

CRS Report for Congress

The History and Effect of Abortion Conscience Clause Laws

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Summary

Conscience clause laws allow medical providers to refuse to provide services to which they have religious or moral objections. In some cases, these laws are designed to excuse such providers from performing abortions. While substantive conscience clause legislation has not been approved, appropriations bills that include conscience clause provisions have been passed. This report describes the history of conscience clauses as they relate to abortion law and provides a legal analysis of the effects of such laws. The report also reviews recent proposed regulations to implement some of the conscience clause laws.

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The History and Effect of Abortion Conscience Clause Laws

Conscience clause laws allow medical providers to refuse to provide services to which they have religious or moral objections. These laws are generally designed to reconcile “the conflict between religious health care providers who provide care in accordance with their religious beliefs and the patients who want access to medical care that these religious providers find objectionable.”¹ Although conscience clause laws have grown to encompass protections for entities that object to a wide array of medical services and procedures, such as providing contraceptives or terminating life-support, the original focus of conscience clause laws was on permitting health care providers to refuse to participate in abortion or sterilization procedures on religious or moral grounds.

Historical Background

In 1973, Congress passed the first conscience clause law, commonly referred to as the Church Amendment,² in response to the U.S. Supreme Court’s decision in *Roe v. Wade* and a U.S. district court decision that enjoined a Catholic hospital from prohibiting a physician from performing a sterilization procedure at the facility.³ During consideration of the Church Amendment, Senator Frank Church explained the need for the conscience clause, stating, “It clears up any ambiguity in the present law by making it explicitly clear that it is not the intention of Congress to mandate religious hospitals to perform operations that are contrary to deeply held religious beliefs.”⁴

The Church Amendment provides that individuals or entities that receive grants, contracts, loans, or loan guarantees under the Public Health Service Act (PHSA), the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act may not be required to perform abortions or sterilization procedures or make facilities or personnel available for the performance of such procedures if such performance “would be contrary to [the individual or

¹ Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights*, 51 Stan. L. Rev. 1703, 1703 (1999).

² P.L. 93-45, § 401(b), (c), 87 Stat. 91 (1973). Additional conscience provisions supplemented the Church Amendment in 1974 and 1979. See P.L. 93-348, § 214(b), 88 Stat. 353 (1974); P.L. 96-76, § 208, 93 Stat. 583 (1979).

³ See 119 Cong. Rec. 9,595 (1973) (statement of Sen. Church).

⁴ *Id.* at 9,600.

entity's] religious beliefs or moral convictions.”⁵ The Church Amendment also prohibits entities that receive federal funds under the specified statutes or under a biomedical or behavioral research program administered by the Department of Health and Human Services (HHS) from engaging in employment discrimination against doctors or other medical personnel who either perform abortions or sterilization procedures or who refuse to perform such services on moral or religious grounds.⁶

By 1978, five years after the Court's decision in *Roe*, virtually all of the states had enacted conscience clause legislation in one form or another.⁷ From 1978 to 1996, there was a lull in conscience clause activity, with one exception. When Congress enacted the Civil Rights Restoration Act in 1988, it adopted the Danforth Amendment, which mandates neutrality with respect to abortion.⁸ Specifically, the amendment clarifies that Title IX of the Education Amendments of 1972, which prohibits sex discrimination in federally funded education programs, may not be construed to prohibit or require any individual or entity to provide or pay for abortion-related services, nor may it be construed to permit the imposition of a penalty on any person who has sought or received abortion-related services.⁹

Nearly a decade after the Danforth Amendment, Congress passed additional conscience provisions in the Omnibus Consolidated Rescissions and Appropriations Act of 1996.¹⁰ Under the act, which added Section 245 to the PHSA, the federal government and state and local governments are prohibited from discriminating against health care entities that refuse to undergo abortion training, provide such training, perform abortions, or provide referrals for the relevant training or for abortions.¹¹ Section 245 protects doctors, medical students, and health training programs from being denied federal financial assistance or a license or certification that they would otherwise receive but for their refusal to provide abortion services or training.¹²

One year after passing the 1996 omnibus legislation, Congress again revisited the abortion conscience clause issue when it approved the Balanced Budget Act of 1997.¹³ Concerned that managed care plans might seek to prevent doctors from informing patients about medical services not covered by their health plans, Congress

⁵ 42 U.S.C. § 300a-7(b).

