

HOW CONGRESS CAN HELP RAISE VACCINE RATES

*Dorit Rubinstein Reiss & Y. Tony Yang**

2019 saw an unusually high number of measles cases, and other preventable disease outbreaks, at least in part linked to vaccines refusal. States are considering legislative responses. This Essay examines what role the federal government can fill in increasing vaccines rates. The Essay suggests that the federal government has an important role to fill in funding research, coordination, and local efforts. It also suggests that a federal school vaccine mandate is likely not the solution: first, such mandates can run into plausible constitutional challenges, and second, there are policy arguments against it. The policy contentions include the unfairness of imposing a mandate before solving access problems throughout the country, the risk of a federal mandate that is weaker or stronger than the state requirement, and the risk that a conditional mandate will lead to states losing funding needed to prevent outbreak, ending with the ironic result of more outbreaks as a result of such a law.

INTRODUCTION

Measles in the United States exceeded one thousand cases in 2019, making it the year with the highest number of measles cases since 1992.¹ Most of the cases were in unvaccinated individuals, and many in unvaccinated children (though some were in unvaccinated or under-vaccinated adults).²

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1 *Measles Cases and Outbreaks*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/measles/cases-outbreaks.html> (last updated Aug. 19, 2020). The final case count for 2019, as of December 31, 2019, was 1282 cases. *Id.*

2 Manisha Patel et al., *National Update on Measles Cases and Outbreaks—United States, January 1–October 1, 2019*, 68 MORBIDITY AND MORTALITY WKLY. REP. 893, 893 (2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6840e2-H.pdf>. The main exception was Michigan, where an outbreak was centered mostly in under-vaccinated and

Unsurprisingly, concerned legislators sought a response. The state of Washington, facing a large measles outbreak, passed legislation to remove the personal belief exemption to the measles, mumps, rubella vaccine requirement for school (leaving in place the religious exemption)—a limited measure, but a significant change in a state with previously very permissive vaccination policies.³ Going further, Maine and New York eliminated their nonmedical exemptions to school immunization mandates.⁴ New Jersey also proposed a bill to eliminate its nonmedical exemption, but the law was not brought to a vote when proponents found themselves without enough votes to pass the bill.⁵ At the federal level, Congress held two committee hearings to discuss the crisis⁶ and proposed several bills, including bills addressing infrastructure, funding, and a bill to create a federal school immunization mandate.⁷

unvaccinated adults who reasonably believed they were, in fact, protected. See Lena H. Sun, *Unaware He Had Measles, A Man Traveled from N.Y. to Michigan, Infecting 39 People*, WASH. POST (Apr. 16, 2019, 6:00 AM), <https://www.washingtonpost.com/health/2019/04/16/how-patient-zero-spread-measles-across-state-lines-infected-people/>.

3 Associated Press, *New Law Removes Certain MMR Vaccine Exemptions for Washington State Schools*, K5 NEWS (July 27, 2019, 10:19 AM), <https://www.king5.com/article/news/health/new-law-removes-certain-mmr-vaccine-exemptions-for-washington-state-schools/281-7615e2bd-c343-4745-bcbc-e5dc4739f34d>. This law seems to echo a proposal by Dr. Douglas Opel and co-authors, published in the medical journal *Pediatrics*. See Douglas J. Opel et al., *Childhood Vaccine Exemption Policy: The Case for a Less Restrictive Alternative*, PEDIATRICS, April 2016, at 1, 1.

4 See Meredith Gingold, *The Path is Cleared: A Growing Body of Case Law Uphold States' Removal of Non-Medical Vaccination Exemptions; Minnesota Should be Next*, MINN. L. REV.: DE NOVO (Dec. 4, 2019), <https://minnesotalawreview.org/2019/12/04/the-path-is-cleared-a-growing-body-of-case-law-upholds-states-removal-of-non-medical-vaccination-exemptions-minnesota-should-be-next/>; Evan Simko-Bednarski, *Maine Bars Residents from Opting out of Immunizations for Religious or Philosophical Reasons*, CNN (May 27, 2019, 11:36 AM), <https://www.cnn.com/2019/05/27/health/maine-immunization-exemption-repealed-trnd/index.html>.

5 Sharon Otterman & Tracey Tully, *Strict Vaccine Law Stumbles in N.J. Legislature*, N.Y. TIMES (Dec. 17, 2019), <https://www.nytimes.com/2019/12/16/nyregion/vaccines-measles-nj-religious-exemptions.html>.

