

EXHIBIT 7

Comments by the American Psychiatric Association



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August 9, 2019

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Secretary Alex Azar
U.S. Department of Health and Human Services
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington DC 20201

**RE: Nondiscrimination in Health and Health Education Programs or Activities –
Docket No.: HHS-OCR-2019-0007**

Altha J. Stewart, M.D.
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Dear Secretary Azar,

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On behalf of the American Psychiatric Association (APA), a national medical specialty society representing more than 38,500 physicians specializing in psychiatry, we are writing in response to the Department of Health and Human Services' (HHS or the Agency) proposed rule, *Nondiscrimination in Health and Health Education Programs or Activities*¹, as published in the Federal Register on June 14, 2019. We appreciate the opportunity to comment on this important proposal and focus our comments on the potential negative impacts it may have on health outcomes and patients' mental health.

Background

Franciscan Alliance v. Azar enjoined the implementation of a regulation that would define "on the basis of sex" to include gender identity and termination of pregnancy. The court then granted HHS a remand and stay in order to allow the Agency to correct the problem the court identified.² In the proposed rule, HHS deleted the definition of "on the basis of sex," which had included gender identity and termination of pregnancy and altered the definition of covered entities. As a result, the proposed rule will now encourage discrimination in all facets of health care against gender diverse people and women.

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Recorder

The Agency and this Administration do not intend that health care providers should have carte blanche to engage in rank discrimination against entire classes of people

Administration
Saul Levin, M.D., M.P.A.
CEO and Medical Director

¹ Notice of Proposed Rulemaking, "Nondiscrimination in Health and Health Education Programs or Activities," Federal Register, Vol. 84, No. 115, Friday, June 14, 2019, pgs. 27846-27895.

² The issues of whether discrimination "on the basis of sex" includes gender identity and sexual orientation is currently under consideration by the United States Supreme Court in the combined cases *Altitude Express Inc. v. Zarda*, *Bostock v. Clayton County, GA*, and *R.G. & G.R. Harris Funeral Homes Inc V EEOC*. These cases will consider the issue in the context of Title VII.

with whom they disagree under the cloak of religious freedom. The plaintiffs in *Franciscan Alliance* made it clear that the religious objection was to providing the *service* or *procedure* that is in contrast to their religious beliefs, and **not** to the patient as a person. Thus, plaintiffs challenging provision of gender transition and abortion services recognized the obligation to treat transgender individuals and women who had terminated a pregnancy for “health issues ranging from the common cold to cancer,” but stopped short of providing transition related services and abortions. This limit on the claim to religious or conscientious objection is a basic and well-understood tenant of our law:

- HHS explicitly recognized a concern “that the proposed regulation could serve as a pretext for health care workers to claim religious beliefs or moral objections....in order to discriminate against certain classes of patients, including illegal immigrants, drug and alcohol users, patients with disabilities or patients with HIV, or on the basis of race or sexual preference.” 73 Fed. Reg. at 78,079 -80 (2008). It clarified that the regulation was not intended to permit unlawful discrimination on any basis, for “the health care provider conscience protection provisions have existed in law for many years, and this regulation only implements these existing requirements. As a result, there is nothing in this regulation that newly permits” discrimination against categories of individuals based on their individual characteristics for any reason (including, e.g., on the basis of race, color, national origin, disability, age, sex, religion, or sexual preference). 73 Fed. Reg. at 78,080 (2008).
- In 2011, an HHS action rescinded much of the 2008 Federal Health Care Conscience Rule, at least in part, as a response to litigation that was filed contesting it. The 2011 issuance made clear that the “conscience statutes were intended to protect health care providers from being forced to participate in *medical procedures* that violated their moral and religious beliefs. They were never intended to allow providers to refuse to provide medical care to an individual because the individual engaged in behavior the health care provider found objectionable.” 76 Fed. Reg. at 9,973-74 (emphasis added).

