WHEN RELIGION HIJACKS HEALTHCARE: A CONGRESSIONAL SOLUTION TO THE PROBLEM WITH RELIGIOUS SOLE COMMUNITY HOSPITALS

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The First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities.

Hand[1]

I. INTRODUCTION

Rural America makes up roughly twenty percent of the nation's population.[2] For rural Americans, healthcare is a limited resource.[3] Rural hospitals face significant financial constraints due to the smaller populations they serve and their lower economic status.[4] In response to this crisis, Congress enacted a statute providing additional federal funding to hospitals serving rural areas, provided they meet certain qualifying criteria.[5] These hospitals are called sole community hospitals.[6] Many sole

1. *Otten v. Balt. & Ohio R. Co.,* 205 F.2d 58, 61 (2d Cir. 1953).

2. AM. HOSP. ASSOC., RURAL REPORT (2019) [hereinafter RURAL REPORT], https://www.aha.org/system/files/2019-02/rural-report-2019.pdf. [https://web.archive.org/web/20210318222245/https://www.aha.org/system/files/2019-02/rural-report-2019.pdf].

3. Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, ASSOC. OF AM. MED. COLLS. (Oct. 31, 2017), https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities [https://web.archive.org/web/20210325021509/https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities].

4. Phil McCausland, *Rural Hospital Closings Cause Mortality Rates to Rise, Study Finds*, NBC NEWS (Sept. 6, 2019, 10:23 AM), https://www.nbcnews.com/news/us-news/rural-hospital-closings-cause-mortality-rates-rise-study-finds-n1048046 [https://web.archive.org/web/20210325021906/https://www.nbcnews.com/news/us-news/rural-hospital-closings-cause-mortality-rates-rise-study-finds-n1048046].

5. 42 C.F.R. § 412.92 (2020).

6. *Id.*

community hospitals are religious hospitals, and, as such, are excused from providing certain medical services due to their religious affiliations.[7]

However, problems with these exemptions arise because these hospitals service roughly twenty percent of the American populace, most of whom are unable to receive healthcare anywhere else.[8] These hospitals may refuse to provide medical care such as contraceptive and abortion services due to their religious beliefs, despite the Supreme Court determining that access to these services constitutes a fundamental right under the Constitution.[9] Combating this problem provides its own issues because it considers two conflicting constitutional rights: the hospitals' rights under the Religion Clauses of the First Amendment[10] and the patients' fundamental rights as determined by the Supreme Court.[11]

This Note proposes that the most appropriate solution to this problem is through congressional action. As this Note will show, Congress has the authority to place conditions on funding it provides to entities under its Spending Powers.[12] While there are limitations on what conditions Congress may impose on its funding recipients,[13] this Note argues that the fundamental rights at stake render these limitations inapplicable to religious sole community hospitals.[14] This Note further argues that the imposition of conditions requiring sole community hospitals who receive federal funding to provide contraceptive and abortion services does not violate the Free Exercise Clause[15] and is, indeed, required under the Establishment Clause.[16] Finally, this Note argues that, even absent congressional conditions, sole community hospitals should qualify as state actors,[17] who, under the Supreme Court's strict scrutiny and undue burden

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7. JULIA KAYE ET AL., AM. C.L. UNION, HEALTH CARE DENIED 24 (2016), https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied [https://web.archive.org/web/20210325024212/https://www.aclu.org/report/report-health-care-denied?redirect=report%2Fhealth-care-denied] [hereinafter ACLU REPORT]; 42 U.S.C. § 300a–7.

8. RURAL REPORT, *supra* note 2; *see also* Warshaw, *supra* note 3.

9. *See generally* Whole Women's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

10. U.S. CONST. amend. I; South Dakota v. Dole, 483 U.S. 203 (1987).

11. *See generally Hellerstedt*, 136 S.Ct. 2292; *Casey*, 505 U.S. 833; *Roe*, 410 U.S. 113; *Eisenstadt*, 405 U.S. 438; *Griswold*, 381 U.S. 479.

12. *See infra* Part III.A.

13. *See, e.g.,* Nat'l. Fed'n. of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

14. *See infra* Part III.A.1.

15. *See infra* Part III.A.2.

16. *See infra* Part III.B.

17. *See infra* Part III.C.

tests,[18] violate the constitutional rights of their patients in refusing to provide contraceptive and abortion services.[19]

Part II of this Note discusses: (1) the requirements to be classified as—and the federal funding provided to—sole community hospitals; (2) how many of these hospitals claim religious exemptions; and (3) Congress's constitutional authority to impose conditions on the funds it provides to these hospitals. Part III analyzes: (1) the application of Congress's Article I powers to impose such conditions; (2) the different constitutional rights at stake between the hospitals and their patients; and (3) the hospitals' independent obligations to provide these services to their patients absent congressional conditions. Part IV concludes by recommending that Congress amend its statute funding sole community hospitals to include conditions requiring that these hospitals provide fundamental healthcare such as contraceptive and abortion services.

II. BACKGROUND

A. Sole Community Catholic Hospitals

Rural areas in the United States often suffer from inadequate healthcare as compared to their more developed counterparts.[20] Due to distance, time, and socioeconomic constraints, patients in these areas often have the choice of only one healthcare provider.[21] A lone hospital that serves these patients is a sole community hospital.[22] The Centers for Medicare and Medicaid Services have defined these hospitals as those located more than thirty-five miles from other like hospitals, or those located in rural areas that meet different distance, capacity, or other accessibility restraints.[23] Because of limited resources, these hospitals receive additional governmental funding to promote rural area access to healthcare.[24]

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18. *See, e.g.*, Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833 (1992) (establishing the undue burden test for abortion restrictions); Eisenstadt v. Baird, 405 U.S. 438 (1972) (utilizing the strict scrutiny test regarding contraception bans).

19. *See infra* Part III.C.2.

20. Warshaw, *supra* note 3.

21. Lori Freedman, *Dispelling Six Myths About Catholic Hospital Care in the United States*, REWIRE NEWS (June 24, 2014 3:03 PM), https://rewire.news/article/2014/06/24/dispelling-six-myths-catholic-hospital-care-united-states/ [https://web.archive.org/web/20210325034330/https://rewirenewsgroup.com/article/2014/06/24/dispelling-six-myths-catholic-hospital-care-united-states/].

22. 42 C.F.R. § 412.92 (2020).

23. *Id.*

24. *Id.*

Despite increased governmental funding, rural hospital closures have been on the rise.[25] Hospitals in rural areas have suffered more than their metropolitan counterparts, particularly due to job losses of local residents, resulting in the working population emigrating to more lucrative areas.[26] This has resulted in rural hospitals serving shrinking communities comprised of those who did not leave seeking employment—most notably the elderly and ill—for whom the cost of care is generally higher.[27] However, while secular rural hospitals have seen increased closures, Catholic hospitals operating as sole community hospitals have not.[28] According to experts, this endurance can be at least somewhat attributed to Catholic hospitals' nonprofit status, financial backers, and heightened efficiency.[29] As more secular rural hospitals close, sole community Catholic hospitals are becoming more prevalent, with the American Civil Liberties Union (ACLU) identifying forty-six Catholic sole community hospitals in March 2016,[30] this number having grown from an estimated twenty-nine in 2011.[31]

B. Religious Exceptions for Catholic Hospitals

The Supreme Court has carved out various exceptions for religious entities with respect to the law.[32] In *Hosanna-Tabor Evangelical Lutheran Church and School v. E.E.O.C.*, the Court expanded the ministerial exception from protecting only the head of a religious organization to protecting any employee qualifying as a minister.[33] As a reaction to the Affordable Care Act's contraception mandate,[34] the Supreme Court, in *Burwell v. Hobby Lobby,* held that the Affordable Care Act's mandate violated the Religious Freedom Restoration Act (RFRA) as applied to closely held corporations like Hobby Lobby because it impinged on the

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25. McCausland, *supra* note 4.

26. *Id.*

27. *Id.*

28. Anna Maria Barry-Jester & Amelia Thomson-DeVeaux, *How Catholic Bishops Are Shaping Health Care In Rural America*, FIVETHIRTYEIGHT (July 25, 2018), https://fivethirtyeight.com/features/how-catholic-bishops-are-shaping-health-care-in-rural-america/ [https://web.archive.org/web/20210325034515/https://fivethirtyeight.com/features/how-catholic-bishops-are-shaping-health-care-in-rural-america/].

29. *Id.*

30. ACLU REPORT, *supra* note 7.

31. Barry-Jester & Thomson-DeVeaux, *supra* note 28.

32. *See, e.g.*, Hosanna-Tabor Evangelical Lutheran Church and Sch. v. E.E.O.C., 565 U.S. 171 (2012); Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

33. *Hosanna*, 565 U.S. at 190.

34. *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111–148, 124 Stat. 119 (2010) [hereinafter Affordable Care Act].

religious beliefs of Hobby Lobby's owners.[35] Additionally, the Trump administration made efforts to expand these religious protections further, particularly as they apply to LGBTQ rights.[36]

The most notable religious protection legislation in the healthcare context comes in the form of conscience legislation.[37] Various states have their own versions of conscience clauses,[38] but the general idea is that these laws allow healthcare providers to refuse to provide certain services based on their religious or moral beliefs.[39] Congress passed its first conscience clause in 1973.[40] Known as the Church Amendment, the clause's enactment was a swift congressional reaction to the Supreme Court's ruling in *Roe v. Wade*.[41] While the primary scope of conscience clauses prevented federal and state governments from forcing healthcare providers to provide abortion services, both state and federal laws have expanded over the years to cover issues like the provision of contraception.[42]

These conscience clauses create an unavoidable conundrum for patients of Catholic hospitals because most Catholic hospitals do not publicly disclose what services they will and will not provide.[43] As Catholic hospitals permeate the American healthcare system through mergers, more American patients must navigate the complex balancing of their rights as patients with the religious rights of their hospital.[44] As of

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35. *Burwell*, 573 U.S. at 736.

