 (2011) (in 2010, 50 states mandated mammography coverage, 35 mandated coverage for well-child visits, 34 mandated coverage of colorectal cancer screening, 29 mandated coverage of cervical cancer screening, 29 states mandated coverage of contraception, and 25 mandated some form of mental health coverage, but only 3 required coverage of chlamydia screening and only 1 required coverage of smoking cessation); Bondi et al., *supra* note 31, at 214 (reporting results of 2001 survey of employer health plans, finding that "coverage of physical examinations, immunizations, and screenings generally exceeded 50%," but far fewer employers covered

B. The ACA's Preventive Services Mandate

The ACA established a federal floor of coverage mandates tied directly to epidemiological findings that the benefits outweigh the risks at the population level. It required most health plans to cover preventive services recommended by three expert advisory bodies — the USPSTF, the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA) — without any out-of-pocket payments that could discourage people from getting the care they need.[37]

These advisory bodies prioritize public health impact. The USPSTF selects topics for its assessments based in part on their "public health importance," which it assesses in light of the "potential of [a] preventive service to reduce" population-level "burden of suffering."[38] Its assessments may take into account effects of interventions that "extend beyond the individual to society as a whole or to another individual."[39] ACIP includes both public health and medical experts charged with "the development and improvement of public health policies."[40] In the years leading up to the ACA, HRSA's strategic plan adopted rhetoric characteristic of public health, focusing on "healthy communities" and seeking "to impact the broader determinants of health" as part of its mission "to improve health and achieve health equity."[41]

In theory, coverage of evidence-based preventive health services that improve individual and population health should be widely supported. Indeed, the ACA's preventive services mandate includes many uncontroversial services, such as cancer screenings and routine check-ups. But some services recommended by HRSA, ACIP, and USPSTF — particularly those relating to reproductive, sexual, and behavioral health — face considerable political and ideological opposition. Thanks to HRSA recommendations, Department of Health and Human Services (HHS) regulations require insurers and employers to cover FDA-approved contraceptive methods — including oral contraceptives, intrauterine devices, emergency contraceptives, and sterilization.[42] Among many other immunizations, ACIP recommends the HPV vaccine, which protects against a common STI that causes cervical and other cancers.[43] Because of USPSTF recommendations, plans also must include screening tests and prevention counseling for behavioral health conditions such as substance use disorders and for infections that are often transmitted through sexual activity or injection drug use.[44] In 2019, USPSTF issued recommendations for pre-exposure prophylaxis (PrEP), a daily medication that prevents HIV, adding it to the list of mandated services.[45]

C. Employer Incentives and Public Health Goals

Employers are now responsible for more than half of the population's access to evidence-based preventive services that reduce morbidity and mortality by enabling early detection and intervention

services for substance use disorders: only 20% covered tobacco cessation and only 18% of employers provided services for alcohol problem prevention).

[37] 42 U.S.C. § 300gg-13 (2018).

[38] U.S. Preventive Servs. Task Force, Procedure Manual 8 (2021), https://uspreventiveservicestaskforce.org/uspstf/sites/default/files/2023-11/procedure-manual-2023.pdf [https://perma.cc/R25M-DU7M].

[39] *Id.* at 22.

[40] *Advisory Committee on Immunization Practices Policies and Procedures*, Ctrs. for Disease Control & Prevention (2022), https://www.cdc.gov/vaccines/acip/committee/downloads/Policies-Procedures-508.pdf [https://perma.cc/C793-XWT3].

[41] *See* Inst. of Med., *supra* note 12, at 153-55.

[42] *Women's Preventive Services Guidelines*, Health Res. & Servs. Admin., https://www.hrsa.gov/womens-guidelines [https://perma.cc/MJ8W-8TQG].

[43] *Id.*

[44] *Preventive Services Covered Under ACA*, *supra* note 1.

[45] *Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis*, U.S. Preventive Servs. Task Force (Aug. 22, 2023), https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis [https://perma.cc/2MA7-55G8].

and preventing onward transmission of communicable diseases.[46] But the fit between public health and employer responsibility is uneasy.

Because employees and their dependents tend to cycle through multiple types of insurance coverage throughout their lifespan, employers lack incentives to account for long-term consequences when designing health benefits. As Dr. Halley Faust explains,

> [I]f an employer/insurer encourages prevention benefits, and the employee is likely to move to another employer/insurer within 3-5 years (and in any case move into Medicare at 65 for the most expensive years, where prior prevention arguably makes the largest difference), no likely benefit of prevention-related savings in future medical claims would accrue to the particular employer or insurer.[47]

For example, the employer who covers a teenage dependent's vaccination against HPV is unlikely to reap the financial savings when she does not develop cervical cancer decades later.

Employers also do not share the population perspective of public health.[48] They lack incentives to protect people not covered by their health plans. As one of us has previously written, "chances are slim that the insurance company that decides how much a pediatrician is paid to talk with a vaccine-hesitant parent about her concerns will be the same company responsible for the costs of treating an infant who is infected by the unvaccinated child of the hesitant parent."[49] Services like vaccination, testing, and medication for communicable diseases protect people other than the individual patient by preventing onward transmission to social contacts and sexual partners. But in the absence of publicly provided services, they are typically financed through employee benefits that attach to individual plan members.