Because the proposed rule does not clarify the limitation of the religious and conscience objection to providing the *procedure or service* related to abortion, gender identity or sexual orientation, it may empower providers to refuse **any** health care service or information to entire classes of people even if the health care sought is unrelated to the religiously objectionable procedure. **By eliminating the definitions of terms such as “on the basis of sex” and changing the definition of “covered entity,” without making it clear that discrimination against entire classes of individuals for all health services is unlawful, this rule opens to the door to discrimination against vulnerable Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) and female patients, placing them at-risk of serious or life-threatening results in emergency situations.** The Agency cannot mean that people who have had abortions or who are LGBTQ should be lawfully denied access to treatment for cancer, heart disease or mental illness because someone with a religious belief does not think they are worthy of basic health care. Health care providers need clear instruction on what is and is not a permissible refusal to treat a patient under the guise of religious freedom.

Impact on Gender Diverse Patients

As written, the proposed rule would roll back the current definition of sex discrimination, that includes gender identity and sex stereotyping. This policy change would allow providers to refuse to treat LGBTQ patients, further endangering access to care for an already-vulnerable patient population. Additionally, if

implemented, the proposed rule would allow covered entities, such as insurers, to deny, limit, and impose additional cost-sharing for gender-specific services (such as cervical cancer screenings for women) or services related to gender transition (such as hormone therapy, mental health counseling, and surgeries) that a transgender patient may seek. As physician experts, we know that appropriately evaluated transgender and gender diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.³ It is our official policy to oppose categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.

We are especially concerned about the rule’s potential to exacerbate health disparities among LGBTQ patients. There is ample evidence that patients in protected classes (e.g. LGBTQ patients) are already hesitant to seek medical and mental health care and that discriminatory policies have detrimental mental health and medical impacts on the population subject to discrimination.⁴ Despite the need for health services, half of gender minorities educate their own providers about necessary care and 20 percent report being denied care.^{5,6} The literature on the “minority stress model” highlights the impact of social prejudice, isolation and invisibility as the primary factors leading to an increased health burden and greater risk of mental health issues, homelessness and unemployment.⁷ Research shows that LGBTQ patients have many of the same health concerns as the general population, but they experience some health challenges at higher rates, and face several unique health challenges shaped by a host of social, economic, and structural factors. LGBTQ individuals are two and a half times more likely to experience depression, anxiety, and substance misuse. These patients also experience higher rates of sexual and physical violence against them as compared to their heterosexual counterparts.⁸ Like other minority groups, transgender individuals are more likely to experience prejudice and discrimination in multiple areas of their lives (e.g., employment, housing, school, healthcare), which exacerbate these negative health outcomes and makes access to appropriate medical care all the more important. Due to their limited access to care, transgender patients have significantly increased rates of mental disorders, substance use, and suicide,⁹ while the risk of physical conditions is also intensified with increased rates of

³ American Psychiatric Association. Position Statement on Access to Care for Transgender and Gender Diverse Individuals (2018). <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf>

⁴ Hatzenbuehler ML, McLaughlin KA, Keyes KM, Hasin DS. 2010. The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: a prospective study. *Am J Public Health.* 100(3): 452 - 459.

⁵ Grant JM, Lisa A, Mottet Justin, Tanis Jack, Harrison Jody, Herman L, Keisling Mara. Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC; National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.

⁶ Sandy James et al., 2015 U.S. Transgender Survey 11, 12, 14 (2016), <http://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF>

⁷ Ilan Meyer. “Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence” *Psychological Bulletin.* 2003 Sep; 129(5): 674–697.

⁸ Jen Kates et al., “Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.” August 2017.

