

# Health Care in Motion

Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

February 19, 2019 4:30PM EST

## Trump Administration Emboldens Religious Refusals to the Detriment of Patients

On the long list of objections that health care access advocates must raise in the current political climate is the formalized protection of providers who discriminate against patients on religious or moral grounds. Over the past year, the Trump Administration has taken steps to embolden health care providers who refuse to treat patients on the basis of personal convictions. In January 2018, the Administration established a new [Conscience and Religious Freedom Division](#) (the “Division”) within the Department of Health and Human Services, tasked with enforcing existing statutory “conscience protections” for health care providers. These “conscience protections” are rules that enable doctors, nurses, and other health care providers to refuse to provide care that purportedly violates religious or moral convictions. As we wrote about [here](#), this development was followed by expanded grounds for religious or moral objections to the contraceptive mandate—the Affordable Care Act’s requirement that insurance coverage include an array of contraceptive methods with no out-of-pocket costs for the consumer. In a sign of its further evolution, the Division has now flexed its newly sculpted muscles by closing its first investigation with a [Notice of Violation](#). According to the Division, a California law seeking truth and transparency in the provision of reproductive health services impermissibly impinges on religious rights.

This issue of *Health Care in Motion* examines this trend in the Trump Administration’s willingness to invoke its regulatory power to sanction objections of health care providers on religious grounds and thereby protect discriminatory behavior. Most importantly, this development has harmful effects on vulnerable patients, and creates opportunities for advocates to ensure that religious refusals do not restrict access to health care.

### Legal Rights to Religious Refusals in Health Care

Protections for religious refusals are not new in health care; they have been written into several federal and state laws. For example, the [federal Church](#) (enacted in 1973), Coats-Snowe (enacted in 1996), and Weldon (enacted in 2005) Amendments address the rights of providers to refuse to provide or otherwise participate in abortion care (e.g., offer referrals or provide information) if doing so conflicts with their religious beliefs. Abortion is a significant focus of such laws, but it is not the only one. Other targeted types of care include [transition-related medical care](#), [sterilization procedures](#), [contraceptives](#), and [end-of-life care options](#).

The newly created [Conscience and Religious Freedom Division](#) is housed in the Office of Civil Rights (OCR) of the Department of Health and Human Services (HHS). The creation of the Division does not, in and of itself, create new laws under which health care providers are legally permitted to deny care. Rather, with the Division’s creation, the Administration has signaled its intent to enforce existing laws more actively and strictly. A rule [proposed](#) in January 2018, however, could introduce new religious refusal rights in health care by expanding, for example, who may assert a right and the scope of services and programs covered under existing laws. Any rule of this sort would not be effective until HHS issues a final rule. The timing of such a move is anyone’s guess.

# Health Care in Motion

## New Enforcement Division Issues Notice of Violation in Complaint Against California

While advocates await the new rule, HHS has not been idle. On January 18, 2019, the Division made its first investigative [findings](#). The OCR determined that the California FACT Act illegally discriminated against “crisis pregnancy centers” by requiring that they provide information about the availability of abortion in California. The [FACT Act](#) required that pregnancy resource centers provide factual information about pregnancy and abortion. Contact information for free- and low-cost reproductive care, including abortions, is encompassed by the Act. The law also required that pregnancy centers disclose if they did not have licensed medical professionals on staff. (Among the problems that the FACT Act sought to remedy were non-medical professionals impersonating licensed providers when providing pregnancy counseling at crisis pregnancy centers.)

The OCR’s finding will have no immediate effect. Last June, the United States Supreme Court held that the FACT Act was unconstitutional in [NIFLA v. Becerra](#). The Court held that the law violated the First Amendment by restricting speech based on its content. Following the Court’s decision, the law was permanently enjoined.

The fact that the California law struck down by the Supreme Court and no longer operative raises interesting questions as to the Division’s motivation. Why focus on a defunct state law? The OCR could have begun with this complaint because it was an easy target in the wake of the Supreme Court’s pronouncement. Alternatively, OCR may have started with the FACT Act because it presented the opportunity to come out of the gate with a show of force against a large, progressive state. If OCR’s motivation is unclear, its future is less so. [Connecticut](#) is currently considering a bill to regulate crisis pregnancy centers on the basis of truth in advertising. A similar ordinance in [San Francisco](#) has been upheld by courts. OCR is likely to have a significant impact on the fate of the Connecticut bill and others like it.

Whatever its origins, OCR has established the Division is up and running. The Trump Administration has its own political motivation to position itself as aggressively protecting religious freedoms. But its political nature also raises the question whether the creation of the Division is a solution in search of a problem. It has been disclosed that OCR received [34 complaints](#) alleging that a health care provider’s religious freedoms were illegally infringed upon between November 2016 and January 2018. During the Obama Administration, OCR received 10. Over similar periods, OCR has received tens of thousands of complaints on other topics, such as patient privacy laws.

## What About Protecting Patients?

Patients who are denied health care are at an increased risk of physical and mental harm. Professional bodies including the [American Medical Association \(AMA\)](#), [American Nursing Association](#), and the [American College of Physicians](#) have raised concerns about effects on health care access, care outcomes, and discrimination, and have questioned the legal and ethical soundness of expanding religious protections in health care. The AMA, for example, submitted the following statement in its comments urging HHS to abandon the 2018 proposed rule:

*According to the AMA Code of Medical Ethics, physicians’ freedom to act according to conscience is not unlimited. Physicians are expected to provide care in emergencies, honor patients’ informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is*

# Health Care in Motion

*imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.*

Many of the health care services that are jeopardized by religious refusal laws, including gender-affirming hormone therapy and abortion care, are time-sensitive. Risk of physical harm is exacerbated in contexts where it is difficult to find an alternate provider. [Eighteen percent of LGBTQ people](#) have said it would be “very difficult” or “not possible” to find health services at a different hospital if they were turned away. This number rises to 41% of LGBTQ people for those living outside of metropolitan areas. The administrative complaint process, like all findings by OCR, allows for a formal [appeal](#). But going down this path can be costly and time-consuming. Appealing future decisions will do little to protect individual patients from being denied essential care in the interim.

## How can advocates help in this evolving landscape?

One option to push back against these activities is through **litigation and legal reform**. For example, if the 2018 proposed rule is finalized, the [ACLU](#) has made it clear they will challenge it in court. Another option for advocates is to focus on **leveraging public and professional pressure**. Advocates can demand transparent policies from local health care providers that enable informed choices by health care consumers. Advocates can also monitor and publicize instances of discrimination in their communities. Media attention has been an effective tool in recent cases where pharmacists, relying on conscience rules, denied [hormones](#) to a transgender woman and [medicine](#) to a woman during a miscarriage. Further, [MergerWatch](#) has a long record of helping communities organize to ensure that people have options, particularly where access to care is threatened by the acquisition of secular health care institutions by religious entities. Third, advocates can **help people remain educated** about their rights to receive care, potential barriers in their community, and what to do upon experiencing a denial of care.

These are only some of the tools available to advocates. If you are interested in learning more about these issues and strategies to protect access to care in your community, CHLPI is here to support you.

*Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Phil Waters, Clinical Fellow; Maryanne Tomazic, Clinical Fellow; and Rachel Landauer, Clinical Fellow.*

*This issue of Health Care in Motion was also authored by Emma Janger, clinical student in the Health Law and Policy Clinic of Harvard Law School.*

*For further questions or inquiries please contact us at [chlpi@law.harvard.edu](mailto:chlpi@law.harvard.edu).*

**Subscribe to all Health Care in Motion Updates**