



The Bush Administration Moves to Block Women's Access to Contraception and Other Reproductive-Health Services

On December 19, 2008, the Bush administration published a regulation that threatens to hinder or block women's access to birth control and other reproductive-health services. It claims to enforce laws already on the books that allow doctors and other health-care professionals to opt out of providing certain health-care services. NARAL Pro-Choice America does not oppose an individual right of conscience, but this regulation goes much further than providing individuals with a right to refuse to provide services that they oppose; in actuality, it may seriously jeopardize patients' rights to receive quality, comprehensive health-care services.

On March 10, 2009, the Obama administration published a proposal indicating its intention to rescind the regulation. The proposal included a 30-day public comment period, which closed on April 9. Soon, the Obama administration is expected to issue its final decision as to whether to rescind the regulation in its entirety or to revise it.

The following provides background on the issue and an analysis of the very serious problems that the regulation may cause, if it is left intact.

Background on Refusal Provisions Already in Law

Several existing laws allow health-care providers – including individuals and health-care corporations – the right to opt out of providing certain services that they oppose on moral or religious grounds. The key laws include:

The Church Amendment¹

The Church amendment, enacted in 1973, states that no individual or health-care entity funded by the Department of Health and Human Services may be required to provide or assist in the provision of abortion or sterilization services. In 1974, the statute was amended in a bill authorizing biomedical and behavioral research and training to include broad language stating that no individual may be required to perform or assist in performing health-care services or research activities funded by the Department of Health and Human Services; however, the extent to which this broad language can be applied has not yet been fully defined.

The Public Health Service Act²

In 1996, the Public Health Service Act was amended to prohibit the federal government and any state or local government from "discriminating" against certain health-care entities on the basis that an entity refuses to receive or provide abortion training, provide abortion care or abortion referrals, or provide referrals for abortion training. In essence, it grants individual employees the right to refuse to provide, train for, or refer for abortion services, and offers certain health-

care entities – specifically, postgraduate physician training programs – the right to refuse to participate in these activities.

The Federal Refusal Clause (Weldon Amendment)³

Enacted in 2005, the Federal Refusal Clause prohibits federal, state, and local government from “discriminating” against a health-care entity that “does not provide, pay for, provide coverage of, or refer for abortions.” It defines a health-care entity as: “an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.” In other words, it grants a broad variety of health-care entities the right to refuse to provide or refer for abortions.

In summary, the Church amendment allows individuals to refuse to provide certain health-care services or participate in research activities, and gives health-care entities the right to refuse to provide abortion or sterilization services; the Public Health Service Act extends individuals and certain health-care entities (postgraduate physician training programs) rights to refuse to provide *referrals* for abortion services; and the Federal Refusal Clause allows entire health-care corporations to refuse to provide, cover, or refer for abortion services.

The Final Regulation

The Bush administration regulation purports to encourage enforcement of, and education about, the existing laws described above. If that were so, the regulation would not be groundbreaking, necessarily. But in fact, the regulation pushes the bounds of current law and introduces several very serious problems:

- It **jeopardizes women’s access to birth control** by leaving open the possibility that providers will be able to define contraception as abortion; allowing them to do so could thereby expand the conscience protections pertaining to abortion to apply to birth control as well.
- It **expands the universe of individuals and institutions that are explicitly afforded refusal rights**. It offers broad rights to employees who are only tangentially involved in providing the services at issue (for example, receptionists scheduling appointments), and it may grant entire health-care corporations (hospitals, HMOs, insurance companies) the same “conscience” rights as those offered to individuals.
- It **allows individuals to refuse to give referrals and information about a broad range of services**. Current law allows individuals the right to refuse to refer or counsel patients for abortion services, but the regulation may allow individuals to refuse to provide referrals and information about *any* health-care services. This could affect reproductive-health services and many other health-care services beyond.
- It **poses particular barriers to health-care services for low-income women and women in rural areas**. Because the regulation gives broad refusal capacities to individuals and entities receiving funding from HHS, it has a disproportionate impact on low-income

women who depend on the federal government for health services. In addition, individuals living in rural areas may be particularly afflicted because there may not be any alternative source of health care in these communities if a provider refuses to offer services.

- It **fails to take into consideration laws that protect patients' rights** to services and information, potentially limiting patients' abilities to make informed decisions about their own health-care needs and to access legal health-care services.