II. Religious Liberty Doctrine's Resistance to Public Health

The assignment of responsibility for preventive care financing to the private sector opened up a new battleground for religious resistance to public health. Initially, lawsuits focused on contraception.[50] They have since expanded to PrEP,[51] and to vaccinations, screening, and treatments for infections transmitted through sexual contact and intravenous drug use.[52] With these claims, employers have sought to cast off their obligations to serve public health goals.

Courts have largely been receptive, resulting in a religious liberty doctrine hostile to public health. The Supreme Court's new religious liberty doctrine employs an individualistic inquiry that endangers efforts to improve population health. *Braidwood* illustrates the repercussions of this shift for prevention of public health risks. The court defers entirely to employers as to the burden on their religion. It then narrows the scope of inquiry to the objector — considering whether the government has a compelling interest in the narrow circumstance of the plaintiff (or similar plaintiffs) instead of looking industry wide. Taken to its extreme, this individualistic inquiry entirely overlooks the population health impact of exemption — the courts' focus is on the specific workplace and its employees. The doctrine threatens the future of public health beyond sexual and reproductive health.

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[46]Keisler-Starkey et al., *supra* note 10, at 2; *Preventive Services Covered Under ACA*, *supra* note 1.

[47]Faust, *supra* note 20, at 119.

[48]For a discussion of public health's population perspective, *see* Wendy E. Parmet, Populations, Public Health, and the Law 14 (2009).

[49]Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 Ohio St. L.J. 843, 890 (2018).

[50]Hundreds of lawsuits were filed. Three reached the Supreme Court: Burwell v. Hobby Lobby, 573 U.S. 682 (2014); Zubik v. Burwell, 578 U.S. 403 (2016); and Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 140 S. Ct. 2367 (2020).

[51]Braidwood Mgmt. v. Becerra, 666 F. Supp. 3d 613, 626 (N.D. Tex. 2022).

[52]First Amended Complaint at ¶ 29, Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022) (No. 4:20-cv-00283-O). The plaintiffs omitted these objections from their amended complaint, sought to revive them in a motion for summary judgment, but eventually conceded that their RFRA claim was limited to PrEP. *Braidwood*, 627 F. Supp. 3d at 637 n.3.

A. The Shift Toward an Individualistic Frame for Religious Liberty Claims

Over the last decade, the Supreme Court has revised each step in religious liberty doctrine in a way that rejects the population-level focus of public health in favor of narrower, more individualistic framing. Under the Religious Freedom Restoration Act (RFRA) — which forms the basis for much of the litigation against the preventive services mandate — a plaintiff may bring suit alleging that the federal government has substantially burdened their free exercise of religion.[53] If they make out their prima facie case, the court must grant an exemption from the challenged governmental action or law unless it is the least restrictive means to further a compelling governmental interest.[54]

First, consider the question of substantial burden. Courts once rigorously questioned whether the burden on a plaintiff's religious exercise was substantial.[55] In earlier cases involving objections to coverage of specific health care, the courts understood the burdens on religion to be attenuated and any complicity diffused by the collective enterprise of insurance.[56] But beginning in 2014 with *Burwell v. Hobby Lobby*, the Supreme Court's decisions on contraceptive coverage "made it abundantly clear that, under RFRA, [HHS] must accept the sincerely held complicity-based objections of religious entities."[57] This deferential approach to substantial burden removes the primary limiting mechanism for RFRA claims. Under what one court described as an "any burden" standard, a religious objector's say-so shifts the burden of proof to the government.[58]

Second, collective interests once treated as compelling — public health chief among them — are revised and narrowed. In evaluating religious challenges to the contraceptive mandate, the *Hobby Lobby* Court described the interest in public health as "couched in very broad terms" and perhaps too general to support requiring coverage of preventive services.[59] Courts, it instructed, must "loo[k] beyond broadly formulated interests" to find sufficient justification for governmental intrusion on religious liberty.[60] Of course, the more narrowly the interest is defined, the less compelling it will seem.

Perhaps more important still, the *Hobby Lobby* Court tells us that judges must "scrutinize[e] the asserted harm of granting specific exemptions to particular religious claimants."[61] Courts used to consider the cumulative effects of compliance with federal law, not the benefits of a specific entity's compliance with law. Now, states must prove a compelling interest in "denying an exception" to the individual objector.[62] In other words, courts no longer evaluate the compelling interest in protecting health at the population level, but rather must look to the interest at the individual or employer level.

A string of cases decided during the height of the COVID-19 pandemic indicates that the existence of a single exception from a law may render a governmental interest less than compelling. When it sided with objectors against a public health measure limiting gathering size in *Tandon v. Newsom*, the Court held that regulations are not generally applicable "whenever they treat *any* comparable secular activity

[53] 42 U.S.C. § 2000bb(b) (2018) (providing that the federal government may only substantially burden a person's exercise of religion when the burden "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest").

[54] *Hobby Lobby*, 573 U.S. at 692.

[55] *See* Ira C. Lupu, *The Failure of RFRA*, 20 U. Ark. Little Rock L. Rev. 575, 594 n.86 (1998) (concluding, based on systematic review of first years of RFRA, that substantial burden requirement "accounted for over 70% of the RFRA defeats in court").

