Introduction: Law, Religion, and Health in the United States

Elizabeth Sepper, Holly Fernandez Lynch, and I. Glenn Cohen

Within the covers of the Bible are the answers for all the problems men face.

– Ronald Reagan

I do not feel obliged to believe that the same God who has endowed us with sense, reason, and intellect has intended us to forgo their use.

– Galileo Galilei

What types of health care institutions ought to be allowed to exercise religion or conscience? Should corporations with religious owners be permitted to deny insurance coverage for contraception or reproductive technologies? How should providers, institutions, and the law respond to religious beliefs expressed by patients or patients' families when they resist modern medical practice with regard to definitions of death, expectation of miracles, or refusal of treatment? When should the law demand that health care professionals disclose their religious beliefs or refer patients whom they cannot counsel for religious reasons – and, more generally, how should the law respond when religious objections in the health care sphere threaten to harm or burden others? What impact might religion have on public health law and interventions, or even the environment? These are but a few of the questions (and potential conflicts) at the intersection of law, religion, and health that are becoming increasingly pressing in our current historical moment.

This volume highlights the complex ways in which these three topics collide. The collisions are ubiquitous, but they may not present as a straightforward conflict between government and believers. Instead, they tend to occur in a complicated web of relationships involving health professionals, patients, and institutions (as diverse as employers, insurers, and hospitals), all of which may hold their own religious (or opposing secular) beliefs and raise religious objections. While religious conflict is certainly not unique to the United States, this country does present a unique environment, combining secular foundations with levels both of religious

and moral pluralism and of religious devotion that stand out among developed nations. From Jehovah's Witnesses who refuse life-saving blood transfusions to certain Ultra-Orthodox Jews who suck blood out of the penis as part of traditional male circumcision, from Caribbean religious practitioners who employ the ritualistic use of mercury to Christians who oppose contraceptives, people in the United States hold every possible variety of religious belief (including none at all). The law understandably refuses to examine the validity of these wide-ranging beliefs and offers the same legal protection across the board. But the protection of religious believers in this country is not absolute, resulting in the need to grapple with a variety of potential conflicts.

Many of these conflicts have been brought to the fore by the landmark 2014 U.S. Supreme Court decision, *Burwell v. Hobby Lobby Stores, Inc.*[1] That case (and related litigation ongoing at the time this volume went to press) not only addressed the specific issue of employers' religious objections to covering contraceptives in employee insurance plans, but also central, unresolved issues in law and religion doctrine that affect health generally and remain important no matter the fate of the contraceptives coverage mandate in the Trump administration.

Spurred by these developments, we brought together leading academics, practitioners, and advocates to consider religion and law within the context of the health care system, bioethics, and public health. The conference, organized by the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, attracted hundreds of thought leaders from across the nation. The result of that discussion – and later debates – is memorialized in the 29 chapters that follow.

The contributors to this volume grapple with many issues at the core of ongoing debates – the definition of health care providers' professional responsibility, the challenges of creating dialogue between religious and secular worldviews, the scope of religious choice by parents for their sick children, and many more. They come from a diverse set of backgrounds and methodologies, including philosophy, public health, law, theology, and medicine. Moreover, they reflect a diversity of perspectives. Often they offer competing visions of what success in balancing religion and health would look like and the best ways to achieve it in law and policy.

In order to provide some common ground for the chapters in this volume, and to avoid the repetition that would inevitably occur if each chapter had to recapitulate the relevant background law, we set the stage in this introduction for what is to come. Many readers will already be familiar with the U.S. legal standards applicable to religious conflicts, but we hope to provide a brief overview for others without this background knowledge.

[1] 134 S. Ct. 2751 (2014).

