Health Advocate

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Health Care Refusals and the ACA – What's Next?

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Key Resources

- Factsheet: The Supreme Court's ACA Decision & Its Implications for Medicaid, available here.
- Read NHeLP's Summary & Analysis of the Supreme Court ACA Decision here.
- Read NHeLP's 10 Advocacy Steps to Support a Medicaid Expansion in Your State, available here.
- Q&A: Disproportionate Share Hospital Payments and the Medicaid Expansion, available here.

Coming in August's Health Advocate:

An in-depth look at the impact of the Supreme Court's decision on the Affordable Care Act.

The Affordable Care Act (ACA) will ensure that millions of currently uninsured women will have access to health coverage starting in 2014. Of the estimated 19 million women who lack insurance today, as many as 15 million could become insured once the ACA is fully implemented.[1] Health insurance coverage does not, however, always equate to access to needed services.

This issue of the Health Advocate provides an overview of the impact of ideological and religious restrictions—particularly institutional restrictions—on access to needed care. It describes how health care refusal policies significantly compromise women's health and, if allowed to expand, will mitigate the potential of the ACA to improve health outcomes in women. Three areas are explored: (1) the scope of covered services, (2) state determination of Essential Health Benefits, and (3) the criteria for insurance plans in the state health benefit exchanges.

WHAT ARE REFUSAL CLAUSES AND DENIALS OF CARE?

Refusal clauses (also known as conscience clauses) are laws and policies that allow health care institutions and individuals to refuse to provide, allow, provide information or referrals about, or cover services to which they have a religious or moral objection. Refusal clauses allow individual providers to "opt out" of offering these services, and also allow institutions such as hospitals to prohibit willing providers from delivering these services on their premises. Refusal clauses shield providers from liability when they refuse to provide or allow care that would otherwise be required by accepted medical standards, licensing requirements or other laws. Most refusal clauses are limited to abortion; however, some are very broad and may allow a wide range of providers and health care workers to refuse to participate in *any* service to which they have a personal objection.[2]

HOW DO REFUSAL CLAUSES IMPACT ACCESS TO CARE?

Every person expects that the medical care she receives will meet accepted standards. For women, there is an evidence-based link between access to reproductive health services, a reduction in health disparities, and an increase in health and well-being.

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[1] Sara R. Collins, Sheila D. Rustgi & Michelle M. Doty, *Realizing Health Reform's Potential: Women and the Affordable Care Act of 2010*, Commonwealth Fund (July 2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Jul/1429_Collins_Women_ACA_brief.pdf.

[2] *See generally State Policies in Brief, Refusing to Provide Health Services as of July 1, 2012*, Guttmacher Institute, (July 1, 2012), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf).

The importance of the ability of women to make decisions to postpone or prevent pregnancy is well-established within medical guidelines across a range of practice areas.[3] For some women with chronic conditions such as hypertension, diabetes, and lupus, pregnancy can seriously exacerbate their conditions. One study found that the risk of maternal death for women with lupus is 20 times the risk of non-lupus pregnant women.[4] Access to family planning, however, allows them to prevent pregnancy until their conditions are better controlled and, as a consequence, to experience healthier pregnancies and improved birth outcomes.

Refusal clauses violate the essential principles of medical practice by permitting professionals to abrogate their responsibilities to patients under accepted standards of care. For example, providing emergency contraception to a victim of sexual assault is the standard of care and may be legally required, but a refusal clause could allow a provider or hospital emergency room to violate that standard with impunity.

Restrictions imposed by institutions controlled by religious entities, particularly Catholic affiliated institutions, have the greatest impact on access to care. Catholic hospitals, clinics and insurers are governed by the *Ethical and Religious Directives for Catholic Health Care Services* ("Religious Directives") and are directly accountable to the Catholic Church hierarchy.[5] The Religious Directives explicitly prohibit contraception, sterilization, some treatments for ectopic pregnancies, fertility treatments, and abortion – even to save the life of a woman. When Catholic health systems merge with community or non-denominational hospitals, they impose all or most of these religious restrictions on the new entity. According to the Catholic Health Association, Catholic hospitals control nearly 15% of the hospital beds in the U.S., and one in six Americans receive service in a Catholic hospital each year.[6]