Examples of Harm the Regulation Could Cause

It Jeopardizes Women's Access to Birth Control

The regulation itself, and the Bush administration's discussion of it, seem deliberately calculated to confuse the definitions of birth control and abortion. First, an earlier, leaked version of the regulation defined abortion to include birth control explicitly. While the final version does not include this definition, it fails to provide *any* definition of abortion. Making matters worse, when the secretary of the Department of Health and Human Services, Michael Leavitt, was asked to clarify that the draft version of the regulation did not apply to birth control, he ducked the question: "This regulation does not seek to resolve any ambiguity in that area," he said. For these reasons, the regulation offers no assurance that current laws about abortion – including those which grant entire health-care corporations the right to refuse to provide or refer for abortion services – will not be stretched to include birth control. In other words, the regulation's deliberate vagueness threatens to grant providers the right to refuse to provide birth control under the guise of refusing to provide abortion services.

Defining abortion to include birth control conflicts with long-standing federal regulations defining when pregnancy begins, which could cause a series of problematical effects in law and policy. Doing so also interferes with many state and federal laws that guarantee women's access to and information about contraception:

- If providers are allowed to consider birth control abortion, this could undermine laws in 27 states that require insurance plans that cover other prescription drugs also to cover birth control (known as contraceptive-equity laws).⁴
- It threatens laws in 15 states and the District of Columbia that guarantee sexual-assault survivors' access to and/or information about emergency contraception in hospitals.⁵
- It could directly undermine laws in seven states ensuring that pharmacies will fill women's birth control prescriptions.⁶
- Finally, it appears to stand in open conflict with at least two federal programs that require contraceptive services to be provided to clients upon request: Medicaid and Title X. The Medicaid program includes birth control as a mandated benefit for patients. Title X is a program whose sole purpose is to provide family-planning and other related reproductive-health services. This regulation could call the provision of these services

into question by telling both individual program staff and health-care institutions that, in spite of the programs' guarantees, they may refuse to provide birth control after all.

It Extends Refusal Rights to a Broad Array of Individuals and Institutions

In addition, the rule expands the universe of health-care individuals and institutions that may refuse to provide services:

- It explicitly extends individual refusal rights to staff who are only tangentially involved in the service or activity that they oppose, such as receptionists who schedule appointments.
- Nothing in the regulation protects against the possibility that entire health-care corporations – such as hospitals, HMOs, and insurance companies – could ultimately claim the same “conscience” rights as individuals. Current law offers *individuals* the right to choose not to provide certain services to which they object, and allows certain health-care *entities* the right to opt out of providing or referring for abortion. However, the regulation leaves open the possibility that, for example, a director of a health-care institution – such as a hospital, HMO or health insurance plan – could claim “conscientious objection” to a health-care service and then claim that his or her role facilitates the provision of these services. As such, it is possible that he or she could exempt the entire corporation from providing these services.

It Allows Providers to Refuse to Provide Referrals and Information about a Broad Range of Health-Care Services

The Church amendment uses language offering individuals who “assist in the performance” of a health-care activity that they oppose the right to refuse to participate in the activity; however, it does not define the phrase “assist in the performance,” leaving open to interpretation the scope of the phrase. The new regulation explicitly defines “assist in the performance” to include referrals and information about services. Therefore, the regulation could allow individuals to refuse to provide even referrals or information about services that they oppose.

So, in addition to threatening birth control, the rule could make it more difficult for patients to receive information about a broad spectrum of reproductive-health services and other health-care services. For example, the regulation may encourage a physician or physician's assistant to deny a patient information about the cervical cancer vaccine because the individual opposes sexual activity outside of marriage. It could also potentially encourage providers to refuse to offer information about end-of-life pain management services; fertilization services for gay and lesbian patients; or HIV/AIDS treatment. Patients who are denied referrals for services often do not know that information has been withheld, and may not have any way of knowing that the services that were not discussed may be viable, legal health-care options for them.

It Poses Particular Barriers to Health Care Services for Low-Income Women, Women of Color, and Women in Rural Areas

Because the regulation gives broad license to individuals and entities that receive funding from HHS to refuse to provide health-care services and information to patients, it has a disproportionate impact on low-income women who depend on the federal government for health services. For example, the regulation jeopardizes women's ability to receive comprehensive family-planning information and services under two programs specifically intended to serve low-income individuals: Medicaid and the federal Title X program.