First, it is essential to recognize that there are both constitutional and statutory protections for religious liberty, and that these protections are found in varying forms at the federal and state levels. The First Amendment to the U.S. Constitution states, in part, that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."[2] Between 1963 and 1990, the Supreme Court interpreted the Free Exercise Clause as offering relatively extensive protection where a law imposed a substantial burden on the free exercise of religion. Under this standard, the government had to demonstrate that the law was *necessary* to advance a *compelling* government interest; if it failed on either prong, the law would be declared unconstitutional.[3] In 1990, however, the Supreme Court held in *Employment Division v. Smith* that neutral laws of general applicability – those that do not specifically target religion and apply equally to believers and nonbelievers – do not merit mandatory religious accommodation even when they burden free exercise, so long as they bear a *rational* relationship to a *legitimate* government interest.[4] The result was that the Supreme Court significantly lowered the bar that laws had to meet in order to survive a constitutional Free Exercise challenge.

In response to the Court's decision in *Smith*, Congress passed the Religious Freedom Restoration Act of 1993 (RFRA) with the support of religious and secular leaders on the political left and right.[5] The law's stated purpose was to restore the compelling interest test with explicit reference to pre-*Smith* Supreme Court precedent. Under RFRA, the federal government may "substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person – (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest."[6]

After the Supreme Court made clear in 1997 that RFRA applied only to action by the federal government, many states passed similar laws of their own.[7] Twenty-one states currently have what are known as "state RFRAs."[8] Beyond these state statutes, state constitutional provisions also safeguard religious exercise, sometimes more broadly than the federal Constitution.

[2] U.S. Const. amend. I.

[3] See *Sherbert v. Verner*, 374 US 398 (1963); *Wisconsin v. Yoder*, 406 US 205 (1972).

[4] 494 U.S. 872 (1990).

[5] 42 U.S.C. §2000bb (1993). For further discussion, see Diane L. Moore and Eric M. Stephen, Ch. 2, this volume.

[6] Id. at § 2000bb-1(b).

[7] *City of Boerne v. Flores*, 521 U.S. 507 (1997) (holding that RFRA's original extension to the states exceeded Congress's power).

[8] National Conference of State Legislatures, State Religious Freedom Restoration Acts (October 15, 2015), available at www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx [https://perma.cc/Z8LW-XCDV].

Because plaintiffs face a lower burden under RFRA than the Constitution (where the *Smith* standard still holds), it is RFRA – and not the First Amendment – that is central to recent litigation in which plaintiffs have sought to challenge various legal requirements as unacceptably infringing their religious beliefs and/or practices. Indeed, the Supreme Court's decision in *Hobby Lobby* addressed the application of RFRA to the government's regulation requiring insurance coverage of contraceptives. Since challenges to the contraceptive mandate are central to many of the chapters in the book, it is worth discussing in greater detail here. As discussed later, it is unclear that the mandate will survive the political process regardless of what happens in court, but it nonetheless offers an important case study of religious conflict with law. We suspect that such conflicts will become increasingly important in the health care space, either by way of laws promoting access to health care services or laws accommodating religious objections to them.

The controversy over the contraceptive mandate originated with the Affordable Care Act's (ACA) so-called "employer mandate," encouraging (most) large employers with fifty or more full-time employees to extend health insurance to their employees.[9] If the employer decides not to provide health insurance and at least one full-time employee enrolls in a health plan and qualifies for a subsidy on one of the government-run exchanges, the employer must pay $2000 per year for *each* of its full-time employees.[10] The ACA also imposes regulations on health insurance plans sponsored by employers. Of particular relevance, all plans must cover "preventive care and screenings" for women without cost-sharing in the form of co-payments, co-insurance, or deductibles.[11] If an employer subject to the mandate provides health insurance, but fails to cover women's preventive care, it will face a $100-per-day tax for each insured individual.[12] Thus, employers face penalties if they choose not to offer health insurance at all, or if they fail to offer the right type of coverage. Based on a review of evidence-based preventive services for women's health and well-being, the U.S. Department of Health and Human Services (HHS) interpreted the ACA's requirement regarding "preventive care and screenings" to mean that insurance plans must cover – without cost to beneficiaries – a wide range of contraceptive methods, including oral contraceptives, intrauterine devices, emergency contraception, and sterilization, as well as patient counseling and education about these options.[13]

[9] 26 U.S.C. § 4980H (2012).
[10] Id. at §§4980H(a),(c)(1).
[11] 42 U.S.C §300gg–13(a)(4).
[12] 26 U.S.C. §§4980D(a)-(b).
[13] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46621-01 (August 3, 2011) (to be codified at 45 C.F.R. pt. 147).