36. Eugene Scott, *Once Again In the Trump Administration, Religious Freedom Trumps LGBT Rights*, WASH. POST (Nov. 5, 2019 10:43 AM), https://www.washingtonpost.com/politics/2019/11/05/once-again-trump-administration-religious-freedom-trumps-lgbt-rights/ [https://web.archive.org/web/20210325034814/https://www.washingtonpost.com/politics/2019/11/05/once-again-trump-administration-religious-freedom-trumps-lgbt-rights/].

37. U.S. DEP'T OF HEALTH & HUM. SERVS., CONSCIENCE PROTECTIONS FOR HEALTHCARE PROVIDERS (Mar. 22, 2018), https://www.hhs.gov/conscience/conscience-protections/index.html [https://web.archive.org/web/20210325042417/https://www.hhs.gov/conscience/conscience-protections/index.html] [hereinafter HHS].

38. *See, e.g.*, ARK. CODE ANN. § 20-16-304 (2016); GA. CODE ANN. § 16-12-142 (2006); UTAH CODE ANN. § 76-7-306 (West 2011); WASH. REV. CODE § 48.43.065 (2006).

39. HHS, *supra* note 37.

40. 42 U.S.C. § 300a-7.

41. JODY FEDER, CONG. RES. SERV., RS21428, THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS (2005).

42. *Id.*

43. Harris Meyer, *Most Catholic Hospitals Don't Disclose Religious Care Restrictions*, MODERN HEALTHCARE (Mar. 15, 2019 11:29 AM), https://www.modernhealthcare.com/operations/most-catholic-hospitals-dont-disclose-religious-care-restrictions [https://web.archive.org/web/20210326021201/https://www.modernhealthcare.com/operations/most-catholic-hospitals-dont-disclose-religious-care-restrictions].

44. Katie Hafner, *As Catholic Hospitals Expand, So Do Limits on Some Procedures*, N.Y. TIMES (Aug. 10, 2018), nytimes.com/2018/08/10/health/catholic-hospitals-

March 2016, the ACLU estimated that one in six hospital patients in the United States is treated in a Catholic hospital.[45]

C. The Spending Powers

Congress has the power to "provide for the common Defence and general Welfare of the United States . . . ."[46] Black's Law Dictionary defines general welfare as "[t]he public's health, peace, morals, and safety."[47] However, congressional spending power is not absolute.[48] The Supreme Court has placed various limitations on Congress's spending power.[49] The Court has established that congressional spending must: (1) be for the general welfare; (2) have conditions that are unambiguous; (3) relate to a federal interest in nationwide programs or projects; and (4) be constitutional.[50]

In *National Federation of Independent Business v. Sebelius*, the Supreme Court struck down the Affordable Care Act's Medicaid expansion as a violation of Congress's spending powers.[51] The Court held that, while Congress may withhold federal funding for a specific program absent compliance of certain conditions in exercising that program, it may not withhold funds from one program to obtain compliance regarding a completely separate program.[52] The Court determined that the new Medicaid expansion was a program independent of the old Medicaid program and held that Congress could not withhold funding from the old program to ensure compliance with the new program.[53]

D. The First Amendment

The First Amendment states that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . ."[54] Known respectively as the Establishment and Free Exercise Clauses, they were introduced in the Bill of Rights to protect the newborn

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procedures.html [https://web.archive.org/web/20210315003731/https://www.nytimes.com/2018/08/10/health/catholic-hospitals-procedures.html].

45. ACLU REPORT, *supra* note 7, at 22.
46. U.S. CONST. art. I, § 8, cl. 1.
47. *Welfare*, BLACK'S LAW DICTIONARY (11th ed. 2019).
48. South Dakota v. Dole, 483 U.S. 203 (1987).
49. *Id.*
50. *Id.* at 207–08.
51. Nat'l. Fed'n. of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).
52. *Id.* at 585.
53. *Id.*
54. U.S. CONST. amend. I.

United States from the horrors of religious wars that had plagued the world.[55]

1. The Free Exercise Clause

The Free Exercise Clause provides citizens with the right to practice their religion without governmental interference.[56] Most notably, this clause introduced the need for certain exemptions from certain mandates due to religion.[57] Originally, there were not many issues that gave rise to a need for religious exemptions.[58] Additionally, until the ratification of the Fourteenth Amendment, the First Amendment applied only to the federal government,[59] but most states had a version of the Free Exercise Clause in their own constitutions as well.[60] However, while most antebellum citizens had recourse for infringements on their religious practices through their state constitutions, these issues rarely came to light in the courts.[61] The nature of the United States governments—both federal and state—was much more limited in scope than it is today, so there was much less need for protection from governmental intrusion.[62]

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55. The split of Christianity into Protestantism and Catholicism based on criticism of the Catholic Church by Martin Luther and John Calvin led to various, incredibly bloody confrontations between the sects. *See generally* W. M. FLINDERS, ET AL., THE BOOK OF HISTORY A HISTORY OF ALL NATIONS FROM THE EARLIEST TIMES TO THE PRESENT 4149–56 (1915). Europe in the Sixteenth Century was plagued with wars over religion, including the Thirty Years' War, which resulted in massive casualties. P.C., *What happened in the Thirty Years War?*, ECONOMIST (Jan. 17, 2016), https://www.economist.com/the-economist-explains/2016/01/17/what-happened-in-the-thirty-years-war [https://web.archive.org/web/20210326022518/https://www.economist.com/the-economist-explains/2016/01/17/what-happened-in-the-thirty-years-war]. Henry VIII's creation of the Anglican Church led to further religious violence, ultimately resulting in the Puritans fleeing England for the Americas. *See generally*, *Religion and the Founding of the American Republic*, LIBR. OF CONG. (Feb. 1, 2020 5:34 PM), https://www.loc.gov/exhibits/religion/rel01.html [https://web.archive.org/web/20210326022740/https://www.loc.gov/exhibits/religion/rel01.html.

56. U.S. CONST. amend. I.

57. *See generally* Sherbert v. Verner, 374 U.S. 398 (1963).

58. John Yoo & James C. Phillips, *More on the Free-Exercise Clause and Religious Exemptions*, NAT'L REV. (Dec. 12, 2018), https://www.nationalreview.com/2018/12/constitution-free-exercise-of-religion-clause-exemptions/ [https://web.archive.org/web/20200221004719/https://www.nationalreview.com/2018/12/constitution-free-exercise-of-religion-clause-exemptions/].

59. U.S. CONST. amend. XIV.

60. MCCONNELL ET AL., RELIGION AND THE CONSTITUTION 4 (Erwin Chemerinsky et al. eds., 4th ed. 2016) (noting that in 1790, all but one state had their own version of the Free Exercise Clause in their state constitutions).

61. Yoo & Phillips, *supra* note 58.

62. *Id.*

As the government and the nation grew, conflicts arising from religious exercise increased.[63] In facing these conflicts, the Supreme Court's initial approach was to adopt a compelling interest test.[64] The compelling interest test required the government to show a compelling interest before burdening a citizen's free exercise of his or her religion and that the measures it took were the least restrictive means of achieving that interest.[65]

However, the Court eliminated the compelling interest test in *Employment Division, Department of Human Resources of Oregon v. Smith*.[66] In *Smith*, an Oregon state law prohibited the intentional possession of a controlled substance that had not been medically prescribed.[67] This resulted in members of the Native American Church losing their jobs and being denied unemployment after ingesting sacramental peyote.[68] The Court held that a state may constitutionally enact neutral rules that may have the effect of impacting, limiting, or punishing religiously mandated behavior so long as the state does not do so with the intention of hurting or otherwise impacting a religiously defined group.[69]

Reacting to *Smith*, Congress passed the Religious Freedom Restoration Act ("RFRA") in 1993.[70] RFRA codified the *Sherbert* rule requiring that any burden on religious exercise be the least restrictive means of attaining a compelling interest.[71] While the Court, in *City of Boerne v. Flores*, held RFRA unconstitutional as applied to the states,[72] RFRA remains in effect federally,[73] with many states enacting similar versions themselves.[74]

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63. *Id.*

64. *See generally* Sherbert v. Verner, 374 U.S. 398 (1963); Wisconsin v. Yoder, 406 U.S. 205 (1972).

65. *Sherbert*, 374 U.S. 398.

66. Emp't Div., Dep't of Human Res. of Oregon v. Smith, 494 U.S. 872, 884 (1990).

67. *Id.* at 874.

68. *Id.*

69. *Id.* at 885–86

70. James E. Ryan, *Smith and the Religious Freedom Restoration Act: An Iconoclastic Assessment*, 78 VA. L. REV. 1407, 1411 (1992).

71. Religious Freedom Restoration Act of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (1993) [Hereinafter RFRA].

72. City of Boerne v. Flores, 521 U.S. 507 (1997).

73. *Federal Religious Freedom Restoration Act Overview*, FINDLAW (Nov. 16, 2019 8:09 PM), https://civilrights.findlaw.com/discrimination/federal-religious-freedom-restoration-act-overview.html [https://web.archive.org/web/20210318054225/https://civilrights.findlaw.com/discrimination/federal-religious-freedom-restoration-act-overview.html].