[56] *See, e.g.*, Erzinger v. Regents of Univ. of Cal., 187 Cal. Rptr. 164, 166 (1983) (rejecting religious objections to abortion coverage in student plan because the objectors only paid a small portion and did not have to use, have, perform, or endorse abortion).

[57] Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657, 681 (2020) (describing the Court's case law).

[58] *See* Gilardi v. Sebelius, 926 F. Supp. 2d 273, 282 (D.D.C. 2013).

[59] 573 U.S. at 726.

[60] *Id.* (citing Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 431 (2006)).

[61] *Id.* (citing *O Centro*, 546 U.S. at 431).

[62] Holt v. Hobbs, 574 U.S. 352, 362–63 (2015) (courts must "scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants ….").

more favorably than religious exercise," even when they treat other secular activity less favorably.[63] The same analysis that finds a law not generally applicable leads to the conclusion that the state has not treated its interest in the law as compelling. For example, in *Fulton v. City of Philadelphia*, the Supreme Court held that the existence of exceptions — even exceptions that had never been granted — fundamentally undermined the contention that the state's interest was compelling.[64] Where the state excepts any secular actors, its interest in enforcement against a religious believer wanes.[65] Lower courts have taken this doctrine to condemn any preference for "life-sustaining" over "soul-sustaining" exemptions.[66] Even the interest of pandemic containment yielded to religion. Cumulative effects of exemptions are discounted; instead, the Court requires the risks to be assessed case by case.

Third, the least-restrictive-means standard has become "exceptionally demanding."[67] The existence of potentially large numbers of objectors no longer suffices to reject religious objections out of hand. Instead, the Supreme Court has repeatedly said, "[a]t bottom, this argument is but another formulation of the 'classic rejoinder of bureaucrats throughout history: If I make an exception for you, I'll have to make one for everybody, so no exceptions.'"[68] Significantly, plaintiffs have advanced, and several courts endorsed, public funding as an alternative to regulating and involving employers in public health efforts.[69] In *Hobby Lobby*, the Court suggested the "most straightforward" approach to contraceptive coverage would be for the government to assume the costs.[70] Contrary to the public-private bargain of the ACA, courts would require the government to implement politically and practically infeasible public programs specific to objected-to services.[71] Instead of the ACA's promise of near-universal availability of evidence-based preventive care to protect the public's health, gaps in coverage emerge.

B. Rejecting Public Health Obligations in Braidwood Management, Inc. v. Becerra

Braidwood shows how this individualistic approach rejects private obligations toward public health. In this case, the plaintiff-owners of for-profit firms believe that PrEP "facilitates and encourages homosexual behavior, intravenous drug use, and sexual activity outside of marriage between one man and one woman."[72] Requiring them to cover PrEP in their employee benefit plans, they argue, substantially burdens their religious exercise by making them complicit in acts they believe to be morally wrong.[73] Their argument effectively shifts from the ACA's public-oriented collective response to health to "a victim-blaming mentality," whereby people vulnerable to HIV bear responsibility for that risk.[74] In response, the government argued that the businesses' ability to carry their burden depended on the (questionable) factual accuracy of their assertion that PrEP facilitates such sexual behavior. The district

[63]Tandon v. Newsom, 593 U.S. 61, 62 (2021).

[64]593 U.S. 522, 542 (2021); *see also* Mast v. Fillmore Cnty., 141 S. Ct. 2430, 2432–33 (2021) (Gorsuch, J., concurring in grant of certiorari and remand in light of *Fulton v. City of Philadelphia*) (noting that courts must give "due weight to exemptions other groups enjoy[,]" and governments must "offer a compelling explanation why the same flexibility extended to others cannot be extended to" religious objectors).

[65]*See Fulton*, 593 U.S. at 534, 542.

[66]Maryville Baptist Church v. Beshear, 957 F.3d 610, 614 (6th Cir. 2020) (reviewing public health precautions).

[67]*Hobby Lobby*, 573 U.S. at 728.

[68]*Holt*, 574 U.S. at 368 (quoting Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal, 546 U.S. 418, 436 (2006)).

[69]Korte v. Sebelius, 735 F.3d 654, 686 (7th Cir. 2013); Newland v. Sebelius, 881 F. Supp. 2d 1287, 1298–99 (D. Colo. 2012), *aff'd*, 542 F. App'x 706 (10th Cir. 2013). For successful arguments against coverage of gender-affirming care, *see* Christian Emps. All. v. U.S. Equal Opportunity Comm'n, No. 1:21-CV-195, 2022 WL 1573689, at *9 (D.N.D. May 16, 2022).

[70]*Hobby Lobby*, 573 U.S. at 728.

[71]Elizabeth Sepper & Lindsay F. Wiley, *The Religious Liberty Challenges to American-Style Social Insurance*, 58 U.C. Davis L. Rev. (forthcoming 2024) (manuscript at 48–49).

[72]Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624, 652 (N.D. Tex. 2022).