Following several revisions, but prior to *Hobby Lobby* and related cases, the HHS rule – which became known as the contraceptives mandate – was to work as follows. It granted an *exemption* to "churches, their integrated auxiliaries, and conventions or associations of churches, as well as the exclusively religious activities of any religious order."[14] These entities did not have to abide by the mandate at all or take any steps to avoid it. The rule also provided an *accommodation* for nonprofit religious organizations, such as certain universities and hospitals.[15] To be accommodated, an organization had to (1) oppose providing contraceptives coverage under the mandate for religious reasons; (2) be organized and operate as a nonprofit entity; (3) hold itself out as a religious organization; and (4) self-certify that it met these criteria. Eligible organizations had to provide notice of their objection to their health insurance issuer, which was then required to provide separate payments for contraceptives for women in the health plan at no cost to the women *or* to the organization.[16] Accommodated organizations did not have to contract, arrange, pay, or refer for contraceptive coverage.[17] Their employees, however, still had access to contraceptive coverage without cost to them.[18] A similar accommodation was available for eligible organizations using self-insured health plans run by third-party administrators.[19]

Compliance with the mandate was expected of all other employers – including all for-profit entities. Several for-profit corporations with religious owners subsequently filed suit under RFRA, requesting exemption from the mandate, and eventually reached the Supreme Court in consolidated cases brought by chain store Hobby Lobby and cabinet manufacturer Conestoga Wood.

The Court's analysis of their claims proceeded in four steps, resulting in a 5–4 decision. First came the threshold question of whether for-profit corporations count as "persons" capable of exercising religion under RFRA. Relying on the near-universal acceptance that RFRA's use of the word "persons" includes nonprofit corporations, the Court determined that "persons" should equally encompass for-profit corporations.[20] It concluded that – like religious nonprofits – closely held, secular for-profit corporations can equally "further[] individual religious freedom" of individuals united in the enterprise.[21]

As RFRA requires, the Court then evaluated whether: (1) the mandate imposed a substantial burden on the objecting corporations' free exercise rights; (2) the

[14] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under Patient Protection and Affordable Care Act, 78 Fed. Reg. 8456, 8461 (February 6, 2013).
[15] Id. at 8462.
[16] Id.
[17] Id.
[18] Id.
[19] Id. at 8463.
[20] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 at 2769 (2014).
[21] Id.

government had a compelling interest in the mandate; and (3) the government had less restrictive alternatives. The majority determined that the objecting corporations were indeed substantially burdened by the mandate, because they faced a choice between paying potentially large tax penalties for noncompliance and violating their religious beliefs.[22] It was irrelevant that they were not required themselves to buy or use contraceptives, as they sincerely objected to being complicit in helping pay, arrange, or contract for those services. The dissent, in contrast, concluded that the "connection between the [owners'] religious objections and the contraceptive coverage requirement is too attenuated to rank as substantial."[23]

The Court assumed, without deciding, that the governmental interest in guaranteeing cost-free access to contraceptives was compelling.[24] It then assessed whether the mandate was the least restrictive means of furthering that interest and concluded that the mandate did not satisfy RFRA's "exceptionally demanding" least-restrictive-means standard.[25] Because the government had accommodated nonprofit religious organizations, the Court determined that it could equally accommodate for-profit corporations.[26] But the Court refused to confirm that the accommodation – which at that time required notification to the employer's insurer – "complie[d] with RFRA for purposes of all religious claims" – leaving the door open to contemporaneous litigation by nonprofits against the accommodation itself.[27]

