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March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington DC 20201

RE: Department of Health and Human Services, Office for Civil Rights RIN 0945-ZA03; (Docket HHS-OCR-2018-0002)

Dear Mr. Severino:

On behalf of the American Psychiatric Association (APA), a national medical specialty society representing more than 37,800 physicians specializing in psychiatry, we are writing in response to the Department of Health and Human Services' (HHS) proposed rule, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, as published in the Federal Register on January 26, 2018. We appreciate the opportunity to comment on this important proposal and focus our comments on certain negative impacts it may have on health outcomes and patients' mental health, if not amended to clearly express its limitations.

As the frontline physicians providing treatment for mental illness and substance use disorders, our goal is to ensure 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, 89.4 percent of people aged 12 or older who needed substance use treatment at a specialty facility did not receive it. In addition, 56.9 percent of adults with any mental illness did not receive mental health care.[1] An untreated mental illness leads to increased incarceration rates (jails are the single largest mental health facilities in the United States), homelessness, and medical services.[2,3,4] 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.[5] Lack of coverage, limited access to providers, and stigma are among the main barriers to accessing care. It is important for us to work together to

[1] Center for Behavioral Health Statistics and Quality. (2017). 2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration, Rockville, MD.
[2] Steadman, Henry, et al., "Prevalence of Serious Mental Illness among Jail Inmates." Psychiatric Services 60, no. 6 (2009): 761–765.
[3] Swanson, Jeffery, et al., Costs of Criminal Justice Involvement in Connecticut: Final Report (Durham: Duke University School of Medicine, 2011).
[4] Angela A. Aidala and William McIlister, "Frequent Users Service Enhancement 'FUSE' Initiative," New York City FUSE II (2014).
[5] 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

address these challenges to reduce the burden of mental health and substance use issues on patients, their families, and the government. 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.

The APA's chief concern is that the proposed rule, if not clarified, may be inappropriately misinterpreted or misapplied by health care professionals to condone or permit discrimination against entire classes of vulnerable patient populations resulting in reduced access to health services. The regulation purports, among other things, to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes. Each of these statutes refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization *procedures*. They do not permit discrimination against patients for their individual characteristics. In other words, the amendments allow a physician to refuse to perform an abortion, but the same physician cannot refuse other treatment because the woman had an abortion.

The wording of the regulation is not clear on these limited circumstances and creates the possibility of an overly broad misinterpretation that goes far beyond what the statutes permit. For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions." Even though longstanding legal interpretation applies this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity could encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* health care service or information for a religious or moral reason.

Previous regulations and court cases dictate that the rule may not be used in such a discriminatory manner and the rule should clearly state and convey to health providers the established limitations of the regulation. Specifically:

- HHS explicitly recognized in 2008 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. 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**.**
- 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.

- Discriminating against an individual in the provision of health care services in general is an action that would be "outside the scope of the health care provider conscience protections. Those laws protect health care workers' conscience rights with respect to particular actions or activities, not with respect to an individual's characteristics that are protected by federal law." 73 Fed. Reg. at 78,080. If a decision to deny health care "is being made based on an individual's characteristics that are federally protected, that is impermissible." Fed. Reg. at 78,084.
- The authority of administrative agencies is constrained by the language of the statutes they administer. When it engages in rule making, an agency's interpretation of the statutory provision it administers must be reasonable and consider all important aspects of the issue. *See Chevron v. Natural Resources Defense Council*, 467 US 837 (1984). The agency must always stay within the bounds of its statutory authority. *City of Arlington, Tex. V. F.C.C.,* 569 US 290, 297 (2013).
- Protections for religious conscience in the realm of health care do not provide a shield for persons or entities who might cloak illegal discrimination as a religious practice and the government has compelling interest to prohibit any such discrimination. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751, 2783 (June 30, 2014).

Accordingly, the regulation should make it clear that religious conscience objections are limited to procedures that are contrary to the health care workers established religious doctrines, and do not allow discrimination against entire classes of individuals whose actions the religious doctrine may not condone. Accommodations should also be made for patients in emergency situations and those living in rural areas. For example, a woman with a complicated pregnancy or in areas where access to health care is limited. Likewise, any notice displayed in healthcare facilities should be required to inform patients and the workforce that **healthcare providers and facilities can refuse to perform procedures for any patient on the basis that the procedure violates the religious or conscious beliefs of the provider, but health care providers may not otherwise discriminate or refuse to provide health care to any individual based on sex, race, color, age, national origin, religion, disability, sexual orientation, gender identity, citizenship, pregnancy or maternity, veteran status, or any other status protected by applicable national, federal, state or local law. Information should also be made available to patients about where they may receive health procedures being refused and the location of such services.**

Without such clear limitations, notices may be broadly interpreted by patients and health care providers alike to permit discrimination against people based upon their protected class, which will interfere with the physician-patient relationship, foster distrust, and negatively impact patient outcomes. There is ample evidence that patients in protected classes are already hesitant to seek medical and mental health care, e.g. LGBTQ patients, and that discriminatory policies have detrimental mental health and medical

impacts on the population subject to discrimination.[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. Additionally, these patients experience higher rates of sexual and physical violence against them as compared to their heterosexual counterparts.[8] Among transgender patients, the risk of physical conditions is also exacerbated with increased rates of tobacco use, HIV and AIDS, and weight problems. Despite the need for health services, half of gender minorities educate their own providers about necessary care and 20 percent report being denied care.[9,10,11] Such discrimination and discouraging use of the health care systems by entire categories of individuals cannot be condoned by the federal government under the guise of a conscience statute and regulations need to clearly preclude such unlawful discrimination.

All patients should be treated with dignity and respect and have access to care without fear of discrimination. **Accordingly, we urge you to clarify that nothing in the law or the rule, which permits conscience and religious objection to performing abortion and sterilization procedures inimical to a health care provider's established religious beliefs, should be construed to permit discrimination in the provision of health care services based on sex, race, color, age, national origin, religion, disability, sexual orientation, gender identity, citizenship, pregnancy or maternity, veteran status, or any other status protected by applicable national, federal, state or local law.**

Thank you again for the opportunity to respond to the proposed rule. If you have questions, please contact Kristin Kroeger, APA's Chief of Policy, Programs, and Partnerships, at kkroeger@psych.org.

Sincerely,

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

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[6] 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.
[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] 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.
[10] 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
[11] Sari Reisner et al., Global Health Burden and Needs of Transgender Populations: A Review. *The Lancet*, 388, 412-436.