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Delineating the Obligations That Come with Conscientious Refusal: A Question of Balance

By Adam Sonfield

In his high-profile commencement speech at the University of Notre Dame in May, President Obama called on the country and its policymakers to "honor the conscience of those who disagree with abortion, and draft a sensible conscience clause." His remarks came just two months after his administration moved to rescind an 11th-hour Bush administration regulation that greatly expanded the scope of several long-standing laws related to religious and moral objections by health care providers. The ultimate fate of the Bush regulation is still unknown, as is how the issue of "conscience" might be addressed in the context of health care reform. It is clear, however, that this issue is and has been for many years a top priority for socially conservative policymakers and advocacy groups across the country, who will continue their attempts to expand the scope of conscience rights well beyond the issue of abortion.

Most of the debate over the past year, and in decades past, has focused on the scope of conscience rights—questions such as which individuals and institutions should have a right to refuse and for how broad a set of services. These are serious, difficult questions about which there is widespread disagreement. Yet, however policymakers answer these questions, their work would not be complete. Rather, whenever federal or state policymakers grant conscience rights, they also need to address questions about how to mitigate the potential harm to patients.

Two steps are critical to making any refusal policy work in everyday situations, so that health care professionals or institutions, in the act of exercising their conscience, do not intentionally or otherwise block patients' access to care. First, any objection to providing a specific service must be made transparent to all relevant parties. Second, those relevant parties that have a legal or contractual obligation to make that service available must take appropriate action to do so.

Refusal, Notice and Obligations

Despite four decades of lawmaking on the subject of conscience clauses, there has been only infrequent consideration of the potential impact on patients and haphazard adoption of any concomitant obligations. These issues perhaps have been addressed most comprehensively in the context of Medicaid, as part of the Balanced Budget Act of 1997, which gave states the authority to mandate enrollment in managed care plans. In doing so, that legislation explicitly gave plans the right to refuse to provide coverage of counseling or referral to which they object on religious or moral grounds. Perhaps more importantly, the regulations that implement the act assume that providers within a plan's network—and sometimes entire plans themselves—will have objections to specific services. In response, the legislation and regulations impose obligations on insurers and state governments to ensure that enrollees' access to care guaranteed under Medicaid is not compromised.

Medicaid managed care plans are required to do their best to maintain an adequate network of providers and guarantee that if they are unable to provide adequate and timely access to any covered service within their network, enrollees must be allowed to obtain that care outside the

network. Plans must allow this option at no additional out-of-pocket cost and explain to their enrollees how out-of-network access works. The example used in the regulation to illustrate a situation requiring out-of-network care was a tubal ligation following a cesarean delivery—a clear reference to religious refusal around sterilization.

To address the issue of refusal by entire plans, states may ensure access by carving specific services out of the managed care contract. In such situations, the law and regulations require that current and prospective enrollees be given specific information on any services that are covered by Medicaid but not available through a given plan, including information on where and how enrollees may access the care, any required cost sharing and how transportation is provided. An alternative way for states to address insurers' refusal is by contracting with religious insurance plans for all covered services, but allowing those plans to set up creative partnerships with outside groups to cover and arrange for any "objectionable" services. Numerous Catholic and other religious health care institutions have quietly agreed to those types of arrangements over the years, albeit not always without controversy.

Federal law has also attempted to provide balance to the conscience rights of employees in the health care field. Title VII of the Civil Rights Act requires employers with at least 15 employees to attempt to accommodate the religious practices of employees, including their refusal to perform specific duties they view as contrary to their religious beliefs. That accommodation has its limits, however. Employers need not allow refusal if doing so would impose an undue hardship on their business, including their ability to serve clients in a timely and appropriate manner.

The Equal Employment Opportunity Commission (EEOC), which oversees this law, released an updated compliance manual on religious discrimination in July 2008 that includes several examples in the health care field of how this balance should work in practice. Two of those examples, based on a real-life case out of Wisconsin, explored a pharmacist's objections to the provision of contraceptives. In the first, the pharmacist's employer, according to the EEOC, provided a reasonable accommodation to the pharmacist—and adequately served its customers—by allowing him to signal a coworker to serve any customers seeking contraceptives. In the second example, the EEOC explained that the employer would not have to allow the objecting pharmacist to simply walk away from a customer or leave a caller indefinitely on hold, actions that would clearly harm a customer (and the employer's business). Furthermore, the guidelines note that the accommodation from the first example may have been an undue hardship for a smaller pharmacy where qualified coworkers might not always be available.