74. *Id.*

2. The Establishment Clause

Acting alongside the Free Exercise Clause, the Establishment Clause forbids the government from promoting or inhibiting a religion.[75] In this respect, the Supreme Court has held that a government action is unconstitutional under the Establishment clause unless it: (1) has a secular purpose; (2) has a primary or principal effect that does not advance or inhibit religion; and (3) does not nurture excessive governmental interaction with religion.[76] The Court later combined prongs (2) and (3) into one prong, requiring that the action have a secular purpose and not have a primary effect of advancing or inhibiting religion.[77]

While there has been no specific case law on religious hospitals, the Supreme Court held, in *Locke v. Davey,* that a state may constitutionally refuse to grant a governmentally funded scholarship to a student pursuing a theology degree under the Establishment Clause.[78] The Court noted that while the State of Washington was applying its own version of the Establishment Clause under its own constitution, not the First Amendment, the two clauses were substantially similar.[79] Therefore, the Court reasoned, the state had a substantial interest in not funding theology degrees out of concern for violating its Establishment Clause, while the failure to receive funding was a relatively minor burden on the students it impacted.[80] The Court, in *Locke*, also addressed the issue regarding the "play in the joints" between the Free Exercise and Establishment Clauses.[81] Introduced over three decades earlier, the concept of the "play in the joints" considers whether a governmental action that is permitted under the Establishment Clause is therefore required under the Free Exercise Clause.[82]

Fleshing out the relationship between the Religion Clauses further, the Court, in *Cutter v. Wilkinson*, established a three-pronged test in determining whether a governmental religious accommodation violates the Establishment Clause.[83] In *Cutter*, the Court addressed a facial challenge to the Religious Land Use and Institutionalized Persons Act ("RLUIPA"), holding that the Act did not violate the Establishment

75. U.S. CONST. amend I.
76. Lemon v. Kurtzman, 403 U.S. 602, 612–13 (1971).
77. Agostini v. Felton, 521 U.S. 203, 232–33 (1997).
78. Locke v. Davey, 540 U.S. 712, 724 (2004).
79. *Id.* at 719.
80. *Id.* at 725.
81. *Id.* at 718.
82. *Id.* (citing Walz v. Tax Comm'n of City of New York, 397 U.S. 664, 669 (1970)).
83. Cutter v. Wilkinson, 544 U.S. 709, 720 (2005).

Clause.[84] In so holding, the Court noted that legislative accommodations to religion are consistent with the Establishment Clause if they: (1) alleviate government-created burdens on private religious exercise; (2) do not impose an excessive burden on third parties; and (3) treat all faiths neutrally.[85]

E. Fundamental Rights in Healthcare

The concept of fundamental rights and substantive due process came to the foreground of American jurisprudence in *Lochner v. New York*.[86] In *Lochner*, the Court held that the right to contract was one that prevailed over the state's police power.[87] While *Lochner* did not expressly use the term "fundamental right," the decision implied the concept.[88] However, the concept of fundamental rights in *Lochner* is significantly different from the prevailing present view.[89] In the *Lochner* era, individual rights were whatever remained outside the limits of the government's power, the understanding being that there are certain natural rights which people may claim beyond what the Constitution provides.[90] The Court in *Lochner*, however, also believed that these rights sometimes must make way for certain governmental interests such as the common welfare.[91]

Following *Lochner*, the Court began to evolve its concept of fundamental rights over the next half-century.[92] Eventually, the Court developed a test when approaching government imposition on fundamental rights: strict scrutiny.[93] Until now, the only time the Court has held this test inapplicable to a fundamental right is with regard to abortion, where the Court introduced the undue burden test.[94] These tests analyze whether the government has acted unconstitutionally when it imposes on a fundamental right.[95] Among these fundamental rights is the

84. *Id.*
85. *Id.*
86. Lochner v. New York, 198 U.S. 45 (1905).
87. *Id.* at 65.
88. *See generally* Victoria F. Nourse, *A Tale of Two Lochners: The Untold History of Substantive Due Process and the Idea of Fundamental Rights*, 97 CAL. L. REV. 751 (2009).
89. *Id.* at 752.
90. Edward S. Corwin, *The "Higher Law" Background of American Constitutional Law*, 42 HARV. L. REV. 149, 167 (1928).
91. *Lochner*, 198 U.S. at 53.
92. *See* Adam B. Wolf, *Fundamentally Flawed: Tradition and Fundamental Rights*, 57 U. MIAMI L. REV. 101, 109 (2002).
93. *See* United States v. Carolene Prods. Co., 304 U.S. 144, 152 n.4 (1938).
94. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874 (1992).
95. *See* Wolf, *supra* note 92.

right to privacy, which has been construed to include the rights to contraception and abortion.[96]

1. The Right to Contraception

In 1965, the Supreme Court in *Griswold v. Connecticut* held that there is a zone of privacy preceding the Bill of Rights that precludes a state from enacting laws preventing married couples from using contraception.[97] In *Griswold*, the State of Connecticut enacted statutes preventing the use of contraception or assisting others in its use.[98] Police arrested Griswold and Buxton for providing medical advice to married couples regarding contraception.[99] In his concurrence, Justice Goldberg noted that when it comes to fundamental rights, states must meet a higher bar than the standard rational basis test.[100]

Continuing the analysis of the right to contraception as a fundamental right to privacy, the Supreme Court next addressed the right of unmarried individuals to contraception.[101] In *Eisenstadt v. Baird*, the Court addressed a Massachusetts statute criminalizing the distribution of contraception to unmarried individuals.[102] The Court held that the dissimilar treatment of married and nonmarried people was unconstitutional under the Fourteenth Amendment's Equal Protection Clause.[103] The Court argued that *Griswold* was not solely carving out an exception for married couples but was addressing the larger issue of the right of the individual to privacy.[104] The Court also noted that the use of contraception is not solely for family planning but also to prevent disease, which is outside the scope of the marital relationship.[105]

The Court cemented the understanding of the right to contraception as a fundamental right in *Carey v. Population Services International*.[106] In *Carey*, the Court held that a New York statute criminalizing the distribution of contraceptives to minors under sixteen-years-old was

96. *See generally* Whole Women's Health v. Hellerstedt, 136 S.Ct. 2292 (2016); *Casey*, 505 U.S. 833; Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

97. *Griswold*, 381 U.S. at 485.

98. *Id.* at 480.

99. *Id.*

100. *Id.* at 497 (Goldberg, J., concurring).

101. *See generally Eisenstadt*, 405 U.S. 438; Carey v. Population Servs. Int'l, 431 U.S. 678 (1977).

102. *Eisenstadt*, 405 U.S. at 440–41.

103. *Id.* at 447.

104. *Id.* at 448–49.

105. *Id.* (quoting *Griswold*, 381 U.S. at 498 (Goldberg, J., concurring)).

106. *Carey*, 431 U.S. 678.

unconstitutional.[107] The Court acknowledged that while the government may exert more control over minors than adults, the right to privacy regarding contraception applies to minors as well.[108]

2. The Right to an Abortion

From the eighteenth to nineteenth centuries, the common law was that abortions prior to "quickening" were legal.[109] Quickening was a term used to describe when movement could be felt in utero.[110] This was often found to be around the fourth month of the pregnancy.[111] No one, including the Catholic Church, believed there was life between conception and quickening.[112] After quickening, there was a moral obligation to have the baby.[113] The most common method of aborting pregnancies pre-quickening was the use of commercialized drugs.[114] In fact, the first statutes enacted addressing abortion were for poison control, since these drugs often resulted in the death of those who took them.[115]

In 1857, the American Medical Association (AMA) lobbied to criminalize abortion at any stage of pregnancy.[116] The initial push by the AMA was the desire to gain the upper hand against competing abortion providers, but the criminalization of abortion gained momentum through gender, socioeconomic, and racial tensions.[117] There was also fear that white Protestants were not having enough children and would become a minority.[118] Doctors began discrediting quickening as the benchmark for the establishment of life, arguing that relying on quickening made the parent, and not the doctor, the diagnostician.[119]

As a result of the AMA's lobbying, new abortion laws swept the country from 1860 to 1880, taking a completely different approach to abortion than the common law had before them.[120] These laws generally eliminated the notion of quickening and banned abortion at any stage of a

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107. *Id.* at 681–82.
108. *Id.* at 692–93.
109. LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867–1973 8 (1997).
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.* at 9.
114. *Id.*
115. *Id.* at 10.
116. *Id.*
117. *Id.* at 11.
118. *Id.*
119. *Id.* at 12.
120. *Id.* at 13.

pregnancy.[121] Some of these laws also punished those who had the procedures.[122] Despite their wide-reaching preclusions, however, these laws still permitted physician-performed therapeutic abortions to protect the life of the parent.[123] Over the next century, abortions became more regulated as their provision was relocated from the home to the hospital.[124] As the demand for better abortion access grew, states increased their restrictions.[125]

Eventually, the abortion debate made its way to the Supreme Court in *Roe v. Wade*.[126] In *Roe*, Roe challenged a Texas statute forbidding abortions except to save the parent's life.[127] The Court held that the fundamental right to privacy encompasses the right to have an abortion.[128] The Court argued that while Texas may have a compelling interest in the life of the fetus, there are multiple theories as to when life begins and Texas cannot use only one of those theories, without more, to override the rights of a pregnant individual.[129] The Court, in *Roe*, held that states may regulate abortions after the first trimester and ban them after the point of viability, absent the need to protect the health of the parent.[130]

Several state legislatures tried to restrict the holding in *Roe*, but the Supreme Court continually struck them down.[131] The Supreme Court ultimately readdressed *Roe* in *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992.[132] In *Casey*, Planned Parenthood challenged five abortion restrictions under Pennsylvania law.[133] Included in these restrictions were the requirement of a twenty-four-hour waiting period, informed consent of a parent for a minor, and the provision of notice by a married woman to her husband.[134] The Court upheld *Roe v. Wade* and held that the majority of the provisions were permissible but that the spousal notification requirement was not.[135] Here, the Court

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121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.* at 15.
125. *Id.*
126. Roe v. Wade, 410 U.S. 113 (1973).
127. *Id.* at 116.
128. *Id.* at 153.
129. *Id.* at 162.
130. *Id.* at 163.
131. *See generally* City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416 (1983); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976).
132. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).
133. *Id.* at 844.
134. *Id.*
135. *Id.* at 839–41.

established the undue burden test for use in abortion cases.[136] This test states that state regulation on abortion cannot place an undue burden on someone's right to one—that is, a regulation whose purpose or effect is to impose a substantial obstacle on someone seeking an abortion is invalid.[137] In *Whole Woman's Health v. Hellerstedt*, the Court doubled down on its undue burden test, holding that a state law requiring physicians that perform abortions have admitting privileges to nearby hospitals was unconstitutional.[138]

Despite still being considered good law, *Roe* currently faces another wave of state challenges with the introduction of heartbeat bills.[139] These bills aim to make abortion illegal after the heartbeat of the fetus can be detected.[140] This often occurs in as little as six weeks into the pregnancy, meaning that some people will be banned from abortions before they even know they are pregnant.[141] Following the appointment of three conservative justices,[142] the general consensus is that the purpose of these bills is to reach the Supreme Court in an attempt to overthrow *Roe v. Wade* and eliminate access to abortion entirely.[143]

In light of the unique monopoly sole community hospitals have over their patients, this Note will discuss Congress's ability and duty to impose conditions on the funds it provides requiring that these hospitals provide fundamental healthcare services such as contraception and abortion.[144]

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136. *Id.* at 876.