⁶ 42 U.S.C. § 300a-7(c).

⁷ Rachel Benson Gold, Guttmacher Institute, Conscience Makes a Comeback in the Age of Managed Care (Feb. 1998), [<http://www.guttmacher.org/pubs/tgr/01/1/gr010101.html>].

⁸ P.L. 100-259, § 3(b), 102 Stat. 28, 29 (1988).

⁹ 20 U.S.C. § 1688.

¹⁰ P.L. 104-134, 110 Stat. 1321 (1996).

¹¹ 42 U.S.C. § 238n(a)(1).

¹² 42 U.S.C. § 238n(b)(1).

¹³ P.L. 105-33, 111 Stat. 251 (1997). The Medicare conscience clause provision is codified, as amended, at 42 U.S.C. § 1395w-22(j)(3)(B). The identical Medicaid conscience clause provision is codified, as amended, at 42 U.S.C. § 1396u-2(b)(3)(B).

amended the federal Medicare and Medicaid programs to prohibit managed care plans from restricting the ability of health care professionals to discuss the full range of treatment options with their patients.¹⁴ The legislation, however, simultaneously exempted managed care providers under these programs from the requirement to provide, reimburse for, or provide coverage of a counseling or referral service if the managed care plan objects to the service on moral or religious grounds. Thus, a Medicare and Medicaid managed care plan cannot prevent providers from providing abortion counseling or referral services, but it can refuse to pay providers for providing such information, although the plan must notify new and existing enrollees of such a policy if it does indeed have one.¹⁵

The effect of the 1997 legislation was to extend the coverage of conscience clause laws beyond the individuals who provide medical care to the companies that pay for such care under the Medicare and Medicaid programs. The law allows Medicare and Medicaid-funded health plans to refuse to provide counseling and referral for abortion-related services. Earlier conscience clause laws permitted providers to opt out only of the actual provision of such services.¹⁶

The 1997 legislation would appear to have a broader impact than the 1973 Church Amendment, both in terms of its effect on the entities that may refuse to provide abortion services and on the individuals who wish to access such services. In a similar vein, recent abortion bills introduced in Congress have proposed changes that would expand the scope of current conscience clause laws. This legislation is discussed in the next section.

Recent Legislation and its Effect on Existing Law

The Abortion Non-Discrimination Act (ANDA) has been introduced in every Congress since the 107th Congress.¹⁷ In general, ANDA would amend the nondiscrimination provision in the PHSA to expand the definition of the term “health care entity” to include hospitals, provider-sponsored organizations, health maintenance organizations (HMOs), health insurance plans, or any other kind of health care facility, organization, or plan.

Supporters of ANDA maintain that expanding the definition of “health care entity” is necessary because some state legislatures and courts have weakened existing conscience clause protections, which proponents view as critical to shielding religious hospitals and other medical providers that oppose abortion. Opponents contend, however, that ANDA would impose serious restrictions on a woman’s

¹⁴ 42 U.S.C. § 1395w-22(j)(3)(A); 42 U.S.C. 1396u-2(b)(3)(A).

¹⁵ 42 U.S.C. § 1395w-22(j)(3)(B); 42 U.S.C. 1396u-2(b)(3)(B).

¹⁶ Despite the new exemptions regarding the provision of counseling and referral or abortion-related services, programs funded by Medicaid are nevertheless required to provide family planning services to their clients, either directly or through referral and payment to other providers. 42 U.S.C. § 1396d(a)(4)(C).

¹⁷ S. 350, 110th Cong. (2007); S. 1983, 109th Cong (2005); H.R. 3664, 108th Cong. (2003); S. 1397, 108th Cong. (2003); H.R. 4691, 107th Cong (2002); S. 2008, 107th Cong. (2002).

access to abortion. Critics also argue that ANDA would allow providers to drop abortion coverage not only for moral or religious reasons, but also for financial reasons, such as the desire to save money by reducing coverage.¹⁸

Although ANDA has not been considered by recent Congresses, conscience clause provisions with similar language were inserted in the FY2005, FY2006, and FY2008 appropriations measures for the Departments of Labor, HHS, and Education.¹⁹ These provisions are commonly referred to as the Weldon Amendment because they were added to the FY2005 appropriations measure following the adoption of an amendment offered by Representative Dave Weldon. The language used in the appropriations measures has remained the same since 2004. The provisions state:

None of the funds made available in this act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.²⁰

The Weldon Amendment defines the term “health care entity” to include “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.”²¹

The Weldon Amendment prevents the federal government and state and local governments from enacting policies that require health care entities to provide or pay for certain abortion-related services. In addition, the Weldon Amendment increases both the number and type of health care providers and professionals who could refuse to provide abortion training or services without reprisals. For example, prior law protected only individual doctors or medical training programs that did not provide abortions or abortion training, and appeared to apply primarily in the medical education setting or to doctors in their individual practices. In contrast, the appropriations provisions allow large health insurance companies and HMOs to refuse to provide coverage or pay for abortions. Because an HMO’s refusal to provide abortion-related services would affect a much larger number of patients than an individual doctor’s refusal to provide such services, the Weldon Amendment has

¹⁸ Reuters, *House Votes Hospitals May Avoid Abortions*, N.Y. Times, September 25, 2002, at A26.

¹⁹ See P.L. 108-447, div. F, § 508(d), 118 Stat. 2809, 3163 (2004); P.L. 109-149, § 508(d), 119 Stat. 2833, 2879 (2005); H.R. 2764, 110th Cong., div. G, § 508(d) (2007). Appropriations for FY2007 were provided pursuant to H.J. Res 20, the Revised Continuing Appropriations Resolution, 2007, 110th Cong. (2007), and were subject to the same conditions that applied to FY2006 funds.

²⁰ P.L. 108-447, div. F, § 508(d)(1), 118 Stat. 2809, 3163 (2004); P.L. 109-149, § 508(d)(1), 119 Stat. 2833, 2879-80 (2005); H.R. 2764, 110th Cong., div. G, § 508(d)(1) (2007).

²¹ P.L. 108-447, div. F, § 508(d)(2), 118 Stat. 2809, 3163 (2004); P.L. 109-149, § 508(d)(2), 119 Stat. 2833, 2880 (2005); H.R. 2764, 110th Cong., div. G, § 508(d)(2) (2007).

the potential of denying abortion-related services to a significantly expanded number of individuals.

Although the Weldon Amendment language is similar to the proposed ANDA, it differs in two important respects. First, ANDA would deny all federal funds to entities that engage in abortion-related discrimination. The Weldon Amendment, however, denies only those funds available under the annual Labor, HHS, and Education appropriations measure. Second, the passage of ANDA would result in permanent legislation, while the Weldon Amendment language remains in effect for only the relevant fiscal years. Thus, although the Weldon Amendment expands prior law, it provides for smaller penalties and is temporary in nature.

Proposed Conscience Regulations

On August 26, 2008, HHS published a proposed rule to implement the Church Amendment, Section 245 of the PHSA, and the Weldon Amendment. HHS indicates that new regulations are needed because the “public and many health care providers are largely uninformed of the protections afforded to individuals and institutions” under the federal conscience clause laws.²² In addition, the agency maintains that the development of a health care environment that is intolerant of certain religious beliefs and cultural traditions “may discourage individuals from diverse backgrounds from entering health care professions.”²³

The proposed regulations identify requirements and prohibitions for recipients of HHS funds. While these provisions are in many ways a reiteration of the statutory requirements and prohibitions, some argue that they would expand the reach of the conscience clause laws and possibly jeopardize the health of individuals by making it more difficult to obtain health care services and information.²⁴ These concerns would appear to be highlighted by some of the new definitions proposed by HHS for relevant terms. For example, the definitions for the terms “Health Service/Health Service Program” and “Assist in the Performance” seem to be broad enough to encompass a variety of activities. Such breadth could result in increased opportunities to refuse participation in the delivery of care or information.

The term “Health Service/Health Service Program” would be defined to include “any plan or program that provides health benefits, whether directly, through

²² Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 50,274, 50,276 (Aug. 26, 2008) (to be codified at 45 C.F.R. pt. 88) (hereinafter referred to as “Conscience Regulations”).