6 See *Hearing on Confronting A Growing Public Health Threat: Measles Outbreaks in the U.S. Before the H. Subcomm. on Oversight and Investigations*, 116th Cong. (2019), <https://energycommerce.house.gov/committee-activity/hearings/hearing-on-confronting-a-growing-public-health-threat-measles-outbreaks>; *Hearing on Vaccines Save Lives: What is Driving Preventable Disease Outbreaks? Before the S. Comm. on Health, Educ., Lab. & Pensions*, 116th Cong. (2019), <https://www.help.senate.gov/hearings/vaccines-save-lives-what-is-driving-preventable-disease-outbreaks>; see also CNN Newsource, *Amid Measles Outbreaks, Senate Hearing to Discuss How Vaccines Save Lives*, ABC 10NEWS SAN DIEGO (Mar. 5, 2019, 11:02 AM), <https://www.10news.com/news/national/amid-measles-outbreaks-senate-hearing-to-discuss-how-vaccines-save-lives>.

7 See Vaccinate All Children Act, H.R. 2527, 116th Cong. (2019); see also Protecting Seniors Through Immunization Act, H.R. 5076, 116th Cong. (2019); VACCINES Act, H.R. 2862, 116th Cong. (2019).

This Essay argues that Congress has an important role to fill in raising vaccine rates, but its most important contributions are not by direct, coercive action. The most important role Congress can fill is two-fold: supporting states with funding to improve immunization rates in a variety of ways and creating the infrastructure to address vaccine hesitancy and access problems nationwide. In contrast, school immunization mandates are better left to the states since federal mandates may face constitutional challenges and raise policy concerns that a more supportive effort would not.

I. CONGRESS CAN IMPROVE VACCINE ACCESS BY IMPROVING INFRASTRUCTURE AND PROVIDING SUPPORT

There are several things that increase the risks of preventable disease outbreak in the United States. A global increase in measles led to more measles coming into the United States;⁸ but if vaccines rates are high enough, herd immunity prevents incoming diseases from spreading. The difference in past years was not just that more measles was coming into the United States, but that it was coming into communities where vaccines rates were low enough that large outbreaks occurred and these communities served as “hotspots” for disease.⁹ The main factor in most measles outbreaks was vaccine refusal. For example, some have linked low vaccine rates to the Minnesota outbreak in 2017,¹⁰ the Washington State outbreak in 2019,¹¹ and the measles outbreak in New York in 2019.¹² Vaccine refusal was a problem in other outbreaks, too,¹³ but it is not the only issue.

8 *New Measles Surveillance Data for 2019*, WORLD HEALTH ORG., <https://www.who.int/immunization/newsroom/measles-data-2019/en/> (last visited Sept. 16, 2020).

9 See Jacqueline K. Olive, Peter J. Hotez, Ashish Damania & Melissa S. Nolan, *The State of the Antivaccine Movement in the United States: A Focused Examination of Nonmedical Exemptions in States and Counties*, PLOS MED., June 12, 2018, at 1, 7, <https://journals.plos.org/plosmedicine/article/related?id=10.1371/journal.pmed.1002578>.

10 See, e.g., Victoria Hall et al., *Measles Outbreak—Minnesota April–May 2017*, 66 MORBIDITY & MORTALITY WKLY. REP. 713, 716 (2017); Dorit Rubinstein Reiss & John Diamond, *Measles and Misrepresentation in Minnesota: Can There Be Liability for Anti-Vaccine Misinformation That Causes Bodily Harm?*, 56 SAN DIEGO L. REV. 531, 532, 551 (2019).

11 See, e.g., *Measles 2019: Measles in Washington State*, WASH. STATE DEPT. OF HEALTH, <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Measles/Measles2019> (last visited Sept. 16, 2020); Jonathan Lambert, *Measles Cases Mount in Pacific Northwest Outbreak*, NPR (Feb. 8, 2019, 1:10 PM), <https://www.npr.org/sections/health-shots/2019/02/08/692665531/measles-cases-mount-in-pacific-northwest-outbreak>.

12 See, e.g., Robert McDonald et al., *Measles Outbreaks from Imported Cases in Orthodox Jewish Communities—New York and New Jersey, 2018–2019*, 68 MORBIDITY & MORTALITY WKLY. REP. 444, 444 (2019).

13 Varun K. Phadke, Robert A. Bednarczyk, Daniel A. Salmon & Saad B. Omer, *Association Between Vaccine Refusal and Vaccine-Preventable Diseases in the United States: A Review of Measles and Pertussis*, 315 JAMA 1149, 1150 (2016).