Furthermore, women of color, who disproportionately work in low-wage jobs that do not offer benefits,⁷ turn at higher rates to public programs such as Medicaid and Title X for affordable health care, and are therefore disproportionately affected by the regulation. In 2006, women of color made up 51 percent of non-elderly Medicaid beneficiaries, but less than 20 percent of the general population.⁸ A 2006 report found that 19 percent of all Title X clients are black and 23 percent identified as Hispanic or Latino,⁹ although they make up 13 and 14 percent of the population, respectively.¹⁰

In addition, low-income women and women of color already face numerous barriers to accessing health-care services that make it particularly burdensome for them to find alternate providers, should their primary provider refuse to offer health-care services. A study by the Kaiser Family Foundation found that low-income women face twice as much difficulty as other women in obtaining the flexible work schedules, transportation, and child care necessary to access health-care services for themselves.¹¹ In addition, the United States Office of Women's Health in the Department of Health and Human Services found that "[s]everal...factors limit the access of minority women to the U.S. health care system. They include social disadvantages, cultural values, discrimination, lack of culturally appropriate services, inadequate childcare, and transportation."¹²

Furthermore, individuals living in rural areas are disproportionately affected by the HHS regulation because there may be no alternate source of health care if a provider refuses to offer full information and services to his or her patients.

Especially in this time of economic crisis, as more and more Americans are at risk of losing their employer-provided health insurance, the government should work to enhance – not limit – patients' access to complete health-care information and services.

It Threatens to Upend the Balance Current Laws Strike Between Patient and Provider Rights

Finally, the regulation threatens to undermine current laws – principally, Title VII of the Civil Rights Act of 1964 – that protect patients' rights to information and services, and that offer guidance on the balance between providers' rights and patients' rights. Under Title VII, employers have a duty to make a reasonable accommodation for an employee or applicant's

religious beliefs or practices, unless doing so places an “undue hardship” on the employer’s business.¹³ This law provides protection for individual beliefs while still ensuring patients’ access to health-care services. However, the regulation raises serious questions as to how the expansive new refusal rights it offers will affect the needs of patients, and fails to outline whether there are any circumstances at all when the needs of the employer or its clients should be taken into account.

January 1, 2010

Notes

¹ Church amendment to the Public Health Service Extension Act of 1973, Pub. L. No. 93-45, Tit. IV, § 401, 87 Stat. 95 (codified at 42 U.S.C.A. § 300a-7).

² Public Health Service Act, 42 U.S.C. § 238n.

³ FY’06 Departments of Labor, Health, and Human Services, and Education Appropriations Act, Pub. L. No. 109-149 (Enacted December 30, 2005); Continued in the Revised Continuing Appropriations Resolution, 2007, Pub. L. No. 110-5 (Enacted February 15, 2007).

⁴ NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women’s Reproductive Rights in the United States* (18th ed. 2009), available at http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/.

Although Texas enacted a contraceptive equity law in 2001, the state enacted a law in 2003 allowing insurers to issue plans that do not include state-mandated health benefits, including coverage for contraception. As a result, Texas now allows insurers to offer, and employers to select, plans without coverage of contraceptive services and supplies. TEX. INS. CODE ANN. Art. 3.80.

⁵ NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women’s Reproductive Rights in the United States* (18th ed. 2009), available at http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/.

⁶ NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women’s Reproductive Rights in the United States* (18th ed. 2009), available at http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/.

⁷ Kaiser Family Found., *Racial and Ethnic Disparities in Women’s Health Coverage and Access to Care: Findings from the 2001 Kaiser Women’s Health Survey* (Mar. 2004), available at <http://www.kff.org/womenshealth/upload/Racial-and-Ethnic-Disparities-in-Women-s-Health-Coverage-and-Access-to-Care.pdf> (last visited Oct. 13, 2009).

⁸ Kaiser Family Found., *Issue Brief: Medicaid’s Role for Women* (May 2006) available at <http://www.kff.org/womenshealth/upload/Medicaid-s-Role-for-Women-May-2006.pdf> (last visited Oct. 13, 2009).

⁹ Research Triangle Institute, *Family Planning Annual Report, 2005*, (Nov. 2006).

Overall, 64 percent of Title X clients are classified as white—the percentages total more than 100 because some clients self-identify as Latino in regard to ethnicity but as white in terms of race.)

¹⁰ U.S. Census Bureau. “African-American History Month: February 2006.” *Facts for Features*. January 25, 2006; “Hispanic Heritage Month, September 15-October 15, 2006,” September 5, 2006.

¹¹ Kaiser Family Found., *Women and Health Care: A National Profile* (July 2005), available at <http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf> (last visited Oct. 13, 2009).

¹² U.S. Dept. of Health & Human Services, Office on Women’s Health, *The Health of Minority Women* (July 2003), available at <http://www.4woman.gov/owh/pub/minority/minority.pdf> (last visited Oct. 13, 2009).

¹³ Title VII of the Civil Rights Act of 1964, Pub.L. No. 88-352, Title VII, §§ 701-703 (codified at 42 U.S.C. § 2000e- § 2000e-2).