[73]*Id.*

[74]Lindsay F. Wiley, *The Struggle for the Soul of Public Health*, 41 J. Health Pols. Pol'y & L. 1083, 1091 (2016) (describing the dichotomy between public health approaches and individual responsibility and how victim-blaming undermines collective responses to health issues).

court rejected this response as "inappropriate"; the firms' religious beliefs had to be accepted and "honored."[75]

Mandating PrEP through employer-based insurance then failed the compelling interest analysis. While the government might have a compelling interest in preventing the spread of infectious disease, this framing, the court held, was too broad where religion claims were involved. Instead, it looked at the government's interest in requiring PrEP coverage from the specific business and similarly situated "private, religious corporations."[76] Purported secular exemptions to the preventive services mandate — in the form of grandfathered plans and the application of the ACA only to large businesses — fatally undermined the compelling interest.[77] The court thus concluded, "[d]efendants outline a generalized policy to combat the spread of HIV, but they provide no evidence connecting that policy to employers such as Braidwood, nor do they provide evidence distinguishing potential religious exemptions from existing secular exemptions."[78]

Taken literally, this individualistic inquiry would require the government to justify any law with regard to each employer (or group of employers). And the enforcement of a law against any single employer — let alone any individual — will rarely rise to the level of a compelling interest. Preserving the health of tens of millions of people is compelling, but the need to safeguard enrollees in any particular employer's health plan is less weighty. Constricting the scope of compelling interests thus effectively limits "the authority of the state to regulate economic life."[79]

As *Braidwood* also highlights, the new doctrinal emphasis on secular exemptions is potentially all-encompassing. Few laws (for the protection of public health or otherwise) apply universally. They often have a restricted scope, for example applying only to manufacturing facilities or large employers. They may contain mechanisms to ease the rollout of compliance, such as grandfathering. Or they may include exceptions justified by other interests, like medical exemptions from immunization requirements. Under this new doctrine, courts may label any of these characteristics of lawmaking "secular exemptions." The result is that the compelling interest disappears and the objector succeeds.

The *Braidwood* court also went on to decide that employer-based coverage of PrEP is not the least restrictive means to further public health. Litigants had argued that the government could require all non-objecting health care providers to deliver PrEP drugs free of charge and then could reimburse them.[80] The court agreed: the government could assume the cost for any employees who sought PrEP.[81]

Although the *Braidwood* district court judge is a notorious opponent of the ACA, his opinion is not unique in treating the employer role in insurance as an unjustified burden.[82] The Supreme Court's radical revision of free exercise doctrine has invited courts across the country to disregard the compromise inherent in the ACA.[83] This compromise preserved the interests of employers in keeping control over group plans while setting a minimum baseline for the benefit of their employees and public

[75] *Braidwood*, 627 F. Supp. 3d at 653 (quoting Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657 (2020) (Alito, J., concurring)).

Id.

[76] *Id.* at 653.

[77] *Id.* (citing Burwell v. Hobby Lobby, 573 U.S. 682, 727 (2014)).

[78] *Id.* at 654.

[79] Elizabeth Sepper, *Free Exercise Lochnerism*, 115 Colum. L. Rev. 1453, 1511 (2015).

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

[81] *Id.*

[82] Nicholas Bagley & A. Mark Fendrick, *A Texas Judge Just Invalidated the Preventive Services Mandate. What Happens Next?*, Health Affs. (Mar. 30, 2023), https://www.healthaffairs.org/content/forefront/texas-judge-just-invalidated-preventive-services-mandate-happens-next (last visited Apr. 13, 2024).

[83] Before *Hobby Lobby* was decided, several courts of appeals demanded the government employ a public program as a less restrictive means. *See* Korte v. Sebelius, 735 F.3d 654, 686 (7th Cir. 2013); Newland v. Sebelius, 881 F. Supp. 2d 1287, 1298–99 (D. Colo. 2012), *aff'd*, 542 F. App'x 706 (10th Cir. 2013). More recent decisions granting exemption coverage of gender-affirming care have also concluded that the government must adopt direct provision or subsidy, but not employer regulation, to achieve its goals. *See, e.g.*, Christian Emps. All. v. U.S. Equal Opportunity Comm'n, No. 1:21-CV-195, 2022 WL 1573689, at *9 (D.N.D. May 16, 2022); Religious Sisters of Mercy v. Becerra, 55 F.4th 583, 609 (8th Cir. 2022).

health. Decisions in favor of religious exemption instead portray the public-private system as disruptive of private actors. On this analysis, the failure to pursue a public system means the government has no authority to regulate the workplace.

C. Impact Beyond Sexual and Reproductive Health

Thus far, religious objections from employers have centered on reproductive and sexual health. But their logic extends well beyond contraception and STI prevention. Consider that the *Braidwood* plaintiffs' initial complaint objected to covering PrEP and preventive services for hepatitis B and C based in part on their moral opposition to drug use.[84] From there, objections could easily be expanded to include treatment for substance use disorders and associated conditions. This Section explains the potential for exemptions from coverage of vaccination and mental health services.

Childhood and adult vaccines are obvious targets. The preventive services mandate ensures comprehensive access to vaccinations recommended by ACIP.[85] Just a decade ago, the Supreme Court could breezily dismiss the idea of granting religious exemptions related to vaccination as implausible. It exempted for-profit employers from covering contraception but insisted that "[o]ther 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 different arguments about the least restrictive means of providing them."[86] Planning of pregnancy (and the attendant benefits to maternal and infant health) might be distinguished from preventing the spread of disease.