In July 2015, in response to the Supreme Court's *Hobby Lobby* decision, HHS issued a new version of the rule that allowed certain closely held for-profit entities the same accommodation available to eligible religious nonprofits.[28] The new rule also provided an alternative accommodation mechanism, permitting employers to notify HHS in writing of their religious objection, rather than deliver a specific form to their insurance issuer or third-party administrator.[29]

Despite this expansion, several employers continued to object, claiming that the required process under the accommodation still substantially burdened religious exercise in two ways. First, they argued, submitting notice directly to the insurance issuer, third-party administrator, or even the government simply triggers another party to engage in the objectionable activity without removing the employer entirely from the chain of complicity.[30] Second, they claimed that their religious convictions forbid them from contracting with companies that will provide free coverage for

[22] Id. at 2775–7.
[23] Id. at 2799 (Ginsburg, J., dissenting).
[24] Hobby Lobby, 134 S. Ct. at 2780.
[25] Id. (citing *City of Boerne v. Flores*, 521 U.S. 507, 532 (1997)).
[26] Id. at 2782.
[27] Id.
[28] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under Patient Protection and Affordable Care Act, 80 Fed. Reg. 41323–4 (July 14, 2015).
[29] Id. at 41323.
[30] See, e.g., *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 237 (D.C. Cir. 2014).

the contraceptive services, so it is problematic for them to retain relationships with these insurance companies and third-party administrators at all.[31] Thus, the objecting employers sought an outright exemption, rather than an accommodation, arguing that the government has ample alternative means to provide access to cost-free contraceptives to their employees without burdening employers' religious exercise.

In response to these claims, eight out of nine appellate courts to hear the cases concluded that no substantial burden on religious exercise existed under the accommodation.[32] The accommodation, they decided, excused objecting employers from any involvement; private insurers' compliance with their own legal obligations to offer contraceptive coverage did not substantially burden the plaintiffs.[33]

In its October 2015 term, the Supreme Court took up a number of these accommodation cases, consolidated under the name *Zubik v. Burwell*.[34] After oral argument, however, having taken the unusual step of proposing a possible alternative process for accommodation from the mandate and requesting supplemental briefing on that alternative, the Court issued a unanimous per curiam opinion remanding the cases to the appellate courts with the instruction to afford the parties "an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage.'"[35] The Court took great pains to provide a list of matters it was explicitly *not* deciding, such as "whether petitioners' religious exercise has been substantially burdened, whether the Government has a compelling interest, or whether the current regulations are the least restrictive means of serving that interest."[36] While many attributed the decision not to rule on the merits to the fact that the Court had an even number of justices following the death of Justice Scalia, there is significant dispute as to what the Court did or did not signal through its opinion.[37]

[31] See, e.g., *Univ. of Notre Dame v. Burwell*, 743 F.3d 547, 557 (7th Cir. 2014).

[32] *Eternal Word Television Network, Inc. v. Sec'y of U.S. Dep't of Health & Human Servs.*, 756 F.3d 1339 (11th Cir. Feb. 18, 2016); *Catholic Health Care Sys. v. Burwell*, 796 F.3d 207 (2d Cir. 2015); *Little Sisters of the Poor Home for the Aged, Denver, Colo. v. Burwell*, 794 F.3d 1151 (10th Cir. 2015); *E. Texas Baptist Univ. v. Burwell*, 793 F.3d 449 (5th Cir. 2015); *Geneva Coll. v. Sec'y U.S. Dep't of Health & Human Servs.*, 778 F.3d 422, 427 (3d Cir. 2015); *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 2523 (D.C. Cir. 2014); *Mich. Catholic Conference & Catholic Family Servs. v. Burwell*, 755 F.3d 372, 389 (6th Cir. 2014); *Univ. of Notre Dame v. Burwell*, 743 F.3d 547 (7th Cir. 2014). Only the Eighth Circuit decided a substantial burden exists. *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927 (8th Cir. 2015).