137. *Id.* at 877.

138. Whole Woman's Health v. Hellerstedt, 136 S.Ct. 2292, 2313 (2016).

139. Maya Salam, *The Race to Limit Abortion Access*, N.Y. TIMES (May 10, 2019), https://www.nytimes.com/2019/05/10/us/abortion-laws-alabama-georgia.html [http://web.archive.org/web/20210512024505/https://www.nytimes.com/2019/05/10/us/abortion-laws-alabama-georgia.html].

140. *Id.*

141. Anna North & Catherine Kim, *The "Heartbeat" Bills That Could Ban Almost All Abortions, Explained*, VOX (June 28, 2019), https://www.vox.com/policy-and-politics/2019/4/19/18412384/abortion-heartbeat-bill-georgia-louisiana-ohio-2019 [https://web.archive.org/web/20210420154415/https://www.vox.com/policy-and-politics/2019/4/19/18412384/abortion-heartbeat-bill-georgia-louisiana-ohio-2019]. Despite the lull in this legislation in 2020, these bills show no signs of stopping, with the latest bill as of this writing being South Carolina's heartbeat bill enacted February 18, 2021. Amanda Watts & Caroline Kelly, *South Carolina Governor Signs Bill Prohibiting Most Abortions When a Fetal Heartbeat is Detected*, CNN (Feb. 18, 2021), https://www.cnn.com/2021/02/18/politics/south-carolina-abortion/index.html [https://web.archive.org/web/20210408042416/https://www.cnn.com/2021/02/18/politics/south-carolina-abortion/index.html].

142. Anita Kumar, *Trump's Legacy is Now the Supreme Court*, POLITICO (Sept. 26, 2020), https://www.politico.com/news/2020/09/26/trump-legacy-supreme-court-422058 [https://web.archive.org/web/20210403192504/https://www.politico.com/news/2020/09/26/trump-legacy-supreme-court-422058].

143. Salam, *supra* note 139.

144. *See infra* Parts III.A–B.

The challenges religious sole community hospitals will raise against such conditions will be addressed specifically because of the disparate impact such conditions will have on religious and non-religious sole community hospitals.[145] Furthermore, this Note argues that sole community hospitals should be treated as state actors due to the monopoly and crucial nature of their positions when considering their patients' right to contraception and abortion.[146]

III. ANALYSIS

A. Congress Has Authority Under the Spending Clause to Require that Sole Community Hospitals Provide Fundamental Medical Care

Under its spending powers, Congress has the authority to condition the funds it provides to sole community hospitals upon their provision of fundamental medical care.[147] *South Dakota v. Dole* enunciated the prevailing test for determining whether congressional action is within its spending powers.[148]

1. The Dole Test

In 1987, the Supreme Court introduced the rule for determining whether congressional action exceeds its spending powers under the Constitution.[149] In *Dole*, the Court adopted a four-pronged test to this end.[150] Under the *Dole* test, congressional spending must: (1) be for the general welfare; (2) have unambiguous conditions; (3) be related to a federal interest in nationwide programs; and, of course, (4) be constitutional.[151] Congressional conditions on funding to sole community hospitals pass muster under the *Dole* test, satisfying all four elements.

i. The General Welfare

Black's Law Dictionary describes general welfare as "[t]he public's health, peace, morals, and safety."[152] Sole community hospitals, religious

145. *See infra* Part III.A.2.
146. *See infra* Part III.C.
147. The term "fundamental medical care" will be used to describe those medical services to which access has been deemed a fundamental right by the Supreme Court.
148. *See* South Dakota v. Dole, 483 U.S. 203 (1987).
149. *Id.*
150. *Id.*
151. *Id.* at 207–08.
152. *Welfare*, BLACK'S LAW DICTIONARY (11th ed. 2019).

or otherwise, are essential to the provision of adequate healthcare to underserved areas.[153] Federal funding of these hospitals helps bridge the gap between the level of care these hospitals provide to their patients and that of a metropolitan hospital.[154] While disparities exist even with federal subsidies, without them, these hospitals would be doomed.[155] Rural areas account for roughly twenty percent of the American population.[156] The failure of these hospitals would leave this twenty percent without readily-accessible, adequate healthcare. The use of federal funds to help these hospitals survive is, therefore, explicitly promoting the general welfare as it pertains to public health.

Additionally, the lack of access to abortion and contraceptive services directly impairs the general welfare because the absence of these services leads people to turn to "back-alley" abortions and black-market contraceptives.[157] Numerous studies have shown that decreasing access to abortion services does not decrease the actual rate of abortions.[158] In fact, evidence shows that the steady decline the United States has seen in

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153. Sharita R. Thomas et al., *The Financial Importance of the Sole Community Hospital Payment Designation*, NC RURAL HEALTH RSCH. PROGRAM (Nov. 2016), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/11/SCH-Financial-Importance-1.pdf [https://web.archive.org/web/20210420154619/https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/11/SCH-Financial-Importance-1.pdf].

154. Warshaw, *supra* note 3 (explaining that healthcare in rural areas is often substandard compared to metropolitan counterparts due to a lack of resources).

155. *See* Guy Gugliotta, *Rural Hospitals, Beset By Financial Problems, Struggle to Survive*, WASH. POST (Mar. 15, 2015), https://www.washingtonpost.com/national/health-science/rural-hospitals-beset-by-financial-problems-struggle-to-survive/2015/03/15/d81af3ac-c9b2-11e4-b2a1-bed1aaea2816_story.html [https://www.washingtonpost.com/national/health-science/rural-hospitals-beset-by-financial-problems-struggle-to-survive/2015/03/15/d81af3ac-c9b2-11e4-b2a1-bed1aaea2816_story.html].

156. RURAL REPORT, *supra* note 2.

157. *See generally* Olga Khazan, *When Abortion Is Illegal, Women Rarely Die. But They Still Suffer.*, ATLANTIC (Oct. 11, 2018), https://www.theatlantic.com/health/archive/2018/10/how-many-women-die-illegal-abortions/572638/ [https://web.archive.org/web/20210408173633/https://www.theatlantic.com/health/archive/2018/10/how-many-women-die-illegal-abortions/572638/]; Catherine New, *Craigslist Contraception: Women Pushed To Buy Birth Control On Black Market*, HUFFPOST (Mar. 9, 2012), https://www.huffpost.com/entry/craigslist-contraception_n_1326743 [https://web.archive.org/web/20210420155116/https://www.huffpost.com/entry/craigslist-contraception_n_1326743].

158. Elizabeth Nash & Joerg Dreweke, *The U.S. Abortion Rate Continues to Drop: Once Again, State Abortion Restrictions Are Not the Main Driver*, GUTTMACHER INST. (Sept. 18, 2019), https://www.guttmacher.org/gpr/2019/09/us-abortion-rate-continues-drop-once-again-state-abortion-restrictions-are-not-main [https://web.archive.org/web/20210417031316/https://www.guttmacher.org/gpr/2019/09/us-abortion-rate-continues-drop-once-again-state-abortion-restrictions-are-not-main].

abortions is simply due to a decrease in pregnancies.[159] While there are multiple factors that can contribute to this phenomenon, access to contraception is likely a key player.[160] Limiting access to safe abortions leads desperate people towards unsafe procedures.[161] Statistics show that somewhere between eight and eleven percent of pregnancy-related deaths are caused by botched abortions in countries that have made abortion illegal.[162]

The link between protecting pregnant people from harm, and thus promoting the general welfare, seems obvious. Easier access to safe abortions will lower the mortality rate of those seeking abortions, and easier access to contraception will not only decrease complications from fake birth control but will also decrease the need for abortions to begin with.

ii. Unambiguous Conditions

In requiring that conditions be unambiguous, *Dole* aims to give the recipients of conditional funds the chance to exercise a choice and understand the consequences of their actions.[163] By requiring that religious sole community hospitals provide specific, enumerated services, this test is satisfied.[164] In putting this condition on these hospitals, the federal government is providing these hospitals with the clear choice: accept the funds and provide what the Supreme Court has deemed to be fundamental healthcare, or reject the funds to preserve the religious environment.

iii. Federal Interest in a Nationwide Program or Project

The nationwide program garnering federal interest in this case is the sole community hospital program itself.[165] The program was designed to decrease the disparities between rural and urban healthcare.[166] The ultimate goal is to provide adequate healthcare to the roughly twenty percent of Americans who live in rural areas and do not have easy access to metropolitan hospital systems.[167] This purpose is compromised when religious sole community hospitals are permitted to refuse to provide

159. *Id.*
160. *Id.*
161. Khazan, *supra* note 157.
162. *Id.*
163. South Dakota v. Dole, 483 U.S. 203, 207 (1987).
164. *See, e.g.*, *id.*
165. *See generally* 42 C.F.R. § 412.92 (2018).
166. Thomas, *supra* note 153.
167. RURAL REPORT, *supra* note 2.

abortion and contraceptive services. While the overall abortion rate in the United States has been steadily declining, this is not due to the increased difficulty Americans face in obtaining the procedure.[168] Instead, this is due to an overall decrease in pregnancy, which is likely a result of increased access to contraception.[169]

Allowing these hospitals to refuse to provide contraception leaves their patients with few options. By definition, these hospitals are the only substantial healthcare providers for miles in these areas, and most people in these rural areas have neither the time nor the means to make the significant trip to another provider to safely obtain these services.[170] This leaves those who do not wish to have a child with two main options: either they can obtain black market contraception that may not even work or they can get a "back-alley" abortion after becoming pregnant.[171]

The main issue with buying contraception from an unreliable source is that it could be fake.[172] While the issue of fake birth control is not as prevalent in the United States as some other countries, there are still risks.[173] The most obvious risk is that if the contraceptive does not work, the result is pregnancy.[174] This leads to the second, deadlier issue: back-alley abortions. Those without access to contraception are much more likely to get pregnant.[175] Furthermore, it has been shown that the lack of access to abortion is not the cause of their decrease in frequency.[176] Therefore, without access to a safe abortion, someone who becomes pregnant, whether it be due to fake contraceptives or otherwise, who does not want to have the child is likely to seek out illegal, far more dangerous alternatives to end the pregnancy.[177]

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168. Nash & Dreweke, *supra* note 158.

