Refusing to Participate In Health Care: A Continuing Debate

For nearly 30 years, policymakers have debated the circumstances in which it may be appropriate for individuals and institutions involved in health care to refuse to participate in services to which they object as a matter of conscience. The rise of managed care and recent debates over mandating insurance coverage of contraception have brought into focus the many facets of this issue, including the rights and responsibilities of such corporate players as health plans and employers.

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Among the host of national controversies unleashed by the Supreme Court's *Roe* v. *Wade* decision is the issue of whether individuals and institutions should be permitted to refuse to participate in health care services on the grounds of religious belief or moral objection. However, what had originally presented itself as a matter involving individual clinicians and facilities in the actual provision of abortion and sterilization procedures has broadened in the nearly three decades since Roe to include a range of issues concerning more indirect forms of involvement in a wider array of services. The result is a complex and interrelated web of federal and state laws and policies addressing the fundamental questions of whose nonparticipation should be allowed and for what services (see chart). Some of these public policy questions—especially as they pertain to the actual provision of medical care and, specifically, the provision of abortion and sterilization services—have not been actively debated in many years. Others, concerning involvement less directly related to the hands-on provision of medical care and the breadth of allowable reasons for noncompliance, remain highly controversial. What is certainly least developed, however, is a body of public policy addressing the other side of the equation: the ability of individuals to obtain health care services to which they are entitled, by law or under the terms of their insurance plan, in a system in which a range of key players are allowed to opt out.

Conscience and Health Care Providers

Within weeks of the *Roe* decision in 1973, Congress adopted legislation proposed by then-senator Frank Church (R-ID) that permits individual health care providers receiving federal funding or working for entities receiving such funding to refuse to perform or assist in performing abortions or sterilizations if these procedures violate their religious beliefs or moral convictions. The provision also prohibits discrimination against health care providers because of their nonparticipation—or participation—in abortions or sterilizations.

At least as related to abortion, states quickly emulated, and expanded, the federal model. More than half the states adopted laws by the end of 1974, and currently, 45 states allow health care providers—whether or not public funds are involved—to refuse to participate in the delivery of abortion services. Only three of these states require providers to notify patients of their refusal. Moreover, while 39 states protect providers who refuse to participate in abortion from discrimination, only eight follow the federal law in also protecting those who do choose to participate.

Several states apply these types of provisions to other reproductive health services. Twelve states allow individuals to refuse to provide sterilization services, while 13 states allow health care providers, public employees or both to refuse to provide contraceptive services or information related to contraception. (Two additional states have general provisions allowing providers to refuse to participate in any health care service.)

In addition to allowing individuals to opt out, the federal Church amendment allows institutional health care providers, such as hospitals, receiving federal funding to refuse to permit their facilities to be used for abortions or sterilizations if those procedures contravene the facility's religious beliefs or moral convictions. However, the law offers no criteria for determining when a health care facility—a corporate entity—appropriately may claim a religious or moral belief.

Similar provisions allowing institutions to refuse to participate in the delivery of abortion services were adopted by 42 states, although, significantly, only a handful of these statutes mirror the federal provision by limiting the grounds for refusal to religious or moral beliefs. Moreover, five states specifically allow facilities to refuse to provide even advice and counseling about or referral for abortion. And only seven require institutions to notify the public, through a posted public notice or directly to the patient, of their policy.

Federal and State Policies Allowing Nonparticipation in Reproductive Health Care

	Individual Providers	Institutional Providers	Insurers	Employers
Federal	A*, S*	A*, S*	C†, G‡	
Alabama				
Alaska	A	A§		
Arizona	A	A		
Arkansas	A, S, C	A, S, C§		
California	A	A**		C††
Colorado	A, C	A, C§		
Connecticut	A			C††
Delaware	A	A		
Florida	A, C	A		
Georgia	A, S, C‡‡	A, S		
Hawaii	A	A		C††
Idaho	A, S	A, S		
Illinois	A, G	A, G	G	
Indiana	A	A§		
Iowa	A	A§		
Kansas	A, S	A, S		
Kentucky	A, S	A§		
Louisiana	A	A		
Maine	A, C	A, C§		C††
Maryland	A, S	A, S		C††
Massachusetts	A, S	A§, S§, C§	A	
Michigan	A	A		
Minnesota	A, C‡‡	A§		
Mississippi				
Missouri	A	A		
Montana	A, S	A§, S§		
Nebraska	A	A		
Nevada	A	A§	C	
New Hampshire				
New Jersey	A, S	A§, S§, C§		
New Mexico	A	A, S		
New York	A, C‡‡			
North Carolina	A	A		C††
North Dakota	A	A, G		
Ohio	A	A		
Oklahoma	A	A§		
Oregon	A, C‡‡	A§		
Pennsylvania	A, S	A§, S§	G	
Rhode Island	A, S			
South Carolina	A	A§		
South Dakota	A, C§§	A		
Tennessee	A, C	A, C§		
Texas	A	A§	G	
Utah	A	A§		
Vermont				
Virginia	A	A, C**		
Washington	A, G	A§, G	G**	G
West Virginia	C‡‡			
Wisconsin	A, S, C‡‡	A, S		
Wyoming	A, C‡‡	A§		