[33] See, e.g., *Wheaton College v. Burwell*, 791 F.3d 792, 795 (2015).

[34] 136 S. Ct. 444 (2015).

[35] *Zubik v. Burwell*, 136 S. Ct. 1557 (2016) (per curiam).

[36] Id.

[37] For a variety of views, see ScotusBlog, *Zubik v. Burwell Symposium*, available at www.scotusblog.com/category/zubik-v-burwell-symposium/ [https://perma.cc/9CUN-9EDH] (last visited May 26, 2016).

As this volume goes to press, much is in flux. Months after the remand, the Obama administration announced that the parties had found no ground for compromise and it had concluded that no feasible approach would satisfy the religious objectors.[38] The accommodation, therefore, would not be altered further unless by court order. The *Zubik* line of cases – and the issues of substantial burden, compelling interest, and potential alternatives – thus may return to the Court shortly in the same, or similar, posture. With Justice Neil Gorsuch now sitting on the Court, the prior deadlock is likely to be broken. Alternatively, through the notice and comment process, the Trump administration may propose a new women's preventive services rule that either expands the exemption to any religious objector or altogether removes the requirement to cover some, or all, contraceptives; President Trump signed an executive order on May 4, 2017, indicating an intention to make it easier for objectors to avoid covering women's preventive care, including contraceptives, in employee health plans. Finally, federal law related to health care may change. With political power shifting to the Republican Party in 2017, now controlling both Congress and the Presidency, GOP promises to repeal the Affordable Care Act have become plausible. If the underlying employer mandate were repealed, litigation over the contraceptives mandate would be moot; objecting employers could simply avoid providing any insurance coverage at all.

Irrespective of the path that the contraceptive challenges ultimately take, important questions addressed in the chapters that follow remain open, including how far the government must and should go to accommodate religious believers in the health care sphere and beyond. The volume begins with several chapters that frame the issues and explain what is and was at stake in the contraceptive litigation, comprising Part I of the book, Testing the Scope of Legal Protections for Religion in the Health Care Context.

Douglas Laycock, a leading scholarly voice in religious freedom debates, argues that much of the scholarly and popular discussion of *Hobby Lobby* and *Zubik* is misguided. He defends *Hobby Lobby* as a narrow decision but is skeptical of the claim for accommodation in *Zubik*. His chapter, *Religious Liberty, Health Care, and the Culture Wars*, tries to divide the world between "real issues" – for example, religious pharmacists who face demands for emergency contraception and religious schools that seek to terminate the employment of individuals who use in vitro fertilization – and "hypothetical issues" envisioned by Justice Ginsburg in dissent in *Hobby Lobby* and by others that he claims "have never happened, and are not likely to happen."

[38] U.S. Dep't of Labor, Employee Benefits Security Administration, *FAQs About Affordable Care Act Implementation* Part 36 (January 9, 2017), available at www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf.

In this category, he argues, are employers refusing to insure blood transfusions, antidepressants, vaccinations, and the like. Along the way he discusses duties to refer on the part of religious physicians and issues relating to religious hospital concentration in a market.

In *From* Smith *to* Hobby Lobby: *The Transformation of the Religious Freedom Restoration Act, Diane L. Moore and Eric M. Stephen next explore the social and political shifts that took place between RFRA's passage in 1993 and the Hobby Lobby* ruling in 2014. Adopting a cultural studies lens, they argue that RFRA's ambiguity on what constitutes a compelling interest was not accidental but instead meant "to adapt and respond to ever changing understandings of rights and justice . . . allow[ing] for a multiplicity of interpretations to be produced whenever there exist differences of opinion over what should be considered socially just." Through a close examination of the alliances and litigation strategy giving rise to *Hobby Lobby*, they argue that the case and its progeny may best be understood as *both* a legal attempt to countenance developing theological understandings of complicity that have gained prominence due to several faith communities' rising anxieties over evolving social norms, *and also* a politically motivated attempt to mobilize those theological concerns in the interest of party politics and neoliberal economics.