Today, however, a rising tide of religious exemption claims has overtaken vaccine mandates. The courts have begun to accept religious challenges that they previously would have summarily rejected.[87] On an individualized inquiry, the aggregation of the public's interest in avoiding disease exposure is largely overlooked. Lower courts have granted religious exemptions on the ground that medical exceptions — for people whose health is endangered by vaccination — equally undermine the state's goals.[88] Although the Supreme Court has not gone so far, Justices Gorsuch, Alito, and Thomas would constitutionalize religious exemptions to immunization.[89]

The same reasoning that has led the lower courts to grant individual religious exemptions from COVID-19 vaccination mandates could also extend to religious employers who object to financing vaccination through employee benefit plans. Religious objectors assert a range of reasons for their opposition to vaccination. One frequently cited concern is that some vaccines have been developed using fetal cell lines.[90] It is easy to imagine an employer arguing that including such vaccinations in its benefit plan would make it complicit in immoral activity.

With regard to immunization, a high-level perspective on the governmental interest is essential. The herd immunity required to stem outbreaks demands high levels of uptake. This threshold varies depending on the pathogen, the vaccine, and the characteristics of the population. For example, measles, an extremely contagious disease, requires a 95 percent vaccination rate to keep outbreaks from getting

[84] *See supra* note 45.

[85] 42 U.S.C. § 300gg–13(a)(2) (2018).

[86] Burwell v. Hobby Lobby Stores, 573 U.S. 682, 733 (2014).

[87] *See* Zalman Rothschild, *Individualized Exemptions, Vaccine Mandates, and the New Free Exercise Clause*, 131 YALE L.J. F. 1106 (2022); *see generally* Dorit R. Reiss, *Thou Shalt Not Take the Name of the Lord Thy God in Vain: Use and Abuse of Religious Exemptions from School Immunization Requirements*, 65 HASTINGS L.J. 1551 (2014) (discussing the abuse of religious exemptions).

[88] U.S. Navy SEALS 1-26 v. Biden, 578 F. Supp. 3d 822, 835 (N.D. Tex. 2022); Poffenbarger v. Kendall, 588 F. Supp. 3d 770, 794–95 (S.D. Ohio 2022).

[89] Dr. A. v. Hochul, 142 S. Ct. 2569, 2571 (2022) (Thomas, J., dissenting); Does 1–3 v. Mills, 142 S. Ct. 17, 20 (2021) (Gorsuch, J., dissenting) (both involving COVID-19 vaccine mandates for health care workers with medical exemptions).

[90] Meredith Wadman, *Abortion Opponents Protest COVID-19 Vaccines' Use of Fetal Cells*, SCIENCE (June 5, 2020), https://www.science.org/content/article/abortion-opponents-protest-covid-19-vaccines-use-fetal-cells.

out of hand.[91] The individualized inquiry — to the objecting business — seems to neglect consideration of the aggregate.

Mental health benefits could also be susceptible to religious objection. The preventive services mandate encompasses coverage of depression screening, anxiety screening, and child behavioral and developmental assessments.[92] Federal law also requires a measure of mental health parity, prohibiting plans from imposing limits on mental health or substance use disorder benefits that are less favorable than limits imposed on medical benefits.[93] Many states have enacted more thorough-going parity laws that require plans to include mental health benefits.[94]

While religious people hold a broad spectrum of beliefs about mental illness, common beliefs within conservative Christianity associate mental illness with sin, character flaw, or insufficient faith.[95] A study by Marcia Webb and her colleagues into best-selling Christian self-help books illuminates. These enormously popular texts ascribe depression to an attack by Satan or to individual failure to act as good Christians.[96] They emphasize personal responsibility for mental health issues.[97] One author lectured that "[i]f you are depressed you have to understand that nobody is *making* you depressed … You are choosing to remain in that condition."[98] It follows that "a spiritual problem requires a spiritual solution."[99] In a Lifeway Research Survey, nearly half of evangelical Christians agreed that "[w]ith just Bible study and prayer, ALONE, people with serious mental illness like depression, bipolar disorder, and schizophrenia could overcome mental illness."[100] On this view, the appropriate response to mental illness is religious observance,[101] not collective support through insurance coverage.

Such religious objections — and exemptions — are far more plausible than they might initially seem. Religious resistance to substance use disorder treatment and mental health coverage is already reflected in health care sharing ministries, which are exempted from the ACA's regulations.[102] For their members, ministries substitute for insurance and routinely exclude mental health services just as they do reproductive and sexual health care.[103] Consistent with the approach in *Braidwood*, *Hobby Lobby*, and other recent exemption cases, these services too could be subject to employer exemption.

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[91] *Nearly 40 Million Children Are Dangerously Susceptible to Growing Measles Threat*, Ctrs. for Disease Control & Prevention (Nov. 23, 2022, 1:00 PM), https://www.cdc.gov/media/releases/2022/p1123-measles-threat.html [https://perma.cc/87CX-S88L].

[92] *Preventive Services Covered Under ACA*, *supra* note 1.

[93] 29 U.S.C. § 1185a (2018); Kaye Pestaina, *Mental Health Parity at a Crossroads*, KFF (Aug. 18, 2022), https://www.kff.org/mental-health/issue-brief/mental-health-parity-at-a-crossroads/ [https://perma.cc/2A4L-Z8D5].