*Applies to recipients of federal funds and participants in programs receiving federal funds. †Applies to five named religious plans and any other that objects on the basis of religious beliefs participating in the Federal Employees Health Benefits Program (FEHBP). ‡Applies to Medicaid managed care plans and FEHBP participating plans with respect to counseling and referral only, not to the actual provision of services. §Applies only to private institutional providers. **Applies only to religious entities. ††Applies only to religious employers. ‡‡Applies only to public employees. §§Applies only to pharmacists with respect to medication that may "destroy an unborn child…from fertilization until live birth." *Note:* A=abortion; S=sterilization; C=contraception; G=general policy applying to any medical service.

Eleven states allow some or all facilities to refuse to provide sterilization services, and seven states allow them to refuse to provide contraceptive services or information related to contraception. (Three additional states have general provisions that cover all health care services.)

Sparked in part by the Food and Drug Administration's approval in September 1998 of "emergency contraception," birth control pills packaged specifically for use within 72 hour of unprotected intercourse—as well as by concerns over the potential legalization of assisted suicide—some pharmacists, and even some pharmacies and pharmacy chains, have begun to assert a right to refuse to fill certain prescriptions (*TGR,* Vol. 2, No. 3, June 1999). In 1998, South Dakota enacted a law allowing pharmacists to refuse to fill prescriptions related to assisted suicide and euthanasia or to the destruction of "an unborn child"—defined under state statute to include a fertilized egg. Similar legislative proposals were seriously considered in four states in 1999, but none was adopted. However, many of the state laws allowing providers to refuse to provide contraception could be interpreted to apply to pharmacists or pharmacies.

Coverage Mandates and Plan Noncompliance

Federal and state mandates that a specific package of benefits be covered, and the rise of managed care, together and separately raise a series of thorny policy questions about the circumstances under which health plans that pay for care, rather than provide it, should be permitted to opt out of covering services to which they may object. In Medicaid, the joint federal-state insurance program for low-income Americans, the two issues are joined.

Medicaid covers six million women of reproductive age, almost all of whom now get their health care through some type of managed care arrangement. Family planning is one of the few services mandated by federal Medicaid law, giving Medicaid recipients nationwide a legal entitlement to unfettered access to contraceptive services and supplies.

In an effort to ensure that access to family planning would not be impeded because individual providers, or even entire managed care plans, refuse to provide the care, the federal Medicaid statute was amended in the mid-1980s to allow managed care enrollees to obtain family planning services from the provider of their choice, even if outside their managed care plan. This provision remains one of the few conscious attempts by policymakers to mitigate the impact of noncompliance on people seeking services. Because the individual states historically organized and operated their own Medicaid managed care systems, implementation of this provision was left to them (*TGR,* Vol. 1, No. 4, August 1998).

States' latitude over their Medicaid managed care efforts was limited in 1997, when Congress, as part of far-ranging budget legislation, moved to establish the first uniform national standards for Medicaid managed care. In so doing, Congress extended to Medicaid managed care enrollees key elements of a package of protections, known as the Consumers' Bill of Rights and Responsibilities, that had been developed by a presidential advisory commission. A central component of this package is an "antigag provision," designed to preclude plans from prohibiting providers from discussing treatment options not covered by the plan.

When Congress extended the antigag protection to Medicaid enrollees, however, it also added a provision allowing plans to refuse to cover counseling and referral services to which the plan has a religious or moral objection. While this provision applies only to counseling and referral and not the actual provision of services, advocates were fearful of the impact on low-income women's reproductive health of such an invitation to decline to provide time-consuming counseling and referral services.

Advocates also feared that the joining of the counseling and referral exemption to the antigag provision would be a precedent for subsequent extensions of the protections of the Consumers' Bill of Rights and Responsibilities to other groups of managed care enrollees. These fears quickly proved to be well founded. In 1998, Congress embarked on an effort to extend these consumer protections to privately insured Americans. As the measure languished in the face of stiff opposition, an impatient Clinton administration used an executive order to extend the protections where it could, including to the nearly 300 plans participating in the Federal Employees Health Benefits Program (FEHBP). Unfortunately, in doing so, the administration continued the pairing of the antigag and noncompliance provisions. Whether that pairing will be continued at such time as Congress actually passes a consumer bill of rights for privately insured Americans is now very much an open question.