²³ *Id.*

²⁴ See, e.g., Comments from Am. Civ. Liberties Union to U.S. Dept. of Health and Hum. Services 3 (Sept. 25, 2008), available at [http://www.aclu.org/images/asset_upload_file467_36942.pdf] (“[T]he expansion of the refusal statutes and the confusion caused by the Proposed Rule comes at the expense of the public’s health, particularly the health of low-income women.”).

insurance, or otherwise, which is funded, in whole or in part, by [HHS].”²⁵ In the background section of the proposed rule, HHS indicates that it would construe the term broadly:

Building on this broad definition, we propose that the term ‘health service program’ should be understood to include an activity related in any way to providing medicine, health care, or any other service related to health or wellness, including . . . health insurance programs where federal funds are used to provide access to health coverage (e.g., SCHIP, Medicaid, and Medicare Advantage). Similarly we propose that the term ‘health service’ means any service so provided.²⁶

A broad understanding of the term could possibly lead to more individuals declining to provide health services or perform part of a health service program.

Under the proposed 45 C.F.R. § 88.4(d)(1), any entity that carries out any part of any health service program funded in whole or in part under a program administered by HHS could not require any individual to perform or assist in the performance of any part of the health service program if such service or activity would be contrary to his religious beliefs or moral convictions.²⁷ If the term “health service” is understood to include activities related in any way to providing medicine, it seems possible that the distribution of oral contraceptives could be affected.²⁸ Chain and independent pharmacies are, in fact, identified by HHS as entities that would be subject to the agency’s proposed certification requirements.²⁹

The term “Assist in the Performance” would be defined by the proposed regulations to mean “to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity, so long as

²⁵ Conscience Regulations at 50,282.

²⁶ *Id.* at 50,278.

²⁷ *Id.* at 50,283.

²⁸ If a final rule is promulgated with few changes to the definition of the term “Health Service/Health Service Program,” it may be necessary for a court to determine ultimately whether the definition encompasses the distribution of contraceptives. Although Michael O. Leavitt, the Secretary of HHS, has not discussed specifically the term “Health Service/Health Service Program,” he has been reported as stating that some medical providers may want to “press the definition” and argue that some contraceptives are tantamount to abortion. See Stephanie Simon, *Rules Let Health Workers Deny Abortions — Regulation’s Effect on Contraception Remains Unclear*, Wall St. J., Aug. 22, 2008, at A3.

²⁹ Conscience Regulations at 50,284. Under the proposed regulations, recipients and sub-recipients of HHS funds would be required to certify that they will not discriminate on the basis of past involvement in, or refusal to assist in the performance of an abortion or sterilization, and will not require involvement in procedures that violate an individual’s conscience as part of any health service program in accord with all applicable sections of 45 C.F.R. part 88.

the individual involved is a part of the workforce of a Department-funded entity.”³⁰ In the background section of the proposed rule, HHS indicates that it “proposes to interpret this term broadly, as encompassing individuals who are members of the workforce of the Department-funded entity performing the objectionable procedure.”³¹ Employees who clean the instruments used in a particular procedure, for example, would be considered by HHS to assist in the performance of that procedure.³²

Opponents of the proposed regulations have criticized the possible breadth of the term “Assist in the Performance.” Some have argued that the definition could provide conscience protections to seemingly tangential employees, such as staff members tasked with scheduling appointments, and others involved with purchasing and inventorying supplies.³³ While the use of the word “reasonable” in the definition for “Assist in the Performance” would seem to suggest a common sense approach to determining who would be covered within the definition, the agency’s stated intention to interpret the term broadly could, in fact, provide such employees with conscience protections.

The comment period for the proposed rule ended on September 25, 2008. It appears that at least 2,074 comments were received by HHS prior to the end of the comment period.³⁴ The agency is expected to review the comments and make a decision about whether to issue a final rule.

³⁰ *Id.* at 50,282.

³¹ *Id.* at 50,277.

³² *Id.*

³³ See Comments from Guttmacher Inst. to U.S. Dept. of Health and Hum. Services 4 (Sept. 24, 2008), *available at* [<http://www.guttmacher.org/media/resources/2008/09/24/GuttmacherInstitute-re-ConscienceRegulation.pdf>].

³⁴ Information on the comments received by HHS is available at [<http://www.regulations.gov/fdmspublic/component/main?main=DocketDetail&d=HHS-OS-2008-0011>]. Additional concerns about the proposed regulations, including the possible conflict between the regulations and the provision of family planning services under Title X of the Public Health Service Act, have been expressed in the comments.