In some states, vaccines might be inaccessible (or hard to access) to parts of the population; children who live outside metropolitan areas or are on Medicaid are less likely to be fully vaccinated, and these rates vary across states.¹⁴ As a result, some states have lower coverage for some vaccines because of their rate of children in poverty or living in rural areas; lower coverage for lack of access can also create pockets of vulnerable, susceptible children.¹⁵

Children are not the only ones with access problems: unvaccinated adults, and especially seniors, may also lack access, though problems in adult access also include lack of opportunities or attention.¹⁶

These different problems require different solutions and Congress can help with all of them. The first thing Congress can do is improve our understanding of vaccine hesitancy and coordinate national efforts to combat anti-vaccine misinformation. Some very positive proposals in that direction were included in a bipartisan Senate bill in 2019, S. 1619, The Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety Act of 2019 (“VACCINE Act”).¹⁷ The VACCINE Act would provide for grants distributed from the Centers for Disease Control and Prevention (“CDC”) to examine vaccine hesitancy and conduct a national campaign to increase awareness about vaccines and combat misinformation—a campaign subject to important requirements, such as consulting with experts, making decisions grounded in evidence, and coordinating with other efforts.¹⁸

In addition to providing for such infrastructure, Congress should provide more targeted grants. Take the Somali community in Minnesota and the Ukrainian and Russian-speaking communities in Washington, for example. Both saw measles outbreaks (primarily in unvaccinated children) in recent years, which is an example of where the primary need for confidence building is in these communities.¹⁹ The VACCINE Act would also specifically empower the CDC to award grants to address the need of specific communities and solve access problems.²⁰

14 Holly A. Hill et al., *Vaccination Coverage Among Children Aged 19–35 Months—United States, 2017*, 67 MORBIDITY & MORTALITY WKLY. REP. 1123, 1123–24, 1127 (2018). For an example of problems in access, see Suzanne Potter, *NV Children Uninsured Rate Worsens—First Time in Almost a Decade*, PUB. NEWS SERV. (Nov. 29, 2018), <https://www.publicnewsservice.org/2018-11-29/childrens-issues/nv-children-uninsured-rate-worsens-first-time-in-almost-a-decade/a64755-1>.

15 Hill et al., *supra* note 14, at 1127.

16 See Albert T. Bach et al., *Addressing Common Barriers in Adult Immunizations: A Review of Interventions*, 18 EXPERT REV. VACCINES 1167, 1181 (2019).

17 Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety Act of 2019, S. 1619, 116th Cong. (2019).

18 *Id.*

19 See Hall et al., *supra* note 10, at 716 (discussing the outbreak in the Somali community in Minnesota); *US Health Officials Seek to Stem Measles Outbreaks Traced to Israel, Ukraine*, MEDICAL XPRESS (Apr. 16, 2019), <https://medicalxpress.com/news/2019-04-health-stem-measles-outbreaks-israel.html>.

20 See S. 1619.

In a recent post in the *Health Affairs Blog*, two experts with decades of public health experience explained that to overcome access problems, reforms are needed to insurance, such as “expanding Medicaid coverage, continuing to guarantee no-cost preventive services, and addressing cost barriers that have long plagued Medicare beneficiaries,” and specifically for Medicare, to “ensure all vaccines are provided without cost sharing.”²¹ Further, the same post pointed out that fully funding the immunization program would, in reality, save money by reducing disease costs.²²

More generally, Congress can also allocate grants to allow states to experiment with different approaches to improve their vaccine rates, providing there is some evidence that the approach may work by using a competitive allocation process. This would give states flexibility to experiment with different policy options—from immunization registries with automatic reminders to immunization drives, school clinics, broader educational efforts, or stronger implementation of school vaccination mandates (or funding of improved mandates that require legislation).

Congress must also help by directing institutions under its control, like the Government Accountability Office, to examine issues limiting vaccine access and by directly funding more research into the causes of and solutions to vaccine hesitancy.

Finally, Congress should reduce disease rates by requiring vaccines for certain travelers. Congress already dabbles in this sort of legislation by requiring immigrants to meet vaccination requirements.²³ While we think that the level of activity in our airports is likely too high to justify global vaccine requirements on entry and exit, Congress should add vaccination requirements to the passport process so that Americans seeking to travel have to meet certain requirements.²⁴

21 J. Nadine Gracia & Amy Pisani, *Vaccine Infrastructure and Education Is The Best Medical Investment Our Country Can Make*, HEALTH AFF. BLOG (Jan. 21, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200117.291021/full/?emci=aedcfca-773c-ea11-a1cc-2818784d084f&emdi=134535f4-773c-ea11-a1cc-2818784d084f&ceid=6545598>.