169. *Id.*

170. Tracee Saunders et al., *Variation in Title X Leads to Contraception Deserts*, GENDER POL'Y REP. (Aug. 14, 2018), https://genderpolicyreport.umn.edu/variation-in-title-x-leads-to-contraception-deserts/ [https://web.archive.org/web/20210205004442/https://genderpolicyreport.umn.edu/variation-in-title-x-leads-to-contraception-deserts/].

171. New, *supra* note 157; Khazan, *supra* note 157.

172. Bedsider, *Black Market Birth Control? Let's Go With No…*, BEDSIDER (May 29, 2012), https://www.bedsider.org/features/225-black-market-birth-control-let-s-go-with-no [https://web.archive.org/web/20210420155501/https://www.bedsider.org/features/225-black-market-birth-control-let-s-go-with-no].

173. *Id.*

174. *Id.*

175. *Family planning/Contraception*, WORLD HEALTH ORG. (Feb. 8, 2018), https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception [https://web.archive.org/web/20210420155546/https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception].

176. Nash & Dreweke, *supra* note 158.

177. Geoffrey R. Stone, *Here's What Life Was Like for American Women in America Before* 'Roe v. Wade', DAILY BEAST (Jul. 10, 2018), https://www.thedailybeast.com/heres-

The end-result of these hospitals refusing to provide contraceptive and abortion services is that pregnant people will be seriously harmed or killed through seeking alternate means to prevent or end unwanted pregnancies. The sole community hospital program's entire purpose is to provide sufficient healthcare options to people in rural areas.[178] Allowing these hospitals to refuse to provide two fundamental services that are far more available in metropolitan areas, exposing their patients to heightened risk because of it, defeats this purpose.

iv. Constitutional

Supreme Court jurisprudence has held that access to contraception and abortion are fundamental rights under the Constitution.[179] In this situation, these rights come into direct conflict with the First Amendment rights of religious sole community hospitals to free exercise of religion.[180] Further, the question about whether Congress is "respecting an establishment of religion" comes into play as well.[181]

2. The Free Exercise Clause

There are two ways that Congress can address the issue of Free Exercise as applied to conditional funds to religious sole community hospitals. The first is by proving that, under RFRA, the religious sole community hospitals' First Amendment rights were not violated. The second is by including a clause in the statute amendment proposed by this Note requiring these hospitals to provide these services stating that RFRA does not apply. While the second approach is clearly much simpler, it is possible that Congress would be hesitant to include such a provision for fear of beginning a steady process of chipping away at RFRA's authority even more than the Court in *Boerne* did.[182] However, regardless of which approach Congress chooses to take, this condition passes muster.

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what-life-was-like-for-american-women-in-america-before-roe-v-wade [https://web.archive.org/web/20201121023031/https://www.thedailybeast.com/heres-what-life-was-like-for-american-women-in-america-before-roe-v-wade].

178. Thomas et al., *supra* note 153.

179. *See generally* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 4388 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

180. U.S. CONST. amend. I.

181. *Id.*

182. City of Boerne v. Flores, 521 U.S. 507 (1997).

i. Applying RFRA

RFRA § 3(a) prohibits the federal government from "substantially burden[ing] a person's exercise of religion even if the burden results from a rule of general applicability . . . ."[183] However, Congress provided for an exception.[184] In § 3(b), RFRA states that the federal government can substantially burden religious exercise if it demonstrates that the burden: "(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest."[185] Thus, the use of congressional spending requiring these sole community hospitals to provide these health services comes down to three questions: (1) are these hospitals eligible for religious exemptions and protected by RFRA; if yes, then (2) is there a substantial burden on religious exercise; and, if so, (3) does the government have a compelling interest in requiring that these hospitals provide these services, and is the method it is using the least restrictive means of doing so?

The issue of whether corporations and other organizations are protected by RFRA was decided in *Burwell v. Hobby Lobby*.[186] In her dissent, Justice Ginsburg voiced concern over granting RFRA protection to a corporation, emphasizing that RFRA protected a "person's" exercise of religion, not a corporation's.[187] The majority, however, did not adopt this view. It held that a "person" includes various organizations, including corporations as well as individuals.[188] It therefore follows that religious sole community hospitals are protected by RFRA.

Unfortunately, Congress did not define "substantial burden" when it enacted RFRA.[189] The task has therefore been largely left to the lower courts to decide the term's meaning and its application. However, the Supreme Court seems to have weighed in on the definition in *Hobbie v. Unemployment Appeals Commission of Florida*, in which it seemed to imply that a substantial burden is one where the state puts substantial pressure on a religious observer to perform in a way that would violate his or her beliefs.[190]

Based on this understanding, there have been two general theories as to what constitutes a substantial burden, and they depend on where the

183. RFRA, *supra* note 71.
184. *Id.*
185. *Id.*
186. *See generally* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).
187. *Id.* at 750.
188. *Id.* at 707–08.
189. RFRA *supra* note 71.
190. Hobbie v. Unemployment Appeals Comm'n of Fla., 480 U.S. 136, 136 (1987).

word "substantial" is emphasized.[191] Some believe that a substantial burden is one where any amount of pressure is applied to require a religious observer to deviate substantially from his or her practice.[192] Others believe that a substantial burden is one where a substantial amount of pressure is applied to require a religious observer to deviate from his or her practice in any manner.[193] This Note argues that the latter definition is superior to the former, simply due to efficiency. Requiring a court to determine how far a deviation in religious practice must be to be considered substantial would require it to inquire into the centrality of a religious belief. However, this inquiry would be in direct conflict with the Court's holding in *Thomas v. Review Board* that courts cannot evaluate the validity of religious practices.[194]

Accordingly, the question is whether conditional funding requiring these hospitals to provide fundamental health care qualifies as substantial-enough governmental pressure that causes a religious hospital to act contrary to its beliefs. Because *Thomas* forbids a court from investigating technicalities of religious practice, the hospitals' assertion that providing these services violates their beliefs is sufficient.[195] Furthermore, due to how important governmental funding is to sole community hospitals, any act resulting in withholding these funds is likely to impose substantial pressure.[196] Therefore, a condition upon federal funds in this respect is likely a substantial burden on the religious practice of these hospitals.

Because there is likely a substantial burden on these hospitals, the government bears the responsibility of proving that it has a compelling interest in requiring that these hospitals provide these services and that this interest cannot be achieved by less restrictive means.[197] In its analysis of the compelling interest test under RFRA, the Supreme Court has generally come down more favorably on the side of the religious claimant.[198] A mere allegation of a compelling interest is not enough—the government must

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191. Chad Flanders, *Substantial Confusion About "Substantial Burdens",* 2016 U. ILL. L. REV. ONLINE 27, 28 (2016).

192. *Id.* at 29.

193. *Id.*

194. Thomas v. Rev. Bd. of Ind. Emp. Sec. Div., 450 U.S. 707, 716 (1981) (noting that, "[p]articularly in this sensitive area, it is not within the judicial function and judicial competence to inquire whether the petitioner or his fellow worker more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation.").

195. *Id.*

196. Gugliotta *supra* note 155.

197. RFRA, *supra* note 71.

198. *See, e.g.*, Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014); Gonzales v. O Centro Espirita Beneficente Unaio Do Vegetal, 546 U.S. 418 (2006); Masterpiece Cakeshop, Ltd. v. Colo. Civ. Rts. Comm'n, 138 S. Ct. 1719 (2018).

provide adequate proof of this interest that outweighs any evidence to the contrary offered by the religious claimant.[199]

Here, there are three arguments Congress may use in establishing its compelling interest: the first is that the government has a compelling interest in providing adequate contraceptive care to protect an individual's liberty.[200] The second is that the government has a compelling interest to provide equal access to medical care throughout the United States.[201] The third, and perhaps strongest argument, is that the government has a compelling interest in ensuring citizens' access to their fundamental rights.[202] The Supreme Court has held that access to contraception and abortion are fundamental rights.[203] Therefore, Congress's most viable claim is that its compelling interest is ensuring access to fundamental healthcare for all Americans, regardless of financial status or residence.

It can hardly be argued that Congress's stance here is theoretical. The case law is clear in establishing these fundamental rights, and there is ample evidence to prove that these services are not being provided by these hospitals.[204] Consequently, there is a clear and proven governmental interest in ensuring that these services are offered to Americans nationwide. The next step, therefore, is determining whether this goal can be pursued through less restrictive means.