The question of whether plans could refuse to comply with a federal mandate also surfaced when Congress in 1998 took the historic step of mandating contraceptive coverage for federal employees and their dependents under the FEHBP. The final measure included a provision allowing noncompliance by five named religious health plans, as well as any other existing or future plan that objects on the basis of its "religious beliefs."

Plan noncompliance with a contraceptive coverage mandate also has figured in state contraceptive coverage debates; a statute enacted in 1999 in Nevada, for example, exempts an insurer affiliated with a religious organization if it objects to such coverage on religious

grounds. At the same time, policymakers and plans alike have tried to find creative ways to mitigate the impact on enrollees. Under a 1999 Connecticut contraceptive coverage mandate, for instance, a managed care plan that objects to providing such coverage may have a financial arrangement with a third party to pay for services for enrollees, thereby keeping the plan at arm's length from the actual payment for contraception while ensuring coverage for enrollees. Similar tactics, in fact, have been adopted quietly by religious plans across the country in order to participate either in Medicaid programs that require coverage of contraception and other reproductive health care or in a private marketplace when such health care is demanded by consumers (*TGR,* Vol. 1, No. 6, December 1998).

Finally, broad-based managed care laws in at least four states (Illinois, Pennsylvania, Texas and Washington) explicitly give plans a general right to refuse to pay for any health care service that is in violation of some standard of conscience, moral belief or religious conviction. (The noncompliance provision in Washington is especially broad and also includes employers with "a religious or moral tenet opposed to a specific service.") In fact, such laws are not entirely new. A 1979 Massachusetts statute allows HMOs to refuse to pay for or provide referrals for abortions not necessary to prevent the death of a woman, and several other longstanding provisions relating to abortion or family planning are written so broadly that they could be construed to cover managed care organizations or other insurance providers.

Employer Rights and Responsibilities

Since most people in this country obtain insurance for themselves and their dependents through the workplace, calls for contraceptive coverage mandates inevitably have sparked a debate over the circumstance in which employers might be allowed to refuse to comply.

The Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), pending in both houses of Congress, would mandate contraceptive coverage in private, employment-related insurance policies nationwide. As initially proposed, neither the House nor the Senate version included a noncompliance provision. (And the issue was essentially irrelevant to the FEHBP debate, because the employer in this case is the federal government itself.)

But at the state level, where contraceptive coverage mandates have received more serious consideration and several have been enacted, the question of whether employers have a right to refuse to comply with a contraceptive coverage mandate has been a focal point of debate (*TGR,* Vol. 2, No. 4, August 1999). In 1995, a bill approved by the California legislature was vetoed by then-governor Pete Wilson (R) specifically because it failed to include such an employer exemption.

So far, 10 states have enacted comprehensive, EPICC-like contraceptive coverage legislation; six of these 10 laws allow at least some employers to decline to comply. While all six of the laws allow so-called religious employers to refuse to include contraceptive coverage in the plans they purchase for their employees, they differ significantly in how they define "religious employer." Maryland, the first state to enact a mandate, is at one end of the spectrum; its 1998 law includes no definition of religious employer at all, allowing employers to refuse to cover contraceptives if doing so would be against their "bona fide religious beliefs and practices."

California is at the other end of the spectrum. Legislation finally signed into law by Gov. Gray Davis (D), following three vetoes by his predecessor, narrows noncompliance to an employer that is a nonprofit organization whose purpose is to further "the inculcation of religious values" and that primarily employs and serves people who share the religious tenets of the employer.

One of the recent state laws contains an interesting provision aimed at balancing an employer's right to claim a conscientious exemption with ensuring access to contraception for individuals covered under the policy. Legislation enacted in Hawaii allows employees in firms claiming the exemption to purchase contraceptive coverage directly from the insurance plan itself, bypassing the employer entirely. Employees choosing this coverage would be required to pay no more than what would have been paid if contraceptive coverage had been included in the group policy.

As states return to their first legislative session of the new century, it is likely that the question of mandating contraceptive coverage will continue to occupy a prominent place on their agendas. If last year is a barometer, that discussion will often include debate over the circumstances under which employers, plans and providers may refuse to comply. The issue is also likely to arise should Congress seriously consider EPICC in this or a subsequent legislative season. For their part, those advocating for access to reproductive health services in either the federal or the state legislation will continue to search for innovative strategies to mitigate the extent to which such noncompliance impedes access to this important care.

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