22 *Id.*

23 *Vaccination Requirements*, U.S. CITIZENSHIP & IMMIGR. SERVICES, <https://www.uscis.gov/tools/designated-civil-surgeons/vaccination-requirements> (last updated Jan. 10, 2020).

24 To get a passport for international travel, applicants are already required to submit documentation and provide photos and information. Adding a requirement that applicants attach a medical record of immunization, or alternatively obtain a medical provider signature on a pre-prepared form, would allow for federal vaccine oversight. Such a requirement would need to allow for medically approved exemptions. The advantage of such a requirement is that it will provide an incentive to vaccinate at a point of vulnerability: many United States outbreaks of measles, for example, start with travelers. *See Measles (Rubeola): Plan for Travel*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/measles/plan-for-travel.html> (last updated June 18, 2019). It could help prevent and reduce outbreaks directly, by protecting people who go to areas where disease is endemic, and it is an area where the federal government has clear authority. On

II. WHAT ABOUT MANDATES?

Strong school immunization mandates have important benefits and protect both children and the community; in our view, states should adopt them. Vaccines have large benefits and small risks.²⁵ They are among the major modern medical advances in the twentieth century.²⁶ States have used school immunization mandates since the nineteenth century to increase immunization rates.²⁷ These mandates have been described as the “gold standard for preventing the spread of contagious diseases,”²⁸ and stronger mandates lead to fewer outbreaks.²⁹ It is unsurprising that when the United

the other hand, it will add a burden to people who travel, and is a limit on freedom of movement. This proposal could benefit from further and separate development, but we think it is worth putting on the table.

25 See, e.g., Cynthia G. Whitney, Fangjun Zhou, James Singleton & Anne Schuchat, *Benefits from Immunization During the Vaccines for Children Program Era—United States, 1994–2013*, 63 MORBIDITY & MORTALITY WKLY. REP. 352, 354 (2014), <https://www.cdc.gov/mmwr/pdf/wk/mm6316.pdf> (reporting that vaccines prevent numerous deaths and harms); Margaret A. Maglione et al., *Safety of Vaccines Used for Routine Immunization of US Children: A Systematic Review*, 134 PEDIATRICS 325, 325 (2014) (finding that vaccines have risks, but those are rare and outweighed by their benefits); *Vaccines Are Safe*, THE NAT’L ACADEMIES OF SCI., ENGINEERING, & MED., <http://sites.nationalacademies.org/BasedOnScience/vaccines-are-safe/> (last visited Sept. 16, 2020) (noting that vaccines “have many health benefits and few side effects”).

26 See Michael Worboys, *Vaccines: Conquering Untreatable Diseases*, BMJ (Jan. 4, 2007), https://www.bmj.com/content/334/suppl_1/s19.

27 See Dorit Rubinstein Reiss & Lois A. Weithorn, *Responding to the Childhood Vaccination Crisis: Legal Frameworks and Tools in the Context of Parental Vaccine Refusal*, 63 BUFFALO L. REV. 881, 892 (2015).

28 *Brown v. Smith*, 235 Cal. Rptr. 3d 218, 226 (Ct. App. 2018).

29 See, e.g., Nina R. Blank, Arthur L. Caplan & Catherine Constable, *Exempting Schoolchildren from Immunizations: States with Few Barriers Had Highest Rates of Nonmedical Exemptions*, 32 HEALTH AFF. 1282, 1289 (2013) (confirming the inverse relationship “between non-medical exemption rates and the complexity of exemption application procedures and show[ing] higher exemption rates in states permitting exemptions for philosophical, rather than solely religious, reasons”); Jennifer S. Rota et al., *Processes for Obtaining Nonmedical Exemptions to State Immunization Laws*, 91 AM. J. PUB. HEALTH 645, 645 (2001) (finding that less complex nonmedical exemption application processes increase the number of parents claiming exemptions for children); Stephanie Stadlin, Robert A. Bednarczyk & Saad B. Omer, *Medical Exemptions to School Immunization Requirements in the United States—Association of State Policies with Medical Exemption Rates (2004–2011)*, 206 J. INFECTIOUS DISEASES 989, 989 (2012) (finding that states with easier medical exemption methods had an increased number of exemptions); W. David Bradford & Anne Mandich, *Some State Vaccination Laws Contribute to Greater Exemption Rates and Disease Outbreaks in the United States*, 34 HEALTH AFF. 1383, 1389 (2015) (“[W]e also found a link between our index of exemption law effectiveness and the incidence of preventable diseases. . . . Vaccine exemption policy is thus an important part of a comprehensive plan for reducing preventable diseases.”); Jana Shaw et al., *Immunization Mandates, Vaccination Coverage, and Exemption Rates in the United States*, OPEN FORUM INFECT. DISEASES, May 31, 2018, at 1, 1 (“We found higher vaccination coverage and lower nonmedical exemption rates for MMR and DTaP vaccines in states adopting Advisory Committee on Immunization Practices guidelines for school entry.”); Sindiso Nyathi et al., *The 2016 California Policy to Eliminate*