[94] *Mental Health Benefits: State Laws Mandating or Regulating*, Nat'l Conf. of State Legislatures (Dec. 30, 2015), https://www.ncsl.org/health/mental-health-benefits [https://perma.cc/N65Y-VYKW].

[95] *See* Kristine Hartog & Kathryn M. Gow, *Religious Attributions Pertaining to the Causes and Cures of Mental Illness*, 8 Mental Health, Religion & Culture 263, 272–73 (2005); John R. Peteet, *Approaching Religiously Reinforced Mental Health Stigma: A Conceptual Framework*, 70 Psychiatric Servs. 846, 847 (2019).

[96] Marcia Webb et al., *Representation of Mental Illness in Christian Self-Help Bestsellers*, 11 Mental Health, Religion & Culture 697, 704 (2008).

[97] *Id.* at 706.

[98] *Id.* (quoting Joel Osteen, Your Best Life Now: 7 Steps to Living at Your Full Potential 102 (2004)).

[99] Lily A. Mathison et al., *Stigma and Mental Health in the Abrahamic Religious Traditions*, *in* The Cambridge Handbook of Stigma and Mental Health 347, 354 (David L. Vogel & Nathaniel G. Wade eds., 2022).

[100] Bob Smietana, *Mental Health: Half of Evangelicals Believe Prayer Can Heal Mental Illness*, Lifeway Rsch. (Sept. 17, 2013), https://research.lifeway.com/2013/09/17/mental-health-half-of-evangelicals-believe-prayer-can-heal-mental-illness/ [https://perma.cc/6DEJ-XAXD].

[101] Jennifer Huang Harris, *Mental Illness Stigma in Christian Communities*, *in* Christianity and Psychiatry 21, 28 (John R. Peteet et al. eds., 2021).

[102] *See generally*, JoAnn Volk et al., *Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?*, Commonwealth Fund (Aug. 2018), https://www.commonwealthfund.org/sites/default/files/2018-08/Volk_hlt_care_sharing_ministries.pdf [https://perma.cc/7M5R-CK33].

[103] Rachel E. Sachs, *Religious Exemptions to the Individual Mandate: Health Care Sharing Ministries and the Affordable Care Act*, *in* Law, Religion, and Health in the United States 143, 145–46 (Holly Fernandez Lynch et al. eds., 2017).

III. Free Exercise Lochnerism and the Future of Public Health

In the courts' disregard for public health harms, we detect echoes of the past. The twentieth century began with four decades of pro-business constitutional deregulation led by the Supreme Court.[104] This doctrine was ultimately repudiated. But today, the Court again wields constitutional provisions to deregulatory ends. While public health law scholars have long recognized the risks from free speech Lochnerism,[105] religious liberty doctrine — in the form of exemption claims from business — now plays a similar role.[106]

A. From Liberty of Contract to First Amendment Lochnerism

The *Lochner* era of the twentieth century draws its name from *Lochner v. New York*, a decision that epitomized judicial resistance to the protection of labor and public health.[107] There, the Court leveraged the right of contract of employers and workers to invalidate a restriction on bakers' hours that the state argued was needed to safeguard health. The 60-hour workweek provision targeted in the case was situated within a comprehensive regulatory regime specifying standards for ventilation and cleanliness.[108] As Matthew Bewig explains, "[t]he bakers' agitation for the underlying Bakeshop Act focused heavily on public health issues, particularly on the contention that bakery work created an unacceptable risk of disease, especially consumption [now known as tuberculosis], to themselves and to consumers."[109]

Positioning themselves as the defenders of freedom against tyranny, the justices in the *Lochner* majority substituted their own assessment of public health evidence for that of the legislature. The majority disregarded population-level harms altogether — stating that "[t]he law must be upheld, if at all, as a law pertaining to the health of the *individual* engaged in the occupation of a baker."[110] And it ultimately struck down the law based on "the common understanding [that] the trade of a baker has never been regarded as an unhealthy one."[111] In the years that followed, regulations protecting occupational health and safety were frequent targets of litigation.[112]

Following the Court's rejection of *Lochner* in 1937,[113] legislatures and executive officials reclaimed their principal role in identifying and advancing collective interests in health and welfare. Businesses' assertions of free exercise of religion did not interfere with these efforts. Prior to *Hobby Lobby*, courts rejected claims from employers for exemption under the First Amendment (and sometimes RFRA) from an array of statutes regulating health and labor standards.[114] Notably, the highest courts of New York and

[104]Commentators typically date the *Lochner* era from the 1897 case of *Allgeyer v. Louisiana* to the 1937 decision in *West Coast Hotel Co. v. Parrish. Lochner Era*, Legal Info. Inst., https://www.law.cornell.edu/wex/lochner_era [https://perma.cc/LEH6-THRQ] (last updated June 2023).

[105]*See e.g.*, Parmet & Smith, *supra* note 5, at 430 ("Public health and the First Amendment may be on a collision course."); Joshua M. Sharfstein, *Public Health and the First Amendment*, 93 Milbank Q. 459 (2015).

[106]Sepper, *supra* note 71, at 1508.

[107]198 U.S. 45, 58, 61 (1905).