Although health care facilities generally have no legal obligation to provide specific services, in some cases they do. For example, health centers accepting federal or state grants to provide specific care—such as Title X funding to provide family planning services—are obliged to provide that care regardless of the objections of individual employees. Moreover, many state laws require health care facilities to provide specific services in specific circumstances. For example, 16 states have required hospital emergency departments to provide information about emergency contraception to sexual assault victims, dispense the drug upon request or both. Even if individual hospital employees object, the hospital itself is responsible for ensuring that patients receive the required services. Similarly, several states have adopted policies affirming that pharmacies have a duty to dispense lawfully prescribed contraceptives and other drugs, regardless of the beliefs of their individual employees (related article, Spring 2008, page 2).

Principles for Future Reform

These attempts to ensure access to care in the face of refusals have traditionally been piecemeal, responding to specific, well-publicized problems—such as the refusal of some pharmacists to dispense emergency contraception—and to narrowly tailored legislation. Late in June, however, the Louisiana legislature approved a bill extending new refusal rights to individual health care providers for a list of specific services that includes abortion, embryonic stem cell

NOTICE AND OBLIGATIONS

Whenever federal or state policymakers grant a right to conscientious refusal, they should also codify a set of obligations to help minimize potential obstructions to patients' access to care.

Refusing Providers or Entities…	…Must Provide Advance Notice…	…and Responsible Parties Must Take Appropriate Action
Providers with insurance contracts Private practitioners Hospitals Health centers	To any insurers with whom they contract	Public or private insurers must: 1) provide notice of provider refusals to their enrollees; and 2) maintain a provider network adequate to ensure access to covered services or allow out-of-network care
Health care employees	To their employer	Employers' obligations and rights are governed by Title VII of the Civil Rights Act; if patient access is guaranteed by right or contract (e.g., by receipt of a government grant), employers must ensure that other employees are always available or make alternative arrangements to ensure access to services
Hospitals (in relation to doctors)	To providers requesting or receiving admitting privileges	
Health care facilities (in relation to the public) Hospitals Health centers Pharmacies	To the general public via a posted sign in an appropriate public section of the facility	
Insurance plans	To potential and current enrollees and to any government-run insurance program or market in which they participate (e.g., Medicaid, an exchange)	Government agencies running a market (e.g., an exchange) must 1) provide notice of this refusal to potential enrollees; and 2) maintain an adequate choice of participating insurers; government-run insurance programs (e.g., Medicaid) must also allow for and faciliate out-of-plan care

research and assisted suicide. The legislation explicitly states that refusal may not compromise patient access to health care. Accordingly, it requires providers to give written notice of their objections to current and potential patients and employers, and it requires facilities employing such persons to ensure they have sufficient staff to provide patient care. Although many states have included limited notice requirements in their conscience laws (typically from employees to employers), the built-in protections in this new law are groundbreaking, and even more notable coming out of a state as socially and politically conservative as Louisiana.

Going forward, federal and state policymakers are certain to put forth numerous new proposals on the issue of conscientious refusal. One obvious platform for such a proposal is the health care reform legislation making its way through Congress, which touches on virtually every facet of the U.S. health care system. That legislation could radically change how individuals and small businesses select and pay for coverage, via mandates, subsidies, regulation and a new health care "exchange" or "gateway" through which potential enrollees would be provided with the information they need to make an informed choice from among competing plans. Yet, whenever and wherever the conscience issue is addressed, and no matter how broad or narrow the refusal rights granted, policymakers should codify an accompanying set of obligations as an integral component of any policy, to ensure that individual access to care is compromised as little as possible. These obligations are outlined in the chart above and discussed in detail below.

Providers with insurance contracts. One set of obligations arises in the context of contracts between health care providers and insurance plans. Any provider—such as private practitioners, hospitals, health centers and pharmacies—contracting with a public or private health insurance plan should be required to notify the plan in advance if it has an objection to the provision of a specific service or supply. This notice is necessary for insurers to fulfill their own contractual obligations to make available all services for which they provide coverage. Specifically, plans should be required to either ensure that there are sufficient health care providers and facilities in

their network that provide each covered service, or else allow access to and provide reimbursement for out-of-network services when their network is inadequate. Insurers should also be required to ensure that potential and current enrollees receive the information they need to access care, including notices of refusal and explanations of when and how they may go outside of the network.