In order to ensure that citizens serviced by these religious sole community hospitals have access to fundamental medical care without burdening these hospitals' free exercise of religion, the government would arguably need to set up its own medical center next to every religious sole community hospital. This would be impractical for a slew of reasons, but the most notable one is cost. Even if these centers are designed only to provide the specific services these religious hospitals oppose, the amount of money it would require to fund these auxiliary centers would be astronomical. Consider using Planned Parenthood as an example. Planned Parenthood has forty-nine affiliates.[205] According to its Annual Report for 2017–2018, 30.5% of all Planned Parenthood's services were for

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199. *See Gonzales*, 546 U.S. at 421.

200. *See Burwell*, 573 U.S. at 741 (Ginsburg, J., dissenting).

201. *See generally* 42 C.F.R. § 412.92 (2018).

202. *See generally* Roe v. Wade, 410 U.S. 113 (1977).

203. *See generally* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); *Roe*, 410 U.S. 113; Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

204. *See generally Hellerstedt*, 136 S. Ct. 2292; *Casey*, 505 U.S. 833; *Roe*, 410 U.S. 113; *Eisenstadt*, 405 U.S. 438; *Griswold*, 381 U.S. 479; Hafner *supra* note 44.

205. *Who We Are*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/about-us/who-we-are [https://web.archive.org/web/20200107173635/https://www.plannedparenthood.org/about-us/who-we-are] (last visited Jan. 22, 2020).

contraception or abortion.[206] The total expenditures Planned Parenthood reported for all of its affiliates for that year was $871.4 million.[207] Accordingly, Planned Parenthood's cost for providing abortion and contraceptive services for that period amounts to $265.777 million. As of 2016, there were forty-six Catholic sole community hospitals in the United States.[208] Therefore, the amount it would plausibly cost the federal government to fund auxiliary centers to provide contraceptive and abortion services for these hospitals would be roughly $249.504 million.[209] This number does not account for the likely increase in Catholic sole community hospitals since 2016, nor does it consider the funds the federal government already provides sole community hospitals to begin with.[210]

It seems unnecessarily burdensome for the government to take on nearly $250 million in excess spending just to ensure that the portion of the population that relies on religious sole community hospitals to whom it is already providing additional funds can access fundamental medical care. Therefore, placing a condition on these hospitals' receipt of federal funds is the least restrictive means of achieving the compelling government interest of providing access to comprehensive, fundamental medical care.

ii. Ignoring RFRA

Should Congress choose to exempt its conditions from RFRA's requirements, its actions would be subject to the test created by the Supreme Court in *Smith*.[211] Here, the government would have to prove that

206. *Annual Report 2017–2018*, PLANNED PARENTHOOD, 23 (2017–2018), https://www.plannedparenthood.org/uploads/filer_public/4a/0f/4a0f3969-cf71-4ec3-8a90-733c01ee8148/190124-annualreport18-p03.pdf [http://web.archive.org/web/20210608214020/https://www.plannedparenthood.org/uploads/filer_public/4a/0f/4a0f3969-cf71-4ec3-8a90-733c01ee8148/190124-annualreport18-p03.pdf].

207. *Id.* at 29.

208. Paige Minemyer, *Number of Catholic Hospitals in US Has Grown 22% Since 2001*, FIERCE HEALTHCARE (May 5, 2016), https://www.fiercehealthcare.com/healthcare/number-catholic-hospitals-us-has-grown-22-since-2001 [https://web.archive.org/web/20210330143611/https://www.fiercehealthcare.com/healthcare/number-catholic-hospitals-us-has-grown-22-since-2001].

209. Forty-nine centers costing $265.777 million in total means a single center costs approximately $5.424 million to run. Auxiliary centers next to the forty-six Catholic hospitals mentioned in the study would therefore equate to $249.504 million.

210. Thomas, *supra* note 153 (noting that "[s]ince 2006, SCHs also receive an additional adjustment set at 7.1% above the Outpatient Prospective Payment System (OPPS) rate for outpatient services. Additionally, SCHs can qualify for adjustments due to decreases in inpatient volume, participation in the Hospital Value-Based Purchasing Program, and participation in the Hospital Readmissions Reduction Program.").

211. Emp. Div., Dep't of Hum. Res. of Or. v. Smith, 494 U.S. 872 (1990).

the conditions are of general applicability and facially neutral.[212] Here, the proposed condition would be placed on the funding Congress provides to *all* sole community hospitals, not only religious ones. The only reason this Note explicitly addresses religious sole community hospitals is because these are the sole community hospitals most likely to push back on a congressional condition requiring their provision of contraceptive and abortion services. In contrast, secular hospitals do not have any religious investment in the provision or prohibition of these services. Because this condition would apply to all sole community hospitals receiving federal funds, the law is generally applicable.

In addressing neutrality, the Supreme Court stated that "if the object of a law is to infringe upon or restrict practices because of their religious motivation, the law is not neutral . . . ."[213] The Court went on to clarify that laws enacted "'because of,' not merely 'in spite of,'" a religious practice, are not neutral.[214] Here, the purpose of the condition is not "because" these religious sole community hospitals refuse to provide these services. The condition is pursuing the neutral goal of satisfactory healthcare for rural areas "in spite of" these hospitals' beliefs. The fact that this condition is applicable to secular sole community hospitals as well further establishes this point. The condition is generally applicable and neutral and is therefore constitutional under *Smith*.[215]

3. The Establishment Clause

It seems to be taken for granted that federal funding of religious hospitals is permitted under the Establishment Clause. For example, a 1965 study showed that thirty-nine percent of various religiously-affiliated hospitals had received some form of federal funding through the Hill-Burton Hospital Construction Act.[216] Additionally, in her concurrence in *Zelman v. Simmons-Harris*, Justice O'Connor matter-of-factly noted that Medicare provided thirty-six percent of revenue for religious hospitals, and, combined with Medicaid, forty-five billion dollars in federal funding.[217] Because there seems to be little issue with the understanding that the federal government may provide aid to religious hospitals, the question then becomes whether placing conditions on federal funds

212. *Id.*
213. Church of the Lukumi Babalu Aye v. City of Hialeah, 508 U.S. 520, 533 (1993).
214. *Id.* at 540 (quoting Pers. Adm'r of Mass v. Feeney, 442 U.S. 256, 279 (1979)).
215. *Smith*, 494 U.S. 872.
216. Timothy S. Burgett, *Government Aid to Religious Social Services Providers: The Supreme Court's "Pervasively Sectarian" Standard*, 75 VA. L. REV. 1077, 1084 (1989).
217. Zelman v. Simmons-Harris, 536 U.S. 639, 667 (2002) (O'Connor, J., concurring).

requiring sole community hospitals to provide contraceptive and abortion services violates the Establishment Clause. This Note contends it does not.

The *Agostini* Court modified the *Lemon* test into two prongs: governmental action does not violate the Establishment Clause if it (1) has a secular purpose and (2) does not have a primary effect of advancing or inhibiting religion.[218] Here, the purpose of the condition is clear—the goal is to promote equal access to fundamental healthcare for those who are completely reliant on these hospitals. Furthermore, in requiring that these hospitals provide these services, the federal government is not endorsing any religion. There is no religious belief in abortion. As for its inhibition of the hospital's religion, the hospital is still free to exercise its religion if it so chooses—it just cannot do so while using federal funds.

Congress does not violate the First Amendment by placing conditions on its provision of funds to religious sole community hospitals requiring them to provide contraceptive and abortion services. Because Congress does not violate the Constitution by requiring sole community hospitals to provide contraceptive and abortion services, the final prong of the *Dole* test is satisfied. Congress is within its authority under the *Dole* test to place these conditions.

4. Further Restrictions on Congressional Spending Power

Despite satisfying the *Dole* test, Congress has additional limitations on its spending powers to satisfy in order to impose these conditions. In *Sebelius*, the Supreme Court placed an additional restriction on federal spending authority.[219] There, the Court only allowed Congress to place conditions on its funds as "mild encouragement," not "a gun to the head."[220] Despite this requirement, even if the withholding of federal funding is considered more than mild encouragement, the facts at the center of this issue are substantially different from those in *Sebelius*. In *Sebelius*, Congress attempted to withhold funds from the original Medicaid program in order to effectuate its expanded version.[221] The Court reasoned that Congress was essentially holding funds for the old plan hostage as a means of getting states to acquiesce to its new plan.[222] Here, while Congress's withholding of funds could have significant results, the circumstances behind its actions are unique.

218. Agostini v. Felton, 521 U.S. 203, 232–33 (1997).
219. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).
220. *Id.* at 581.
221. *Id.* at 531.
222. *Id*. at 581.

Because these religious sole community hospitals refuse to provide contraceptive and abortion services, the patients they serve already have a gun to their head. They do not have the luxury of going to a different provider, because these hospitals are often their only option.[223] As previously explained, the First Amendment rights of these hospitals are not violated by these conditions.[224] However, the fundamental rights of the rural patients who rely on these hospitals to access contraception and abortion are being violated.[225] Because of this, Congress is holding a gun that it cannot put down. The only question that remains is who takes the bullet. Considering that one group has rights that are being violated while the other does not, the choice seems clear: the interests of religious sole community hospitals must give way to protect the fundamental rights of their patients.

B. Congress is Required to Place Conditions Requiring Contraceptive and Abortion Access on the Aid It Provides to Sole Community Hospitals Under the Establishment Clause.

Not only does Congress have the authority to place conditions on the funds it provides to sole community hospitals, but its failure to do so violates the Establishment Clause. By permitting these hospitals to refuse to provide contraceptive and abortion services, the government is itself respecting an establishment of religion. While Congress has forbidden medical providers who receive federal funds from using those funds to provide abortions, seemingly as a religious accommodation, this statute, as applied to sole community hospitals, is unconstitutional.[226] The Supreme Court has recognized that "[a]t some point, accommodation may devolve into 'an unlawful fostering of religion . . . .'"[227] While the Supreme Court has not found any instance where this is the case, the District Court for the District of Massachusetts determined that, in authorizing the United States Conference of Catholic Bishops (USCCB) to accept governmental funding, but refusing to provide contraceptive or abortion services to

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223. Thomas et al., *supra* note 153.

