

Conscience Makes a Comeback In the Age of Managed Care

By Rachel Benson Gold

A provision quietly added to the Medicaid statute last summer could set the stage for reducing access to key reproductive health care services—even for women not on Medicaid. In fact, while the potential of this so-called conscience clause to reduce availability for Medicaid recipients may be blunted somewhat by the underlying legal requirements of the overall Medicaid program, its impact could be many times more dramatic if applied to private-sector insurance plans, as is likely to be attempted this year.

In a formal way, the issue of conscience—permitting individual medical providers and facilities to decline to provide services to which they are morally or ethically opposed—began with the Supreme Court’s decision in *Roe v. Wade* in 1973. Literally within weeks, Congress passed the so-called Church amendment—named after former Sen. Frank Church (R-ID)—giving individuals and medical facilities the right to decline to provide abortion and sterilization services. The states quickly followed suit. According to a 1997 analysis by The Alan Guttmacher Institute, half enacted parallel laws by the end of 1974, and, by the end of 1978, nearly all states had done so. For a decade, the issue was dormant.

The Managed Care Landscape

In large measure because of the recent rapid expansion of managed care, however, the 1990s health care landscape is far different from the one existing in the mid-1970s when states were enacting their initial conscience laws. The marketplace is now

dominated by huge medical corporations rather than the traditional private practices that once provided the bulk of medical care. This has blurred the once-sharp line between the providers and the payers of care, leading to an array of questions about which entities should appropriately be entitled to claim a conscientious objection to providing “sensitive” medical services. To the extent that the competition among health care providers has led to a wave of consolidations and mergers between religious and secular institutions, issues concerning the dominance of one organization’s religious dictates over those of a previously secular organization have also come to the fore.

The emergence of managed care has both enhanced the impact of existing conscience laws and led to the enactment of new, and wider, conscience provisions. Most managed care plans restrict enrollees to a prescribed pool

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of health care providers, or at the very least make it much more financially advantageous to do so. Limiting the easily available pool of providers clearly heightens the impact of laws allowing individual providers and facilities to decline to provide particular services.

In addition, the managed care revolution is yielding a crop of new conscience laws (North Dakota, Texas and Illinois enacted laws in 1997), which are broadening traditional conscience-law concepts in two key ways. First, these newer laws go beyond abortion and sterilization, the traditional subjects of conscience clauses, to apply to any health service about which an ethical, religious or moral objection is raised. Second, these laws explicitly take into account changes in the health care marketplace by greatly expanding the category of entities allowed to claim a conscientious objection. These now include not only health care providers, whether individuals or medical facilities, but also corporate payers, such as health plans. In other words, the new conscience laws effectively invest a wide range of entities with the right to claim a corporate “conscience” and opt out of paying for any health care service at will.

Impact on Medicaid...

The impact of such legislation is likely to be far different for women insured through the joint federal-state Medicaid program than for women insured through private, employment-related health insurance. Ironically, because of the legal requirements of the Medicaid program—provided they are aggressively enforced by the federal government and the states—the effect on Medicaid recipients may be much less onerous.

Family planning is a mandated service under Medicaid. As a result, Medicaid recipients in all states are legally entitled to publicly funded family planning services; state Medicaid agencies are further charged with making this care accessible to all program enrollees. Beyond that, while Medicaid enrollees may be locked into obtaining all other covered services from providers affiliated with their managed care plans, under current law

PATIENTS MUST BE INFORMED OF THEIR OPTIONS IN ORDER TO GIVE INFORMED CONSENT

The patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice....The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

Principles of Medical Ethics of the American Medical Association (1996–1997 edition)

Since the judgment about which choice will best serve well-being properly belongs to the patient, a physician is obliged to mention all alternative treatments, including those he or she does not provide or favor, so long as they are supported by respectable medical opinion.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982)

they retain the ability to obtain family planning services from the provider of their choice, even if that provider is not affiliated with their managed care plan.

Against this legal backdrop, Congress last year enacted the first conscience language specific to the Medicaid program as part of the Balanced Budget Act of 1997. This provision gives Medicaid managed care plans the right to claim a conscientious objection and refuse “to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds....” Ironically attached to language prohibiting plans from imposing so-called gag clauses on their physicians, this provision allows plans to prohibit physicians from discussing specific services if the plan—whether or not religiously controlled or even affiliated—claims a moral or religious objection to them.

Enactment of this provision moves to center stage the statutory right of Medicaid recipients to obtain family planning services from the provider of their choice. It effectively becomes the only way to reconcile—however imperfectly from the enrollee's point of view—a program

that, on one hand, mandates the availability of certain care and, on the other, allows plans to ban physicians from providing, or even discussing, that care.

As important as this provision may be, however, it is not self-executing; the federal government and the states have an obligation to take the steps necessary to see that it fulfills its ever-more-crucial role. They must ensure that enrollees are clearly notified that family planning is a covered service to which they are entitled and one that may be obtained from outside their health plan; further, they must see that women are given clear and up-to-date information about where these services are available. (The only requirement in the Balanced Budget Act itself is that plans inform enrollees if their providers will not counsel or refer for services to which the plan objects; the law is silent on the subject of notifying enrollees of their options for obtaining legally mandated care.)

...And in the Private Sector

At the federal level, the conscience issue could resurface later this year if Congress, as expected, turns its attention to legislation regulating private-sector managed care plans. It is likely that in that context an attempt will be made to attach a conscience clause similar to the one added to Medicaid.

Women covered through private insurance have none of the legal protections that are available to Medicaid enrollees. Private-sector plans, which cover two-thirds of women of reproductive age, are under no legal mandate to cover family planning services, comprehensively or at all. Indeed, a 1993 study by The Alan Guttmacher Institute shows that most private insurance plans fail to cover the full range of FDA-approved contraceptive methods and that many plans cover no contraceptive services at all.

Nonetheless, while privately insured women may not have a legal right to obtain the care, they at least have the same basic right to informed consent as do their publicly insured counterparts under generally accepted principles of medical ethics; these principles specify that a patient is only capable of giving informed consent if he or she is adequately informed of the full range of alternatives (see box). Clearly, provisions allowing plans to gag physicians from discussing a woman's options on the grounds of corporate conscience are incompatible with those basic principles. Nonetheless, these are the grounds on which the debate is likely to occur.