Health care employees. Religiously motivated refusal in the workplace, as noted above, has long been governed by Title VII of the Civil Rights Act and related laws on religious discrimination. The first step in that context is for an employee to notify his or her employer of a religious practice, such as a religious objection to participating in a specific health care service. Only after receiving that notice can an employer determine how that objection may be accommodated. If the employer (for example, a private practitioner, hospital, health center, pharmacy or other health care facility) has a contractual or legal obligation to provide the service to its patients (for example, under a government grant or a state pharmacy access law), it must take steps to ensure that this occurs. Specifically, it must ensure that other employees are always available to provide the given service or make alternative arrangements that would have the same effect of ensuring timely access to care.

Hospitals (in relation to doctors). In nonemergency circumstances, patients typically initiate care at a hospital through a referral from a physician or other health care practitioner. It is vital, therefore, that hospitals be required to provide advance notice to those gatekeepers—that is, the providers requesting or receiving admitting privileges at the hospital—if they adopt a policy of objecting to a specific health care service. Such notice serves two functions: It allows those providers to make informed decisions about the hospitals with which they wish to work and associate, and it enables providers to steer patients to a hospital that can best serve their needs.

Health care facilities (in relation to the public). Even though patients typically do not walk into a hospital without a referral, hospitals should be required to make their conscientious objection to providing specific services transparent to the community. A conspicuous notice posted in an appropriate public section of the facility would allow prospective patients to learn about these policies in advance (when they visit a hospital for other reasons, for example) and to discuss with their doctor how those policies might affect their care, should they be admitted.

A posted notice of this sort is even more critical in the case of health centers and pharmacies, at which any member of the public may seek services without a referral. Although some prospective clients may have been notified of a health center's or pharmacy's religious objections by their insurance plan, others will have no such source for this information. Posted notice would allow potential clients to make informed choices about which health centers and pharmacies would best meet their needs and fit their values.

Insurance plans. Insurance plans, by their nature as contracts with purchasers, must provide full disclosure of any items, treatments or services excluded from coverage. Yet, such disclosure is too often made through legal fine print that a typical American has little chance of deciphering. For potential enrollees to make an informed choice from among competing plans, this information needs to be far more accessible and comparable than it is today, and insurers should be required specifically to provide notice of any religious objections to providing coverage.

Health insurance plans should be required to provide advance notice of services excluded from coverage to any government agency that is providing relevant oversight, including public insurance programs like Medicaid and government-run markets like the exchanges envisioned under health care reform. Medicaid managed care provides a model for what a public insurance program must do next to ensure that enrollees retain access to care: It must provide notice of any objection by participating plans to all current and potential enrollees in the program, maintain a choice of participating plans adequate to ensure access to all covered services and supplies, and provide and pay for out-of-plan care, when needed, at no additional cost to the enrollee. The first two obligations

can and should be carried over to a government-run exchange. (Because an exchange would not have the capacity to pay for care directly, an out-of-plan option would not be possible.)

An Imperfect Solution

These obligations are minimal. They are intentionally limited to those that can reasonably be required by law as a minimum balance to any conscience rights granted by the government. And the burdens they place on individuals and institutions are equally minimal. It should be difficult for any health care actor or policymaker to complain about such modest steps.

Even under the best of circumstances, however, these modest obligations will not be sufficient to fend off every possible problem that might be created by a provider's or insurer's conscientious objections. Other, voluntary steps might help to head off problems: Primary care providers and specialists, for example, should take care to plan for and discuss potential problems with their patients before they occur; for example, obstetricians should discuss postpartum sterilization with their patients before choosing a hospital for the delivery. Providers that live in a community without any access to a specific service—such as a rural community where the only pharmacy refuses to provide contraception—could attempt to find other solutions, such as care via the Internet or providing the service directly themselves, if legal. Medical associations and boards could also help head off potential problems through educating members, delineating expected standards of care and attempting to prevent or rectify any shortages of willing and qualified providers that might develop.

All of these steps, whether mandated or voluntary, would help ensure access to care in situations involving religious or moral refusal. Ultimately, policymakers and the general public must come to understand that these obligations and protections should be a vital part of any policy granting refusal rights. www.guttmacher.org