States faces outbreaks of preventable diseases, well-meaning federal legislators propose bills for a federal immunization mandate.³⁰

Multiple levels of government take responsibility for public health.³¹ But school vaccine mandates have traditionally been part of the *states'* police powers.³² Based on constitutional and policy considerations, we think it should stay that way. The federal government is a government of limited, enumerated powers. The Constitution does not explicitly give the federal government direct power to regulate infectious diseases or public health, but Congress regulates public health using other constitutional powers.

First, Congress has used its authority under the Commerce Clause to legislate public health matters, most notably by enacting the Public Health Services Act of 1944.³³ Congress's power under the Commerce Clause is not unlimited, and the Supreme Court has been especially wary of this power when Congress tries to regulate activity that is not primarily economic.³⁴ School immunization mandates are not "quintessentially economic."³⁵ Rather, they are more similar to the activity that Congress tried to regulate in *United States v. Lopez*, the first Supreme Court case in decades that limited Congress's Commerce Clause power.³⁶ In *Lopez*, the Court invalidated the Gun Free School Zones Act of 1990, which forbade possessing firearms in a school zone because gun possession was not an activity that fell within the scope of the Commerce Clause.³⁷ The Court acknowledged that Congress could regulate economic activity that "substantially affects interstate commerce,"³⁸ but concluded that gun possession was not such an activity.³⁹

Similarly, school immunization mandates, whose focus is on intrastate schools, likely have no "substantial" effect on interstate commerce. Arguably, school mandates could have some effect if parents choose where to live based on whether such a mandate exists and how strong it is, but such remote

Nonmedical Vaccine Exemptions and Changes in Vaccine Coverage: An Empirical Policy Analysis, PLOS MED., July 12, 2019, at 1, 2 ("Our findings suggest that government policies removing nonmedical exemptions can be effective at increasing vaccination coverage.").

30 *E.g.*, Vaccinate All Children Act of 2019, H.R. 2527, 116th Cong. (2019).

31 *See* INSTITUTE OF MEDICINE, *THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY* 96–170 (2003).

32 *See* LAWRENCE O. GOSTIN & LINDSAY F. WILEY, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 73–79 (3d ed. 2016).

33 Public Health Services Act, Pub. L. No. 78-410, 58 Stat. 682 (1944) (codified at 42 U.S.C. Ch. 6A); Rebecca Bucchieri, *Religious Freedom Versus Public Health: The Necessity of Compulsory Vaccination for Schoolchildren*, 25 B.U. PUB. INT. L.J. 265, 288 (2016); *see also* Jorge E. Galva, Christopher Atchison & Samuel Levey, *Public Health Strategy and the Police Powers of the State*, 120 PUB. HEALTH REPS. 20, 23–24 (2005) (discussing federal Commerce Clause powers to regulate public health).

34 *See* *Gonzales v. Raich*, 545 U.S. 1, 23–24 (2005).

35 *Id.* at 25.

36 514 U.S. 549 (1995).

37 *Id.* at 551, 561.

38 *Id.* at 559; *see also* *United States v. Morrison*, 529 U.S. 598, 610 (2000).

39 *Lopez*, 514 U.S. at 567.

impacts were rejected both in *Lopez*⁴⁰ and in another case limiting the scope of the Commerce Clause, *United States v. Morrison*.⁴¹ Consequently, a federal school immunization mandate likely regulates activity beyond the Commerce Clause power.⁴²

The legislators behind the federal bills appear well aware of the limits of using the Commerce Clause and instead have proposed exercising Congress's second major power to regulate public health: conditional funding. Section 2(a) of H.R. 2527, the Vaccinate All Children Act, conditions funding under section 317 of the Public Health Services Act,⁴³ which allows the federal government to give states grants to finance "preventive health service programs" on a mandate.⁴⁴ Section 317 is not the only source of public health program funding available to states,⁴⁵ but it is a major source of funding for such programs, as summarized in Figure 1 below.