Lawyers on opposing sides of the *Hobby Lobby* case and follow-on litigation square off in the chapters that follow. First, Adèle Keim, Counsel for the Becket Fund for Religious Liberty, argues that religious diversity is good for American health care and that the "background legal principles that have allowed religiously-motivated health care to serve so many people so effectively for so long" are worth defending. Her chapter, *The HHS Mandate Litigation and Religious Health Care Providers*, focuses on the third-party harm arguments raised by the government and others in the litigation. She discusses shifts in the argument from *Hobby Lobby* to *Zubik* and ultimately maintains that these arguments fail "to account for the harm to patients and the broader community that would be caused by pushing religiously-motivated providers out of U.S. health care through inadequate respect for their religious conscience."

On the other side is Gregory M. Lipper, previously Senior Litigation Counsel at Americans United for Separation of Church and State. Lipper's chapter, *Not Your Father's Religious Exemptions: The Contraceptive-Coverage Litigation and the Rights of Others*, seeks to distinguish "garden-variety religious exemptions," such as the right to grow a beard or use certain burial rituals, which do not impose harms on third parties, from those required by *Hobby Lobby*, which he characterizes as providing "a free-exercise right to restrict the benefits and thus to control behavior of others – requiring exemptions that deprive tens of thousands of women of important medical coverage." He also argues that there were reasons to doubt the sincerity of the religious claims in the case, that the case and its progeny harm both women and religion, and that the (non)decision in *Zubik* is particularly troubling.

Finally, in *Recent Applications of the Supreme Court's Hands-Off Approach to Religious Doctrine: From* Hosanna-Tabor *and* Holt *to* Hobby Lobby *and* Zubik, Samuel J. Levine argues that the Supreme Court's hands-off approach to religious liberty claims explains the somewhat unsatisfying and often contentious nature of the Supreme Court's religious liberty cases, including challenges to the contraceptive mandate. While the religious liberty doctrine under the First Amendment and RFRA requires consideration of religious claims, the Court's hands-off approach simultaneously precludes judges from evaluating and deciding questions of religion. Levine shows that, in articulating hands-off approaches in recent cases, the Court has failed to clarify conceptual issues and to resolve practical problems and thus may have rendered religious liberty tests unworkable for the government and lower courts.

As this part shows, courts, policy makers, and members of the public continue to struggle over fundamental questions that implicate health – such as whether and to what extent participation in the health care or health insurance system makes one complicit in others' health care decisions; what it means for a law to substantially burden religious exercise; when and how religious beliefs can be accommodated so as to avoid harming third parties; and what these cases tell us about our employer-based health insurance system. The contraceptive litigation, however, is just the latest and most high-profile manifestation of the vast and deep intersection between law, religion, and health in the United States, which this book explores.

The remainder of the book is divided into parts relating to various institutions in the health care system (e.g., insurance, hospitals) and various areas of health law (e.g., reproductive rights and technologies, public health). Part II of the book, Law, Religion, and Health Care Institutions, is introduced with an essay by Christine Mitchell.

In Part II's first chapter, *A Corporation's Exercise of Religion: A Practitioner's Experience*, Sister Melanie Di Pietro seeks to press back against attempts to dilute the religious character of the religious nonprofit health care corporation. Using examples from a published case study of the SSM Health Care System, Di Pietro argues that a Roman Catholic religious health care corporation exercises religion because Catholic theology requires that "worship and sacrament are inseparable from service" and "is implemented in the structure and operation of the corporation whose theology of mission is openness to 'work in harmony with others' to serve persons wherever they are encountered." She argues for the importance of a legal framework that is sufficiently inclusive of the beliefs of adherents of those religious traditions that operate health care corporations.

In his chapter, *The Natural Person as the Limiting Principle for Conscience: Can a Corporation Have a Conscience If It Doesn't Have an Intellect and Will?*, Ryan Meade urges precision in the use of conscience-speak in contemporary discussions