WHAT'S NEXT FOR THE ACA – HOW REFUSAL CLAUSES CAN LIMIT ACCESS TO SERVICES

The ACA requires the establishment of health benefit exchanges through which individuals and small employers will be able to select and enroll in the public or private health insurance plan that provides the most affordable and comprehensive care that meets their needs.[7] The exchanges will be responsible for ensuring that coverage is accessible, that consumers have good information upon which to make their coverage choices, and that participating health plans are accountable for following the law. Among other important functions, the exchanges will develop criteria, with federal guidance, for all health plans sold through the particular state's exchange. Among these criteria are:[8]

- Does the insurance plan comply with all of the insurance reforms required under the ACA?
- Does the plan cover all of the Essential Health Benefits?
- Does the plan have an adequate network to meet the health needs of its enrollees?
- Does the plan contract with Essential Community Providers?

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[3] Susan B. Fogel & Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women,* National Health Law Program (2010), *available at* http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf; CENTERS FOR DISEASE CONTROL AND PREVENTION, *Recommendations to Improve Preconception Health and Health Care – United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care*, 55 M.M.W.R. 1-233 (Apr. 21, 2006).

[4] Megan E.B. Clowse, Margaret Jamison, Evan Myers & Andra H. James, *A National Study of the Complications of Lupus in Pregnancy*, 199 Am. J. Obstet. Gynecol. 127.e1-e6 (August 2008); *see* Fogel, *supra* note 3.

[5] UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, *Ethical and Religious Directives for Catholic Health Care Services* (June 2001), *available at* www.usccb.org/bishops/directives.shtml.

[6] CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, *Fast Facts: Catholic Care in the United States* (2012), http://www.chausa.org/Pages/Newsroom/Fast_Facts/.

[7] Patient Protection and Affordable Care Act (ACA), 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010); ACA § 1311.

[8] ACA § 1311(c).

As states develop their health exchanges, there are critical junctures for consumer input to ensure that the new structures support access to comprehensive reproductive health services.

Contraception:

The ACA requires that most new health plans cover specific preventive health services without cost-sharing.[9] The Secretary of Health and Human Services (HHS) commissioned the Institute of Medicine (IOM) to make evidence-based recommendations about which women's preventive health services to include. The IOM's report, *Clinical Preventive Services for Women: Closing the Gap*, identified eight services including contraception and sterilization.[10] The IOM associates unintended pregnancy with an increased risk of morbidity for women, insufficient prenatal care, low birth-weight babies, and an increase in unsafe health behaviors during pregnancy.[11]

HHS adopted all of the IOM recommendations, and the coverage requirements go into effect for new health plans beginning August 1, 2012.[12] While the ACA does not include a refusal clause, HHS added an exemption from the contraceptive coverage requirement for some religious employers (generally limited to houses of worship such as churches, mosques and synagogues).[13] Women who work for these religious employers may not have access to contraceptive coverage - whether they are religious leaders, secretaries or janitors, and regardless of their personal beliefs.

The U.S. Conference of Catholic Bishops (the "Bishops") decried the proposed rules, demanding a broad exemption from the contraceptive coverage requirement for *any* employer, religious or secular, who has a religious objection to contraception.[14] In response, HHS issued an Advanced Notice of Proposed Rulemaking seeking recommendations on how to structure an accommodation for other religiously affiliated non-profit organizations, such as a hospitals, universities or social service agencies, that would allow them to refuse to provide contraceptive coverage in their employer or student health plans while still assuring that the women and students at those institutions can obtain contraceptive coverage at no additional cost.[15] The Catholic Health Association and the Bishops have registered formal opposition to any accommodation.[16]

Essential Health Benefits:

The ACA requires that HHS define ten Essential Health Benefits (EHBs) including "Maternity and Newborn Care" and "Preventive and Wellness Services and Chronic Disease Management" that must be covered by Qualified Health Plans (QHP) in the exchanges.[17] Despite clear language in the statute requiring HHS to define the EHBs, HHS has delegated this responsibility to the states. The breadth or narrowness of the scope of coverage will be critical to women's health and well-being. In addition, a number of states have enacted broad refusal clauses that