40 *Id.* at 563–64.

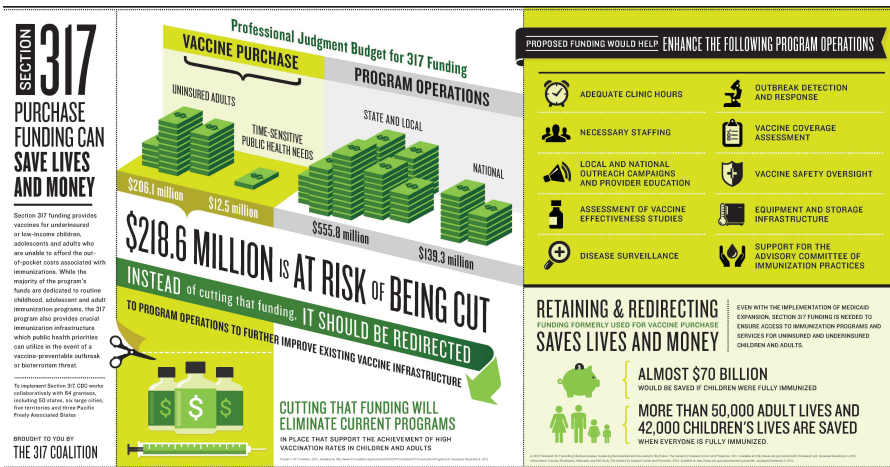
41 *Morrison*, 529 U.S. at 612–17; Christine A. Klein, *The Environmental Commerce Clause*, 27 HARV. ENV'T L. REV. 1, 31 (2003). For a discussion of the equal rights aspect of *Morrison*, see Kermit Roosevelt III, *Bait and Switch: Why United States v. Morrison is Wrong about Section Five*, 100 CORNELL L. REV. 603, 626–28 (2015).

42 In her article, Bucchieri argues the Commerce Clause is broad enough to cover school mandates. Bucchieri, *supra* note 33, at 287–91. Bucchieri does not, however, grapple with the challenge *Lopez* and *Morrison* pose and does not actually answer the points above. *See id.*

43 *See* Vaccinate All Children Act of 2019, H.R. 2527, 116th Cong. § 2(a) (2019); 42 U.S.C. § 247b.

44 42 U.S.C. § 247b(a).

45 VANESSA FORSBERG & CAROLINE FICHTENBERG, AM. PUB. HEALTH ASS'N, THE PREVENTION AND PUBLIC HEALTH FUND: A CRITICAL INVESTMENT IN OUR NATION'S PHYSICAL AND FISCAL HEALTH 20–22 (2012), https://www.apha.org/~media/files/pdf/factsheets/apha_prevfundbrief_june2012.ashx.

FIGURE 1: 317 FUNDING AND PUBLIC HEALTH PROGRAMS⁴⁶

Congress traditionally has broad discretion to attach conditions to funds it provides the states, but that discretion is not unlimited. Most relevant, the conditions cannot be unduly coercive. Under the anticommandeering principle, Congress cannot “commandeer” a state’s legislative process and require a state to enact a federal regulatory program.⁴⁷ Commandeering includes both direct requirements and coercive conditions attached to a state’s receipt of federal funds that effectively force the state to accept the conditions.⁴⁸ The most recent case to consider these principles was *National Federation of Independent Business v. Sebelius*, in which the Supreme Court held the conditions attached to states’ receipt of Medicaid funding under the Affordable Care Act were unconstitutionally coercive.⁴⁹ The Court addressed whether conditioning existing Medicaid funding on a state’s adoption of Medicaid expansion was coercive.⁵⁰ The Court was not entirely clear on what precisely made these conditions coercive.⁵¹ The Court did note, however, that the conditions for effectively expanding Medicaid conditioned states’ funding on their adoption of a “new program” rather than attaching conditions to the existing Medicaid program.⁵² It also emphasized that because Medicaid spending is such a high percentage of states’ budgets, states had no real

46 Prepared for, and provided to the authors via the non-profit, the 317 Coalition.

47 *New York v. United States*, 505 U.S. 144, 161–62 (1992).

48 *Id.* at 161, 167; see *South Dakota v. Dole*, 483 U.S. 203, 211–12 (1987).

49 567 U.S. 519, 581–82 (2012).

50 *Id.* at 575.

51 See Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court’s Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFFS. 1663, 1667–70 (2012); David Orentlicher, *NFIB v. Sebelius: Proportionality in the Exercise of Congressional Power*, 2013 UTAH L. REV. 463, 467–71 (2013).