224. *See supra* Part III.A.2.

225. *See generally* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

226. 42 U.S.C. § 300a-6.

227. Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos, 483 U.S. 327, 334–35 (1987) (quoting Hobbie v. Unemployment Appeals Comm'n of Fla., 480 U.S. 136, 137 (1987)).

trafficking victims, the government was effectively endorsing religion.[228] While the decision was vacated by the First Circuit, it is important to note that the vacation was due to mootness, not improper reasoning.[229]

The relationship between the Religion Clauses of the First Amendment is complex and has been subject to analysis by the Supreme Court in a variety of ways.[230] For instance, the Court's decision in *Locke* revolved around the "play in the joints" between the Free Exercise and Establishment Clauses and how something that is permissible under the Establishment Clause is addressed under the Free Exercise Clause.[231]

However, the relationship between the Religion Clauses does not stop there. This issue revolves around the conflict addressed by the court in *Cutter*: when do government accommodations to religious exercise violate the Establishment Clause?[232] In addressing this, the *Cutter* Court established a three-pronged test to determine whether religious accommodations have run afoul of the Establishment Clause.[233] Governmental religious accommodations are permissible under the Establishment Clause if they: (1) alleviate government-created burdens on private religious exercise; (2) do not impose an excessive burden on third parties; and (3) treat all faiths neutrally.[234]

The Court in *Cutter* did not provide any methodology for balancing the prongs with one another. However, in *Burwell*, the Court implied there was a balancing test to be considered in the application of the *Cutter* test.[235] In this respect, while the religious accommodations provided to religious sole community hospitals technically satisfy the first and third prongs of the *Cutter* test, their violation of the second prong is so egregious that it, when balanced with the other prongs, shows that the accommodations do not satisfy the *Cutter* test. Therefore, the accommodations are prohibited by the Establishment Clause.

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228. Am. C.L. Union of Mass. v. Sebelius, 821 F. Supp. 2d 474, 485 (D. Mass. 2012), *vacated sub nom.* Am. C.L. Union of Mass. v. U.S. Conf. of Cath. Bishops, 705 F.3d 44 (1st Cir. 2013).

229. *U.S. Conf. of Catholic Bishops*, 705 F.3d at 44.

230. *See generally* Locke v. Davey, 540 U.S. 712 (2004); Cutter v. Wilkinson, 544 U.S. 709 (2005).

231. *Locke*, 540 U.S. at 712.

232. *See generally Cutter*, 544 U.S. at 709.

233. *Id.* at 720.

234. *Id.*

235. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 729 n.37 (2014).

1. Prongs One and Three: Alleviates Government-Created Burden on Private Religious Exercise and Denominational Neutrality

The accommodation allowing religious sole community hospitals to refuse to provide certain services under their religious beliefs arguably does alleviate a government-created burden on their religious exercise.[236] Additionally, the accommodations, while probably the result of lobbying from specific religious groups, are facially neutral toward other religious denominations.[237] However, the *Cutter* test does not stop here because the Court has made clear that religious exemptions for one party cannot burden others in practice, which, particularly in the context of religious sole community hospitals, these accommodations certainly do.[238]

2. Prong Two: Does Not Impose Excessive Burdens on Third Parties

While the accommodation that allows religious sole community hospitals to refuse to provide abortion and contraceptive services may satisfy the first and third prongs of the *Cutter* test, it unequivocally fails the second prong. The burdens imposed on third parties by allowing these hospitals to refuse to provide these services are astronomical.[239] These hospitals maintain a monopoly on providing healthcare for roughly twenty percent of the population,[240] and their refusal to provide these services results in substantial hardships for those in need of them.[241]

The Court in *Estate of Thornton v. Caldor* held that a Connecticut statute forbidding employers from forcing their employees to work on their chosen sabbaths was unconstitutional, because it unfairly shifted the burden of the religious observants' duties to the employers and other third parties.[242] This reasoning serves as the foundation of the Court's second prong in *Cutter*, and is an essential factor in weighing the rights of religious observers against non-observers.[243] There is a general consensus

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236. *See generally* Affordable Care Act, *supra* note 34.

237. 42 U.S.C. § 300a-7(d).

> No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

Id. (referencing religion generally).

238. *Cutter*, 544 U.S. at 720.

239. *Supra* Part III.A.1.iii.

240. RURAL REPORT, *supra* note 2.

241. *Supra* Part III.A.1.i.

242. Est. of Thornton v. Caldor, Inc., 472 U.S. 703, 710–11 (1985).

243. Cutter v. Wilkinson, 544 U.S. 709, 720 (2005).

amongst the Court and other parties including "[a]rdent accommodationists, strict separationists, and many in between" that religious accommodations violate the Establishment Clause if they "shift the material costs of practicing a religion from the accommodated believers to those who believe and practice differently."[244] While the Court in *Corporation of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos* upheld a statutory exemption allowing a religious organization to discriminate in its hiring practices,[245] the shift in burden to third parties is distinguishable from that in *Caldor* because of the number of impacted people.[246] The situation here is much more similar to that in *Caldor* because the burden being shifted from these hospitals impacts the massive patient population that they serve.[247]

Not only are these third parties deprived of necessary healthcare services with no alternative providers, these parties are deprived of *fundamental* healthcare services—that is, ones the Supreme Court has deemed are fundamental rights under the Constitution.[248] It therefore follows that the governmental exception provided to these hospitals results not only in excessive burdens on third parties, but ones that violate their constitutional rights to fundamental healthcare. While the *Burwell* Court considered contraception just as this Note does, it is necessary to consider the situational differences between the cases.[249] *Burwell* considered insurance coverage by employers, not actual services of healthcare providers.[250] In this respect, the Court noted that Hobby Lobby's employees were able to access contraceptive coverage in a variety of other ways that sufficiently alleviated their burden under the *Cutter* test.[251]

Unlike Hobby Lobby's employees, the patients of these religious sole community hospitals stand to suffer much more severe hardships.[252]

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244. Frederick Mark Gedicks & Rebecca G. Van Tassell, *RFRA Exemptions from the Contraception Mandate: An Unconstitutional Accommodation of Religion*, 49 HARV. C.R.-C.L. L. REV. 343, 361–62 (2014).

245. Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos, 483 U.S. 327 (1987).

246. Where *Caldor* considered the shifting burden to countless employers and employees, *Amos* considered the shifting burden only to a single employee of a religious organization. *See generally Caldor*, 472 U.S. 703; *id.*

247. *See* RURAL REPORT, *supra* note 2, at 2.

248. *See generally* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

249. *See generally* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

250. *Id.*

251. *Id.* at 729, n.37.

252. *Supra* Part III.A.1.iii.

Unlike Hobby Lobby's employees, the patients of these religious sole community hospitals have nowhere else to go.[253] Compared to Hobby Lobby's employees, the patients of these religious sole community hospitals are far more numerous.[254] The reality is that these hospitals have taken on the mantle of being the sole healthcare providers for a substantial number of Americans, and yet are still allowed to refuse to provide fundamental healthcare to their patients.[255]

C. The Combination of Federal Aid and The Monopoly on Caring for Twenty Percent of Americans Requires that Sole Community Hospitals Be Treated as State Actors Who Fail the Strict Scrutiny and Undue Burden Tests

In addition to Congress's authority and duty to place conditions on the funds it provides to sole community hospitals requiring they provide certain fundamental medical services, these sole community hospitals are arguably inherently required to do so regardless of congressional conditions. The combination of the funds these hospitals receive from Congress and the monopoly they hold over the healthcare of their patients indicates that these hospitals should be treated like state actors.[256] As such, these hospitals should be bound by the same requirements that the state and federal governments face to protect those rights the Supreme Court has deemed fundamental, including those to contraception and abortion.[257] Religious sole community hospitals' refusal to provide these services does not pass muster under the strict scrutiny and undue burden tests set forth by the Supreme Court as exceptions to this general requirement.[258] Therefore, these hospitals should be required, regardless of congressional conditions on funding, to provide access to these services.

1. Sole Community Hospitals are Akin to State Actors

The Supreme Court in *Rendell-Baker v. Kohn* held that a private institution that receives government funds to perform a public function is not necessarily a state actor.[259] The Court reaffirmed its holding in *Blum v. Yaretsky* and *Jackson v. Metropolitan Edison, Co.* by concluding that in order for a private entity performing a public function with governmental

253. Thomas et al., *supra* note 153.
254. RURAL REPORT, *supra* note 2.
255. *See* 42 U.S.C. § 300a-7.
256. *See infra* Part III.C.1.
257. *Id.*
258. *See infra* Part III.C.2.
259. Rendell-Baker v. Kohn, 457 U.S. 830, 842 (1982).

funds to be considered a state actor, the function must have been "traditionally the exclusive prerogative of the State."[260]

However, despite not being a state actor in the traditional sense, sole community hospitals—religious or otherwise—should, due to their unique circumstances, still be treated as state actors. These hospitals have a monopoly on patient care within at least a thirty-five-mile radius.[261] They are the only choice these rural areas have for healthcare and have exclusive access to providing care for roughly twenty percent of the populace.[262] This creates a unique situation not considered by the Court in *Kohn*, *Yaretsky*, or *Jackson*.[263] In this respect, this situation is more akin to the situation in *Marsh v. Alabama*, where the Court held that "[t]he more an owner, for his advantage, opens up his property for use by the public in general, the more do his rights become circumscribed by the statutory and constitutional rights of those who use it."[264] The Court went on to reason that because "these facilities are built and operated primarily to benefit the public and since their operation is essentially a public function, [they are] subject to state regulation."[265]

While *Marsh* is not facially factually applicable to this situation, its reasoning still holds true. When a private entity opens itself up to perform a public function, and—such as the town in *Marsh*—holds a monopoly over those who must use that function, it must be subject to state regulation. Because sole community hospitals exercise a monopoly over the patient care of roughly twenty percent of Americans, they should be treated as state actors and, as such, be bound to follow the constitutional jurisprudence of the Supreme Court regarding fundamental rights.