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[9] ACA § 1001, 42 U.S.C. 300gg-13 (2010) (adding § 2713 to the Public Health Service Act).
[10] INSTITUTE OF MEDICINE, *Clinical Preventive Services for Women: Closing the Gaps* (2011), *available at* http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.
[11] Id. at 103; *see also* CENTERS FOR DISEASE CONTROL AND PREVENTION, *Unintended Pregnancy* (Apr. 4, 2004), http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm.
[12] HEALTH RESOURCES AND SERVICES ADMINISTRATION, *Women's Health Preventive Services: Required Health Plan Coverage Guidelines*, U.S. Department of Health and Human Services, http://www.hrsa.gov/womensguidelines/ (last visited July 9, 2012).
[13] 45 C.F.R. § 147.130(a)(1)(iv)(A) (2011).
[14] U.S. CONFERENCE OF CATHOLIC BISHOPS, *USCCB Submits Comments On Proposed HHS Rulemaking, Urges Re-Opening Of Final Rule Defining Mandate, Exemption* (May 15, 2012), http://www.usccb.org/news/2012/12-084.cfm.
[15] Advanced Notice of Proposed Rulemaking for Certain Preventive Services Under the Affordable Care Act, 77 F.R. 16501 (Mar. 21, 2012) (to be codified at 45 C.F.R. pt. 147); THE WHITE HOUSE, *Fact Sheet: Women's Preventive Services and Religious Institutions* (Feb. 10, 2012), http://www.whitehouse.gov/the-press-office/2012/02/10/fact-sheet-women-s-preventive-services-and-religious-institutions.
[16] Joe Carlson, *CHA Joins Opposition to Reform Law's Birth Control Rule*, Modern Healthcare (June 15, 2012), *available at* http://modernhealthcare.com/article/20120615/NEWS/306159974/breaking-cha-joins-opposition-to-reform-laws-birth-control-rule.
[17] ACA § 1302(b)(1).

allow almost any participant in the health care system to refuse to participate in, cover, refer, or pay for a service to which the individual or institution has an objection. It is unclear how existing state refusal clauses will impact services available through the exchanges and whether states will be allowed to include refusal clauses to exempt QHPs from covering certain reproductive health services.

Network Adequacy:

Qualified Health Plans must maintain a network of providers sufficient to ensure that all covered services are accessible.[18] The adequacy of the network will determine whether covered services – including preventive services for women and covered abortion care – are actually available. If a network consists only of Catholic affiliated hospitals that prohibit most reproductive health services, or if the health care providers in the network refuse to prescribe contraception or perform sterilizations, the network should not be deemed adequate.

Essential Community Providers:

The ACA requires the QHPs to contract with "Essential Community Providers," identified as providers who serve predominantly low-income underserved individuals.[19] In some communities, especially those dominated by religiously affiliated health systems, family planning clinics may be the only sources of confidential quality reproductive health care. It is critical that QHPs be required to contract with them to provide a full range of covered reproductive health services.

CONCLUSION

If allowed to proliferate, refusal clauses and institutional denials of care threaten to undermine the promise of the ACA to ensure affordable, accessible, and quality health care for women. The burdens on low-income women can be insurmountable when women and families are uninsured, locked into managed care plans that do not meet their needs, or when they cannot afford to pay out of pocket for services or travel to another location. In rural areas there may simply be no other sources of health and life preserving medical care.

The role of ideological restrictions in decisions about the implementation of the ACA should be highly scrutinized. Refusal clauses should be evaluated using the same measurements used to evaluate quality generally, with the goal of providing care that is evidence-based, patient-centered, and preventive. All women should have access to the health care services they need based on medical evidence and sound practice, their personal health needs, and their own beliefs. Employers, insurers, hospital corporations, and governments should not be allowed to impose their ideology on women's health.

[18] ACA § 1311(c)(1)(B); 45 C.F.R. § 156.230.
[19] ACA § 1311(c)(1)(C).

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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