52 *Sebelius*, 567 U.S. at 585.

choice about whether to adopt the expansion because they depended heavily on those funds.⁵³

Because the scope of *Sebelius* is unclear, there is some risk the proposed condition in the Vaccinate all Children Act would be struck down. School immunization mandates are different in kind from existing programs funded via section 317, which include public health infrastructure and immunization programs.⁵⁴ They are not directly part of these programs, though they could be seen as related to the general goal of disease prevention that such programs promote. This matters, because *Sebelius* suggested that the closeness of the link between the condition and the goal of the funding is part of the assessment of whether the funding condition is constitutional.⁵⁵ One could argue that if conditioning part of federal highway funds on passing a twenty-one-year-old minimum drinking age law was considered by the court sufficiently linked, as was the case in *South Dakota v. Dole*, conditioning disease prevention money on a school mandate—a mandate that can reduce outbreaks—is also sufficiently linked to be constitutional.⁵⁶ One could also argue, however, that school mandates are qualitatively different from other things that section 317 funds are used for, such as purchasing vaccines for adults, funding infrastructure, and conducting specific immunization programs.⁵⁷ In *Sebelius*, the majority found the change in Medicaid provided by the expansion—although also related to insurance coverage—was a change in kind, not in degree, and there is an argument that this too is a change in kind and not in degree.⁵⁸ This argument, in our view, could very well render the condition unconstitutional.

While section 317 is not the sole source of funding for outbreak prevention and immunization programs, it is an important one, but to what degree is actually unknown. Erica DeWald, who works with the nonprofit organization Vaccinate Your Family on immunization issues, including funding immunization programs, explained:

State financing of vaccines is murky at best. Very few states still allocate funds from their state budget, so they are heavily reliant on [section] 317 and other federal funds. How money is then distributed for immunization programs is unclear. You would have to call about five people in each state to begin to piece together how vaccines are funded. That said, while the

53 *Id.* at 582; see also Orentlicher, *supra* note 51, at 467.

54 FORSBERG & FICHTENBERG, *supra* note 45, at 23.

55 See *Sebelius*, 567 U.S. at 580 (reaffirming the constitutionality of a congressional condition on a state's federal highway funds because the condition "directly related to one of the main purposes for which highway funds are expended—safe interstate travel" (quoting *South Dakota v. Dole*, 483 U.S. 203, 208 (1987))).

56 *Dole*, 483 U.S. at 208–09.

57 FORSBERG & FICHTENBERG, *supra* note 45, at 23.

58 *Sebelius*, 567 U.S. at 583.

exact funding impact would differ from state to state, removal of [section] 317 funding would be devastating in each and every state.⁵⁹

This is not the magnitude in question in *Sebelius*. In *Sebelius*, the Supreme Court found that

Medicaid spending accounts for over 20 percent of the average State's total budget, with federal funds covering 50 to 83 percent of those costs. . . . The threatened loss of over 10 percent of a State's overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.⁶⁰

However, *Sebelius* did not provide clear guidance on how to separate coercion from persuasion, and there is at least an argument that undermining a state's ability to respond to outbreak in an era of increased outbreaks is coercive. Outbreaks can easily cost millions, and that money would have to come from somewhere.⁶¹

There is no certainty that a court would find conditioning the passage of a mandate on section 317 funding unconstitutional. But there is at least a considerable chance that a court would find the condition unconstitutional under the anti-coercion doctrine as set out in *Sebelius*, given the importance of existing section 317 funding, states' long-term reliance on the program, and the difference between a school immunization mandate and existing section 317 programs.

Beyond the constitutional concerns, there are several policy reasons to prefer a state-by-state approach to school immunization mandates. First, not all states could meet the conditions proposed in these bills; in some states, their political environment does not favor federal mandates,⁶² potentially not even if the result is the loss of section 317 funding. Second, and relatedly, antivaccination groups are highly mobilized and often aggressive in their opposition;⁶³ in some states, their arguments may align with the view of a majority of citizens (for example, in a state where parental rights are highly emphasized, or where there is a strong opposition to most state interventions). If a state cannot pass a mandate, it could lose funding that supports existing immunization programs and public health infrastructure, thus reducing rather than increasing vaccine rates and harming other important disease prevention efforts. A potential counter to this argument is that a mandate conditioned on funding changes the balance for a state and can make previously politically unfeasible changes feasible, but our

59 Email from Erica DeWald, Vaccinate Your Family, to authors (Jan. 29, 2020, 11:07 EST) (on file with authors).

60 *Sebelius*, 567 U.S. at 581–82.