Congress has already recognized that private hospitals must be subject to federal control in certain situations.[266] In the Emergency Medical Treatment and Active Labor Act ("EMTALA"), enacted in 1986, Congress used its spending powers under the Social Security Act to require all hospitals that participated in Medicare to provide emergency services to patients regardless of their ability to pay.[267] Before EMTALA, private

260. *Id.* (quoting Jackson v. Metro. Edison Co., 419 U.S. 345, 353 (1974); Blum v. Yaretsky, 457 U.S. 991, 1011 (1982)).

261. 42 C.F.R. § 412.92 (2018).

262. RURAL REPORT, *supra* note 2.

263. The Court in each of these cases was not addressing a private entity with a monopoly on services available to the plaintiff.

264. Marsh v. Alabama, 326 U.S. 501, 506 (1946).

265. *Id.*

266. 42 U.S.C. § 1395dd [hereinafter EMTALA].

267. *Id.*; Ctr. for Medicare & Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, CMS (Mar. 26, 2012), https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA [https://web.archive.org/web/20210326042053/https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA].

hospitals would refuse to admit patients in emergency situations, primarily because of their inability to pay, and would instead transfer them to public hospitals.[268] Two articles published in 1986 and 1987 indicated that for eighty-seven percent of these "dumping" cases, the reason was due to a lack of insurance.[269] Additionally, the articles noted that, of the transferred patients, only six percent had provided informed written consent, and twenty-four percent of transferred patients "were considered to have been transferred in . . . unstable condition[s]."[270] Furthermore, patients that were transferred were "twice as likely to die as those treated at the transferring hospital . . . ."[271]

While there is no directly applicable case law or statute to this situation, the reasoning behind *Marsh* and EMTALA is loud and clear: when a private hospital is a patient's only option, and it accepts federal funds to support itself, it should be treated as a state actor and be required to adhere to the rules and regulations that apply to state and federal governments.

2. Under the Requirements of State Actors, Religious Sole Community Hospitals Fail the Strict Scrutiny and Undue Burden Tests Required by the Supreme Court

Treated as state actors, sole community hospitals are bound by the same rules as the federal and state governments. Additionally, because they are healthcare providers who must be treated as state actors, they must provide contraceptive and abortion services as fundamental rights acknowledged by the Supreme Court, because they do not satisfy the strict scrutiny and undue burden tests permitting exceptions.[272]

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268. Harris Meyer, *Why Patients Still Need EMTALA*, MODERN HEALTHCARE (Mar. 26, 2016), https://www.modernhealthcare.com/article/20160326/MAGAZINE/303289881/why-patients-still-need-emtala [https://web.archive.org/web/20210326042244/https://www.modernhealthcare.com/article/20160326/MAGAZINE/303289881/why-patients-still-need-emtala].

269. Joseph Zibulewsky, *The Emergency Medical Treatment and Active Labor Act (EMTALA): What it is and What it Means for Physicians*, 14 PROCEEDINGS—BAYLOR U. MED. CTR. 339, 339 (2001).

270. *Id.*

271. *Id.*

272. *See generally* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965).

i. Access to Contraception: Strict Scrutiny

The Supreme Court in *Griswold v. Connecticut* held that married couples had a right to use contraception that fell within their right to privacy.[273] Seven years later, the Court in *Eisenstadt v. Baird* held that this right to privacy regarding contraception extended to unmarried individuals under the Fourteenth Amendment's Equal Protection Clause.[274] With these two cases, the Court concluded that the right to contraception is a fundamental right nestled within the fundamental right to privacy.[275] Because access to contraception is a fundamental right, state infringement on that right must survive strict scrutiny.[276] Therefore, treated as state actors, religious sole community hospitals may only constitutionally refuse to provide contraceptive services if they can show that such refusal serves a compelling state interest that is narrowly tailored to serve that interest.[277]

While the *Baird* Court may have been willing to see an interest in discouraging extramarital sexual relations as potentially compelling, a lot has changed in almost fifty years.[278] It is untenable to think that any government today would be able to justify its actions based on a goal of discouraging extramarital sex. Therefore, the only interest these hospitals would have is in their religious beliefs against contraception.[279] However, as state actors, this interest directly violates the Establishment Clause, and therefore cannot be a compelling state interest.[280]

Because these hospitals are the healthcare providers upon whom their patients rely for treatment, and should be treated as state actors, the lack of a compelling interest does not only mean that they cannot ban the services, but that they must affirmatively provide them. Religious sole community hospitals, treated as state actors, should be constitutionally required to provide contraceptive services to their patients.

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273. *Griswold*, 381 U.S. at 485.

274. *Eisenstadt*, 405 U.S. at 453.

275. *See generally id.*; *Griswold*, 381 U.S. at 479.

276. Plyler v. Doe, 457 U.S. 202, 216–17 (1982) (establishing that government action that "impinge[s] upon the exercise of a 'fundamental right' . . . requir[es] the State to demonstrate that its classification has been precisely tailored to serve a compelling governmental interest.").

277. *Id.*

278. *Eisenstadt*, 405 U.S. at 448.

279. Lisa McClain, *How the Catholic Church Came to Oppose Birth Control*, THE CONVERSATION (July 9, 2018), http://theconversation.com/how-the-catholic-church-came-to-oppose-birth-control-95694 [https://web.archive.org/web/20210202215200/https://theconversation.com/how-the-catholic-church-came-to-oppose-birth-control-95694].

280. U.S. CONST. amend. I.

ii. Access to Abortion: Undue Burden

While *Roe v. Wade* established the right to abortion access as a fundamental right, the Court in *Planned Parenthood v. Casey* specifically altered the normal strict scrutiny test in favor of the undue burden test when addressing abortion.[281] *Whole Woman's Health* cemented the undue burden test, holding that "[u]necessary health regulations that have the purpose or effect of presenting a substantial obstacle to [someone] seeking an abortion impose an undue burden on the right."[282] The Court noted that, in analyzing whether a government action is an undue burden, it must weigh the extent to which the action in fact accomplishes legitimate state goals against the degree to which it burdens access to abortion.[283]

It can hardly be argued that a sole community hospital's refusal to provide abortion services is not an undue burden. These hospitals are the sole healthcare providers for roughly twenty percent of the population.[284] Their refusal to provide these services places an undue burden on those who rely on them by effectively eliminating their access to abortions altogether. While these hospitals may try to argue that they are protecting the life of the fetus, this argument is ineffective. Treating these hospitals as state actors, they are not permitted to rely on religious belief to justify their actions, as this would violate the Establishment Clause.[285] Furthermore, while modern religious beliefs may consider life as beginning at conception, there are numerous other viewpoints on the matter with no clear scientific answer.[286] The Court in *Roe* rejected the protection-of-life argument for this precise reason, stating:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.[287]

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281. *See generally* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973).

282. Whole Woman's Health v. Hellerstedt, 136 S.Ct. 2292, 2309 (2016) (quoting *Casey*, 505 U.S. at 878).

283. *Id.* at 2298.

284. RURAL REPORT, *supra* note 2.

285. *Supra* Part III.B.1.

286. Sarah Zhang, *Why Science Can't Say When a Baby's Life Begins*, WIRED (Oct. 2, 2015), https://www.wired.com/2015/10/science-cant-say-babys-life-begins/ [https://web.archive.org/web/20210227190611/https://www.wired.com/2015/10/science-cant-say-babys-life-begins/].

287. Roe v. Wade, 410 U.S. 113, 159 (1973).

Because there is no legitimate goal outside of religious creed in restricting access to abortion, and religious sole community hospitals' refusal to provide the services effectively bars twenty percent of the population from accessing their constitutional right to abortion, the undue burden test is not satisfied.[288]

IV. CONCLUSION

Congress has the authority to impose conditions on the funds it provides to entities under its Article I Spending Powers.[289] While there are limitations on these conditions, these limitations are inapplicable to the issues surrounding religious sole community hospitals because of the weight of the rights at stake absent imposing these conditions.[290] These conditions do not violate RFRA, but, regardless, Congress also has the authority to qualify RFRA's applicability to any enactments it creates.[291] The Free Exercise of these hospitals is not infringed upon by a congressional statute enacted well within constitutional limits.[292]

Further, the "play in the joints" between the Religion Clauses of the First Amendment in this case requires Congress to impose conditions on the funds it provides to these hospitals under the Establishment Clause.[293] Refusal to do so would be egregiously detrimental to the large number of citizens for whom these hospitals are the only option, depriving them of their fundamental rights under the Constitution.[294] Additionally, because of the funding these hospitals receive from Congress and the monopoly they exercise over the healthcare of twenty percent of the population, sole community hospitals—both religious and secular—should be treated as state actors.[295] As such, those who refuse to provide contraception and abortion services due to their religious beliefs violate the fundamental rights of their patients, failing both the strict scrutiny and undue burden tests promulgated by the Supreme Court.[296] As state actors, religious sole community hospitals may not constitutionally refuse to provide contraceptive and abortion services.[297]

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288. RURAL REPORT, *supra* note 2, at 2.
289. *See supra* Part III.A.
290. *See supra* Part III.A.2.
291. *See supra* Part III.A.2.
292. *See supra* Part III.A.1.iv.
293. *See supra* Part III.B.
294. *Id.*
295. *See supra* Part III.C.
296. *See supra* Part III.C.2.
297. *Id.*

For these reasons, Congress should amend the statute granting funding to sole community hospitals to include conditions upon those funds, requiring that these hospitals provide contraceptive and abortion services. Lastly, these sole community hospitals should be held accountable under the rules governing actions of state actors for their failure to provide these services to their patients.