[108]*Lochner*, 198 U.S. at 69–72 (Harlan, J., dissenting) (reviewing epidemiological evidence).

[109]Matthew S.R. Bewig, *Laboring in the "Poisonous Gases": Consumption, Public Health, and the Lochner Court*, 1 N.Y.U. J.L. & Liberty 476, 476 (2005); *see also* Wendy E. Parmet, *From* Slaughter-House *to* Lochner: *The Rise and Fall of the Constitutionalization of Public Health*, 40 Am. J. Legal Hist. 476, 497–99 (1996).

[110]*Id.* at 57 (emphasis added).

[111]*See id.* at 58–59.

[112]*See, e.g.*, Hammer v. Dagenhart, 247 U.S. 251 (1918) (invalidating a child labor law); Bailey v. Drexel Furniture Co., 259 U.S. 20 (1922) (invalidating a federal tax on goods produced by child labor).

[113]West Coast Hotel Co. v. Parrish, 300 U.S. 379, 391– 394 (1937) (upholding law creating minimum wage and safety conditions for women and minor workers under the Due Process Clause).

[114]*E.g.*, United States v. Lee, 455 U.S. 252, 261 (1982) (refusing to exempt employer from Social Security obligations); Droz v. Comm'r, 48 F.3d 1120, 1121–23 (9th Cir. 1995) (rejecting similar claim under RFRA); Tony & Susan Alamo Found. v. Sec'y of Lab., 471 U.S. 290, 306 (1985) (same for federal wage requirements); United States v. Indianapolis Baptist Temple, 224 F.3d 627, 631 (7th Cir. 2000) (same for unemployment insurance).

California had rebuffed a challenge to state contraceptive mandates from religious non-profit employers.[115]

But — as has been well documented in scholarly literature and occasionally noted in judicial decisions — the Supreme Court is now reinventing *Lochner* under the First Amendment.[116] The risks to public health from free speech have been amply explored,[117] but free exercise claims from business merit greater attention from public health policymakers, researchers, and advocates. As one of us has previously written, courts have incorporated the central premises of *Lochner* into religious liberty doctrine.[118] They adopt a "stringent judicial review of economic regulation informed by a baseline of private ordering and a skepticism toward redistribution."[119] Under this approach, regulation is suspect as an unfair imposition — or substantial burden — on the liberty of the business. The government loses its power to alter market conditions via regulation of private enterprise. As we saw in *Braidwood*, it must advance its interests, whether in public health or equality, through fully public programs — or not at all.

B. Implications of Free Exercise Lochnerism for Public Health

Like freedom of contract before it, this reinterpretation of religious liberty renders vulnerable the regulation of industry in the interest of public health.[120] Religious liberty arguments used to be distinguished from other constitutional claims by their result: an individual plaintiff secures exemption but the law otherwise remains intact.[121] However, these corporations are not the minority individuals of past accommodations; they are politically powerful institutions and commercial entities — the very centerpiece of regulatory efforts. The exemption of any single objector more significantly undermines governmental goals.

It is important to note that some religious plaintiffs are no longer satisfied with exemption and seek market-wide injunctions. Some of the plaintiffs in the *Braidwood* case won a permanent injunction in a previous case which barred the government from enforcing the contraceptive mandate against them.[122] But insurers nonetheless did not offer them contraceptive-free policies, finding it "financially unappealing" to design a special plan for these small employers.[123] So, they claimed, the very existence of the mandate constituted injury.[124] The trial court agreed. The plaintiffs suffered injury so long as enforcement existed anywhere in the market; after all, "the Contraceptive Mandate is not called the Contraceptive Suggestion."[125] Without a mandate, it was plausible that "the insurance market would return to its pre-ACA conditions."[126] Although the court ultimately decided the plaintiffs' request for a blanket injunction was barred by res judicata, its favorable disposition indicates the potential reach of RFRA claims into public health.[127]

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[115] *See* Catholic Charities of Diocese of Albany v. Serio, 859 N.E.2d 459, 461 (N.Y. 2006); Catholic Charities of Sacramento, Inc. v. Superior Ct., 85 P.3d 67, 89, 94–95 (Cal. 2004).

[116] *E.g.*, Janus v. Am. Fed'n of State, Cnty & Mun. Emps., Council 31, 138 S. Ct. 2448, 2501 (2018) (Kagan, J., dissenting); Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 138 S. Ct. 2361, 2380–83 (2018) (Breyer, J., dissenting); Leslie Kendrick, *First Amendment Expansionism*, 56 Wm. & Mary L. Rev. 1199, 1207–09 (2015); Jedediah Purdy, *Neoliberal Constitutionalism: Lochnerism for a New Economy*, 77 L. & Contemp. Probs. 195, 197–98 (2014).

[117] *See* sources cited *supra* note 5.

[118] Sepper & Wiley, *supra* note 71, at 1464.

[119] *Id.* (drawing on the influential definition from Cass R. Sunstein, *Lochner's Legacy*, 87 Colum. L. Rev. 873 (1987)).

[120] *Id.* at 1455.

[121] Thomas C. Berg, *Religious Accommodations and the Welfare State*, 38 Harv. J.L. & Gender 103, 148 (2015) ("[R]eligious accommodation does not interfere nearly as greatly with regulation as Lochner did.").