61 See Charlotte A. Moser, Dorit Reiss & Robert L. Schwartz, *Funding the Costs of Disease Outbreaks Caused by Non-Vaccination*, 43 J. LAW MED. & ETHICS 633, 634–36, 645–47 (2015).

62 See Hillel Y. Levin et al., *Stopping the Resurgence of Vaccine-Preventable Childhood Diseases: Policy, Politics and Law*, 2020 ILL. L. REV. 233, 256 (2020).

63 See *id.* at 249.

experience with changing vaccine policies is that the level of resistance from the anti-vaccine minority will be high, and it takes substantial political will to overcome it—and in a state with strong opposition, it will be very hard to do.⁶⁴

Third, there is not actually a consensus on the most appropriate policy to increase vaccine rates. Some scholars and several professional medical associations recommend complete removal of nonmedical exemptions,⁶⁵ while other scholars raise concerns about the backlash this could create.⁶⁶ Some scholars suggest keeping religious exemptions while making it burdensome for parents to opt out of vaccine requirements,⁶⁷ and others offer additional alternatives to complete removal of exemptions.⁶⁸ The lack of scholarly and political consensus will likely be reflected in the amendments to a school immunization mandate law as the bill advances through Congress, and the result may be unacceptable to a significant portion of the country. For example, if Congress, motivated by strong support of religious freedom, adds a religious exemption, states who have removed all nonmedical exemptions would likely be unhappy. Conversely, states with a majority that strongly values religion may be unhappy with a mandate that does not allow such a religious exemption. Other loopholes could weaken the end result, too.⁶⁹

Finally, states vary in the challenges that may lead to pockets of under-immunized residents. In some states, where the main issue is refusal, a mandate can help. But if the main issue is lack of access to vaccines, as described above, a mandate will not solve the problem and can be unfair to those facing real barriers to access.⁷⁰

64 See Dorit R. Reiss & Paul A. Offit, *Improving Vaccine Policy Making: A Dose of Reality*, 38 VACCINE 2273, 2273–74 (2020).

65 *Elimination of Non-Medical Vaccine Exemptions Ranked Top Priority at Annual Leadership Forum*, AAP NEWS (Mar. 16, 2019), <https://www.aappublications.org/news/2019/03/16/alfresolutions031619>; Press Release, Am. Med. Ass'n, AMA Policy Advocates to Eliminate Non-Medical Vaccine Exemptions (June 13, 2019), <https://www.ama-assn.org/press-center/press-releases/ama-policy-advocates-eliminate-non-medical-vaccine-exemptions>.

66 See, e.g., Neal D. Goldstein, Joanna S. Suder & Brett E. Bendistis, *The Politics of Eliminating Nonmedical Vaccination Exemptions*, 139 PEDIATRICS (Feb. 28, 2017), <https://pediatrics.aappublications.org/content/pediatrics/139/3/e20164248.full.pdf>; Mark C. Navin & Mark A. Largent, *Improving Nonmedical Vaccine Exemption Policies: Three Case Studies*, 10 PUB. HEALTH ETHICS 225, 225 (2017), <https://academic.oup.com/phe/article/10/3/225/2993965>.

67 See, e.g., Mark C. Navin, *Prioritizing Religion in Vaccine Exemption Policies* (Apr. 17, 2015) (unpublished manuscript), <https://www.bgsu.edu/content/dam/BGSU/college-of-arts-and-sciences/philosophy/documents/conferences/2015%20Religious%20Exemptions/Navin.pdf>.

68 See, e.g., Opel et al., *supra* note 3, at 2–3; Levin et al., *supra* note 62, at 256–58.

69 See Paul L. Delamater et al., *Assessment of Exemptions from Vaccination in California, 2015 to 2027*, 172 ANNALS INTERNAL MED. 362, 362 (2020) (discussing how exemptions limited the effectiveness of a California law).

70 See *supra* text accompanying notes 14–24.

CONCLUSION

For these reasons, a federal mandate is a problematic policy option. As difficult as state-by-state legislative efforts are, they allow better tailoring of policy to a specific state's needs, avoid removing needed funding, and allow experimentation (and comparison) among states.⁷¹ In other words, the most valuable contribution Congress can provide to raising vaccines rates is not the heavy tool of state-level mandates, such as mandates through (aggressive) funding incentives, but rather to support efforts to raise immunization rates through the power of the purse, thoughtfully directed at where it can do the most good.

71 *But see* Bucchieri, *supra* note 33, at 282–87.