⁹ Agnes Gereben Schaefer et al., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, RAND Corporation (2016).

tobacco use, HIV and AIDS, and weight problems.¹⁰ **We urge the Administration to remove barriers to care and support evidence-based coverage for medical care, which would help the mental well-being of gender diverse individuals.**

Impact on Women's Access to Care

The proposed rule would expand abortion exemptions by incorporating blanket exemptions from Title IX and including intentionally broad language to incorporate future abortion exemptions. While the existing regulation already includes exemptions derived from federal statutory protections for religious freedom and conscience, broadening the language to include exemptions beyond abortion services could have a dangerous effect on women's access to care. In essence, this language would allow a provider to turn away a patient from any health service if they previously sought an abortion, simply because having an abortion violates the provider's religious beliefs. As the U.S. continues to see rising maternal mortality rates,¹¹ enabling providers to turn patients away could worsen health outcomes for women and lead to higher health costs. In rural communities, where women experience poorer health outcomes and have even more limited access to health care,¹² these expanded exemptions could be particularly devastating. **APA opposes governmental restrictions on family planning and abortion services¹³ and as such, recommends that the Administration not expand abortion exemptions.**

Broader Implications for Health Costs and Mental Health

As the frontline physicians providing treatment for mental illness and substance use disorders, our goal is to ensure that all patients have access to effective treatment and receive care that is compassionate to their individual needs. According to the most recent National Survey on Drug Use and Health, 80.7 percent of people aged 12 or older who needed substance use treatment at a specialty facility did not receive it. In addition, 57.4 percent of adults with any mental illness did not receive mental health care.¹⁴ The indirect cost of untreated mental illness to employers is estimated to be as high as \$100 billion a year in the U.S. alone.¹⁵ Ethnic/racial minorities often bear a disproportionately high burden of disability resulting from mental disorders. Lack of cultural understanding by health care providers may contribute to underdiagnosis and/or misdiagnosis of mental illness with language differences between patient and

¹⁰ Sari Reisner et al., Global Health Burden and Needs of Transgender Populations: A Review. *The Lancet*, 388, 412-436.

¹¹ MacDorman, M., Declercq, E., Cabral, H., Morton, C., "Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues: Short title: U.S. Maternal Mortality Trends." *Obstet Gynecol.* 2016 Sep; 128(3):447-55.

¹² American College of Obstetricians and Gynecologists. "Health Disparities in Rural Women" (2014). <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20190730T0304131196>

¹³ American Psychiatric Association. Position Statement on Abortion (2018). <https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Abortion.pdf>

¹⁴ Center for Behavioral Health Statistics and Quality. (2018). 2017 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.

¹⁵ Finch, R. A. & Phillips, K. (2005). An employer's guide to behavioral health services. Washington, DC: National Business Group on Health/Center for Prevention and Health Services. Available from: www.businessgrouphealth.org/publications/index.cfm

provider being a contributing factor. Lack of coverage, limited access to culturally competent providers, distrust in the health care system, and stigma are additional main barriers to accessing effective care for diverse populations.

For this reason, **we oppose the Agency's proposal to eliminate requirements for covered entities to provide non-discrimination notices and grievances procedures. In addition, we oppose the proposal to eliminate the standards ensuring access to language assistance services, including oral interpretation and written translation, for individuals with limited English proficiency.** As an organization, we train physicians to deliver culturally competent care to serve the needs of evolving, diverse, underrepresented patient populations. Clear communication is essential to delivering quality care and these provisions would undermine necessary efforts to reduce disparities in mental health care.

A rule that would allow health care workers to deny any health care services to transgender individuals or women who have terminated a pregnancy and scales back patient protections for underserved patients will only exacerbate existing problems of access. While the proposal boasts cost savings, the proposed rule will result in higher health care costs and mortality rates, a less productive workforce, and an increased need for already scarce mental health and substance use services. It is important for us to work together to address these challenges to reduce the burden of mental health and substance use issues on patients, their families, communities, and the government. Religious freedoms can be respected without jeopardizing the basic health needs of a substantial portion of the population. We must also ensure that we do not exacerbate the need for services by adding barriers, such as discrimination or fear of discrimination against people in need of treatment. **Thus, we strongly urge the Administration to rescind this proposed rule to ensure that all patients have access to care without fear of discrimination.**

Thank you for the opportunity to offer our expertise. If you have any questions, please contact Kathy Orellana, Associate Director of Practice Management Policy, at korellana@psych.org or at 202-559-3911.

Best,

A handwritten signature in black ink that reads "Saul Levin, MD, MPA". The signature is written in a cursive style.

Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director