[122] *See* DeOtte v. Azar, 393 F. Supp. 3d 490, 514 (N.D. Tex. 2019).

[123] *See* Kelley v. Azar, No. 4:20-CV-00283-O, 2021 WL 4025804, at *4 (N.D. Tex. Feb. 25, 2021).

[124] *Id.* For a similar argument from a small employer not subject to the employer mandate and unable to purchase a plan that excluded contraception under an injunction, *see* Annex Med. v. Burwell, 769 F.3d 578, 581 (8th Cir. 2014).

[125] *Kelley*, 2021 WL 4025804, at *5.

[126] *Id.*

[127] The opinion advised the plaintiffs to pursue an amendment to the earlier injunction. *Id.* at *8.

Even where plaintiffs do not make such ambitious requests, the effect of litigation may be to remake the market according to their morals and, in so doing, undermine the public's health and their employees' access to health care. For example, the *Hobby Lobby* decision involved only three plaintiffs, but the Supreme Court's holding necessarily prompted administrative action extending to any closely held corporation with a religious objection. And in 2018, the Trump Administration finalized a distinctly deregulatory rule with a broad "moral" exemption available to for-profit employers.[128] These administrative efforts too can be considered part of free exercise Lochnerism.[129]

Finally, one should not overlook the overlap between religious liberty claims of conservative Christians and libertarian arguments of industry. As Joanna Wuest and Briana Last have meticulously documented, the same industry groups that funded attacks on the constitutionality of the ACA's individual mandate also provide generous support to legal organizations now representing religious business interests.[130] This coalition of corporate and religious interests exploits the "entwining of the public-private administration and provision of healthcare in the U.S." to erode public health programs.[131]

The purported sincerity and religiosity of plaintiffs grant them a degree of deference that, in turn, permits them to escalate attacks on the regulation of health and labor. As Wuest and Last note, religious objectors' "challenges to the ACA's constitutionality have consistently featured a blend of religious liberty appeals and anti-administrativism."[132] Industry-funded Christian litigation shops supported the efforts against the COVID-19 vaccination-or-testing rule — which resulted, notably, in a Supreme Court shadow docket ruling in favor of the National Federation of Independent Businesses.[133] *Braidwood* is an exemplar of this phenomenon. In addition to their RFRA claims, plaintiffs challenge the preventive services mandate in its entirety as unconstitutionally relying on advisory bodies for recommended services. And the district court granted summary judgment in their favor on their Appointments Clause claim with respect to the USPSTF — throwing into jeopardy access to an even larger number of preventive services.[134]

As with liberty of contract a century ago and free speech today, free exercise doctrine increasingly has become the tool of industry against labor and public health. The shrinking of compelling interests denies the cumulative harm of religious exemption and the importance of collective effort to provide large but diffuse benefits. These decisions disrupt the public-private tradeoffs of the ACA and use concessions to employers against the government. Courts hostile to preventive services — from contraception to PrEP — make the calculus that if we must have a public program for prevention or nothing at all, we will get nothing at all.

Conclusion

The longstanding and growing reliance on private institutions to advance public health is running headlong into constitutional doctrine that increasingly grants individual rights to corporate entities. The public-private nature of health financing under the ACA represented a tradeoff: the government

[128]Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57536 (Nov. 15, 2018) (codified at 45 C.F.R. § 147.132).

[129]Nelson Tebbe, *A Democratic Political Economy for the First Amendment*, 105 Cornell L. Rev. 959, 998 (2020) (observing that Lochnerian interpretations of free exercise apply to administrative agencies as well as courts); Mila Sohoni, *The Trump Administration and the Law of the* Lochner *Era*, 107 Geo. L.J. 1323, 1325 (2019) (describing the Trump regulation as part of renovating Lochner).

[130]Joanna Wuest & Briana Last, *Church Against State: How Industry Groups Lead the Religious Liberty Assault on Civil Rights, Healthcare Policy, and the Administrative State*, J.L. Med. & Ethics (forthcoming 2024) (manuscript at 4–5) (https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4306283 [https://perma.cc/882U-X63V]).

[131]*Id.* at 3.

[132]*Id.* at 14.

[133]*Id.* at 29.

[134]Braidwood Mgmt. v. Becerra, 627 F. Supp. 3d 624, 647 (N.D. Tex. 2022).

could advance population health and work toward preventing diseases and disorders, while private employers could maintain much of their traditional role in insuring workers.

Employers' religious liberty lawsuits reject this compromise. Through exemptions, for-profit employers insist both on preserving their control over insurance plans and on freedom from any collective obligation to promote public health. Their lawsuits have permitted the Supreme Court to re-design religious liberty doctrine to prioritize an individualized inquiry and to overlook widespread (but often diffuse) interests in public health. The result is to advance a broader deregulatory campaign of First Amendment Lochnerism.

Public health experts rightly worry about the recent victories of the multi-decade campaign to establish constitutionally protected rights to individual religious exemption from vaccination requirements. Employers' religious objections to providing preventive health benefits should equally prompt their consternation and engagement. Additional decisions elevating the rights of religious objectors over public health may seem inevitable, but there are opportunities for experts to solidify the evidence base for prioritizing public health and to advocate for renewed investments in public programs.

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